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MENTAL HEALTH CARE IN AMERICA: ADDRESSING ROOT CAUSES AND IDENTIFYING POLICY SOLUTIONS

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MENTAL HEALTH CARE IN AMERICA: ADDRESSING ROOT CAUSES AND IDENTIFYING POLICY SOLUTIONS

TUESDAY, JUNE 15, 2021

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:10 a.m., via Webex, in Room SD–215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Cantwell, Carper, Cardin, Bennet, Casey, Warner, Whitehouse, Hassan, Warren, Crapo, Grassley, Thune, Portman, Cassidy, Daines, Young, and Sasse.

Also present: Democratic staff: Eva DuGoff, Senior Health Advisor; Marisa Dowling, Health Policy Fellow; and Kristen Lunde, Health Policy Advisor. Republican staff: Kellie McConnell, Health Policy Director; Gregg Richard, Staff Director; and Stuart Portman, Senior Health Policy Advisor.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Senate Finance Committee will come to order. The Finance Committee meets this morning to discuss mental health care in America, and this issue certainly ought to bring Democrats and Republicans together, starting with a single, clear lodestar. That lodestar is: every American must have mental health care when they need it.

The shameful reality is, the United States does not come close to meeting that bar today. Multiple Federal laws say that mental health care is supposed to be on a level playing field with physical health care. In practice, however, the system still reflects the dangerous, outdated stigma against recognizing and treating mental illness. And that is why millions of Americans are now falling between the cracks.

For someone with a mental illness, it can often be nearly impossible to find a provider who can meet your needs, or one who accepts insurance, particularly in rural communities or communities of color. Insurance claims often get denied or cut off too quickly, particularly for those experiencing homelessness. The outcome of a mental health crisis is often incarceration instead of treatment.

Prior to the pandemic, one in five Americans was living with mental illness. All the evidence suggests that the pandemic is add-

ing to that crisis. The proportion of Americans reporting symptoms of anxiety or depression has nearly quadrupled.

On Friday, the Centers for Disease Control and Prevention released a new report finding that, over the last year, suicide attempts among teenaged girls were up more than 50 percent. Meanwhile, studies that the Government Accountability Office conducted at our request found that many provider offices closed or cut staff during the pandemic, and then too many patients were turned away.

So, there is a lot for this committee to work on on a bipartisan basis. There are a few key challenges.

First, the country clearly needs a larger mental health workforce. There simply are not enough providers, whether psychiatrists or therapists or staff in inpatient facilities. For example, due to a major staffing shortage, the psychiatric hospital in my home State of Salem, OR, is currently being staffed by members of the Oregon National Guard. That is in the State Capitol where there are people and resources to focus on the issue. Many other communities have it far worse. More than one in three Americans lives in an area with a serious shortage of mental health-care professionals.

Second, insurance companies must not be allowed to cut corners when it comes to mental health coverage. I hear about this issue constantly at town hall meetings. People describe having their claims denied. In other cases, insurance only covers a portion of the treatment that people need. Furthermore, it does not make any sense to leave somebody experiencing a true mental health crisis waiting for a green light from an insurance company before they can get treated.

Third, clearly the committee has a big challenge to address racial inequities in mental health care. Black and Latino Americans are roughly half as likely as white Americans to receive treatment for mental illness. Suicide rates are much higher among black kids. There are not enough black, Latino, and Native American mental health providers. So this is a question of equity, and we have a long way to go.

Finally, the committee ought to build on recent telehealth. For example, early in the pandemic this committee led the fight to get Medicare to cover mental health services via telehealth. In December, the Congress made that permanent. I believe that is going to be a game changer, particularly for seniors who live in rural areas, and it is going to work in traditional Medicare as well.

My colleagues all know that so many of our reforms have helped, particularly with Medicare Advantage and other programs where there is coordinated care, but we have to make sure traditional Medicare is afforded these benefits as well.

Finally, Senator Stabenow has been a champion of mental health-care treatment, and I have watched for years as she has led the effort to bring Certified Community Behavioral Health Clinics, a program that she battled for and created, to American communities. These clinics are up and running now in 40 States, including Oregon. It is an approach that works and meets major needs.

I believe the Congress ought to look at ways to build on the success that my colleague has led, and we should also note again the bipartisan route, because I cannot tell Senators how often I have

seen Senator Stabenow and Senator Blunt huddled in intense discussions about how they are going to expand this.

Finally, the Congress also passed a big down payment for pioneering a new approach on mental health services and law enforcement. It is called the CAHOOTS program. It originally comes from Eugene—Eugene, OR—where I went to law school. But it is expanding now all over the country.

Essentially what happens with this approach is, you have a 911 call with somebody experiencing a mental health crisis. And at that point, the mental health-care professionals and the law enforcement in these communities have essentially teamed up and figured out a way to actually meet the needs of the patient and the community.

So, in many instances, these are joint efforts of the mental health professionals and law enforcement—a team, a coalition approach. In Oregon, I have talked to the police officials in Eugene, the mental health professionals in Eugene, and very often the response—and they both have kind of worked up a system to do the right thing—is to use mental health professionals rather than law enforcement. And law enforcement, to their credit, is saying that they want to do that, and often the mental health professionals are the right response.

The American Rescue Plan included a billion-dollar payment to help States build on their own programs, and I think we ought to look at what else ought to be done.

The last point I will make—and Dr. Cassidy is here, and he has great expertise in this area. Colleagues, this is an enormous challenge, and I think it is natural for Democratic and Republican members of this committee to step up and shape a major response that we can take to the full Senate. I look forward to working with all my colleagues.

Senator Crapo?

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you very much, Mr. Chairman. I appreciate you holding this hearing, and I agree with your comments that this is an issue that deeply needs good solutions, and on which we can build strong bipartisan solutions that work. And I look forward to working with you, Senator Stabenow, and all the others that you have mentioned, on these issues.

Ensuring access to high-quality mental health services has been and must continue to be a priority. Far too often, individuals with mental health, addiction, or substance abuse disorders find themselves isolated from their communities and separated from their providers. While Congress has taken decisive steps to address addiction, bolster behavioral health care, and curb substance abuse disorders, challenges remain. This committee has the ability to turn the tide. We can begin by empowering States to craft innovative, targeted solutions. Medicaid functions most effectively when States have the flexibilities they need to address patients' unique care needs and adapt to unforeseen circumstances.

As the Nation's largest payer of mental health and substance abuse disorder services, Medicaid must support rather than subvert State efforts to serve communities in need. Unfortunately, the COVID–19 pandemic has highlighted and exacerbated the mental and behavioral health challenges we continue to confront.

Loss of loved ones, increased isolation, and delayed treatment prompted a spike in anxiety, depression, and other debilitating conditions. While many are returning to their pre-pandemic lives, we should not be content to allow our mental health-care delivery system to revert to its pre-pandemic ways.

Whether for rural communities, urban areas, or tribes, telehealth has undoubtedly increased access to care. Through emergency flexibilities and permanent legislation authored by this committee late last year, we have taken crucial first steps toward modernizing telehealth coverage. I look forward to working with you, Mr. Chairman, and the other members of this committee to build on those efforts in the months ahead.

Further, by partnering with State and local leaders, we can spur care coordination, strengthen the mental health workforce, and drive value through delivery system reforms. While there is no silver bullet here, I am confident we can tackle all of these challenges while upholding core principles of fiscal responsibility and program integrity.

Before concluding, it bears emphasizing that we must continue to make progress in improving understanding of mental health so that people in need are not afraid or ashamed to seek treatment. We cannot discount the impact of stigma on preventing those in need of treatment from receiving care.

I look forward to hearing our witnesses' testimony today, and I appreciate each of you coming here to share your expertise and ideas about how we can achieve these objectives.

Thank you very much.

[The prepared statement of Senator Crapo appears in the appendix.]

The CHAIRMAN. Thank you, Senator Crapo.

We have four terrific witnesses. The one who will testify first—and I think we will do the introductions, because colleagues are juggling a lot this morning—is Dr. Miller. And Senator Bennet will give the introduction for Dr. Miller. And we will introduce all our witnesses, and then we will hear their testimony.

OPENING STATEMENT OF HON. MICHAEL F. BENNET, A U.S. SENATOR FROM COLORADO

Senator BENNET. Thank you, Mr. Chairman. I would like to thank you and Senator Crapo for holding this important hearing. From the perspective of Colorado, it could not come soon enough. In my calls with parents and teachers over the past year, the number one issue has been mental health.

Over the years, the person my office has turned to for advice on these issues is Dr. Benjamin Miller, one of our witnesses today. Dr. Miller is one of the country's foremost experts on mental health. Today he serves as the chief strategy officer for Well Being Trust, a national foundation dedicated to advancing a more holistic approach to the health of every American.

In his early training, which included a doctorate from Spalding University and post-doctoral roles at the University of Colorado and the University of Massachusetts, Dr. Miller saw firsthand how America's inattention to mental health inflicts a terrible cost on our society, from our schools to our foster care, health-care, and criminal justice systems.

Dr. Miller has not just studied these issues in the academy, he has worked on them firsthand in our communities. He has helped emotionally disturbed children make it through school, cancer patients cope with difficult diagnoses, and prisoners plan their reintegration into society. He has also trained physicians to better handle their patients' mental health. These issues are not abstractions for him, they are real people whose lives have directly benefited from greater attention to their mental health.

I know Dr. Miller from his time at the University of Colorado, where he led the University's Health Policy Center for 6 years and was an invaluable resource to my team. During his time at the Center, Dr. Miller led a breakthrough project demonstrating the cost savings of integrating mental health with primary care. That project saved over $1 million for Medicare and Medicaid beneficiaries in Colorado by significantly reducing hospitalizations and other medical needs down the road.

As health-care costs in this country continue to rise, I think the committee has a lot to learn from Dr. Miller's experience and expertise. I could spend the next 5 minutes listing the numerous awards and appointments he has earned over the years, but let me instead conclude by thanking Dr. Miller for joining us today, especially since he is supposed to be on vacation right now with his wife and two daughters. We are grateful for Dr. Miller's time, and for his service to Colorado and the country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

The next witness will be from Oregon, Chantay Jett, who is the executive director of Wallowa Valley Center for Wellness in Enterprise, OR. It is a small community—I have been there often—in rural eastern Oregon. And as is the case for so many people I have the honor to represent, she is the bionic woman. She is basically everywhere, colleagues.

She has worked in the Wallowa River House, a residential treatment facility for folks in Oregon afflicted with severe mental illness. She has been an outpatient mental health clinician. She is a pillar of the community. I remember recently—we have sessions in schools called "Listening to the Future." Chantay was there. And she holds a master's degree in psychology with a child, couple, and family emphasis; a bachelor's degree in business administration; and she also worked with children in the inpatient psychiatric unit at Children's Hospital.

Chantay, thank you for making the long journey from rural Oregon. We are so glad you are here. I know the committee is going to appreciate hearing from you.

Next we will have Dr. Durham, a great advocate for patients and those facing health challenges. Senator Elizabeth Warren is, I believe, online and she can introduce Dr. Durham.

Senator Warren, are you out there in cyberspace?

OPENING STATEMENT OF HON. ELIZABETH WARREN, A U.S. SENATOR FROM MASSACHUSETTS

Senator WARREN. I am. Thank you very much, Chairman Wyden, Ranking Member Crapo. Thank you for having this hearing today.

I have the privilege of introducing Dr. Michelle Durham of Massachusetts. She has agreed to speak to the committee today about the importance of expanding access to mental health services all across our country.

Dr. Durham currently works as a pediatric and adult psychiatrist at Boston Medical Center. Now, BMC is the largest safety-net hospital in New England, and it is also an academic medical center that is located in the heart of Boston. And it is an amazing place. Most of BMC's patients are low-income or from underserved populations. About half are covered by Medicaid. Throughout the COVID–19 pandemic, providers at Boston Medical Center, including Dr. Durham, have gone above and beyond to get patients the health-care services that they need. Our communities owe a great debt to the folks at BMC.

At BMC, Dr. Durham serves as the vice chair of education in the Department of Psychiatry. She also has a joint appointment as assistant professor of psychiatry at Boston University School of Medicine, and she runs the training program for BMC's general psychiatry residency program.

As you say, Chair Wyden, this is another woman who is everywhere. Throughout her career, Dr. Durham has been a tireless advocate of health, equity, and mental health. And she is the associate director of BMC's Global and Local Center for Mental Health Disparities. She also co-leads the TEAM UP for Children initiative at BMC, which works to expand pediatric mental health care at Federally Qualified Community Health Centers.

Dr. Durham was an expert on mental health long before the coronavirus, and she also worked on the front lines of the pandemic. Her testimony today will offer significant insight into how Congress should be considering reforming and improving our mental health system to both build back from the pandemic, and to fix problems that existed long before that pandemic hit.

So, Dr. Durham, I am deeply grateful for the work you do for patients, for students, and for the people of the Commonwealth of Massachusetts. I look forward to having a great discussion today.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Warren. Thanks for your help in assisting us in making sure Dr. Durham could be with us today.

Our last witness will be Tom Betlach, a partner at Speire Healthcare Strategies. Prior to joining Speire, Mr. Betlach served the State of Arizona for 27 years under five different Governors in three different cabinet positions. For 10 years he served as Director of the Arizona Health Care Cost Containment System. That is, as I understand it, Arizona's Medicaid program. He has a bachelor's and a master's in public administration from the University of Arizona, and a bachelor of arts in political science from the University of Wisconsin. So we are very glad you are here as well.

Let's begin, and we will start with Dr. Miller.

STATEMENT OF BENJAMIN F. MILLER, Psy.D., CHIEF STRATEGY OFFICER, WELL BEING TRUST, OAKLAND, CA

Dr. MILLER. Well, thank you for that wonderful introduction, Senator Bennet.

Chairman Wyden, Ranking Member Crapo, and members of the committee, my name is Dr. Benjamin F. Miller, and I am the chief strategy officer for Well Being Trust, a national foundation started in 2016 through a gift by the Providence Health System that is focused on advancing the mental, social, and spiritual health of the Nation.

I am a clinical psychologist by training and have spent most of my adult life pursuing strategies that can advance mental health to a place of priority within our society. This goal has guided much of my work during my time as the founding director of the University of Colorado's Farley Health Policy Center, and is continuing today in my capacity as an adjunct professor at Stanford School of Medicine and at Well Being Trust.

It is an honor to be able to speak to you today about an issue that every American is experiencing, an issue that we need to aggressively pursue, and which COVID–19 has all but exacerbated, especially among communities of color and other marginalized people: their mental health.

Several government reports highlight how broken our mental health system is. The 2020 DoD Inspector General report found over 52 percent of service members and their families who needed mental health care did not receive it. SAMHSA found that over 56 percent of adults with mental illness did not receive any treatment in the past year, nor did 35 percent of those with serious mental illness. And a recent GAO report highlighted a multitude of issues at multiple levels for mental health, including ongoing challenges with health insurance, enforcing laws like mental health parity, and finding the right clinician who can help. In one survey, almost 30 percent of people reported not seeking care because they did not know where to go.

The need to solve these and other existing problems is real and immediate. Clear pathways do not exist for people seeking mental health care. There are not obvious doors to enter, and we have no system that routinely is able to identify and treat people in a timely manner. This is perhaps our greatest challenge as we emerge from the devastating COVID–19 pandemic.

With broad majorities of both parties now understanding the importance of addressing mental health, I believe it is time to enact immediate fixes for people in need, as well as to begin to lay the foundation for a reimagined mental health system, a mental health system that is grounded in community and is an integral part of a broader health-care infrastructure.

There are three key priorities I believe this committee should consider as it pursues both short- and long-term reforms for mental health. First and foremost, we need to bring mental health care to where people are. This includes schools and even our work places. But to most immediately meet this moment, the best place to start is primary care, the largest platform of health-care delivery. In one poll, 70 percent of adults agreed that it would be more convenient

if their mental health and substance use services were integrated into their primary care doctor's office.

To do this, we must create more global and flexible funding mechanisms for primary care practices that are working to integrate mental health. Our payment mechanisms often reinforce a siloed delivery model, and this must change. By first using existing payment structures like those found in Medicaid managed care organizations, Medicare Accountable Care Organizations, and Medicare Advantage Plans to expand mental health integration work, primary care practices would have the flexible financial resources to onboard mental health clinicians as a part of their integrated team.

Second, we must reconsider the design and capabilities of our workforce. Demand for care has far outpaced the supply of mental health clinicians, and it is inconceivable to rely upon clinician recruitment strategies alone to meet our ever-growing need.

There are two things we can do simultaneously to address this workforce issue. First, we can map out mental health utilization gaps to better determine where services are needed, and for whom. Without this, we run the risk of widening disparities, or putting money into places or programs that people are not using for their mental health. Second, we can invest in our community workforce, those like peer support specialists, community health workers, or more broadly, lay people in our communities. We can train them in mental health skills to help become the first line of mental health support, complementing our clinical enterprise and enhancing the overall capacity for communities to address mental health needs.

Finally, we must modernize and connect our Federal programs and systems to collaboratively solve our common mental health problems. I realize it is hard to ask committees to work across jurisdictional boundaries, but so many aspects of our mental health need to be understood together, and implemented together, at both the State and community level. Because there are multiple agencies, funding streams, and programs that support mental health, performing a landscape analysis can create a strategy for synergistic efficiencies by breaking down silos across Federal agencies and departments, and allowing for a more cohesive plan for mental health.

In closing, I thank this committee again for holding this hearing on mental health. This is our moment to be bold in what we can do to boost our Nation's mental health and ultimately save lives.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Miller appears in the appendix.]

The CHAIRMAN. Thank you very much, Dr. Miller.

Okay, I think next we will go to—Dr. Miller has gotten us off to a strong start, and now we will hear from Ms. Jett.

[Pause.]

STATEMENT OF CHANTAY JETT, MA, MFT, EXECUTIVE DIRECTOR, WALLOWA VALLEY CENTER FOR WELLNESS, ENTERPRISE, OR

Ms. JETT. Good morning, Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee. Thank you

for the opportunity to appear before the committee to discuss policy solutions to address both the mental health and substance use crises impacting the United States, and in particular the rural and frontier areas of our Nation. My name is Chantay Jett, and I am executive director of Wallowa Valley Center for Wellness (WVCW), which provides community-based mental health and substance use treatment services in the most remote region of the great State of Oregon.

We represent a truly frontier area of our Nation where the cows outnumber the people and our closest major airport is in Boise, ID, nearly 4 hours away. We are literally at the end of the road, where everyone knows everyone, which unfortunately contributes to the stigma and lack of access for people seeking treatment services.

I am here to tell you that the Certified Community Behavioral Health Clinic model has truly made a difference in our frontier communities. I hope every State in the near future has an opportunity to use the resources this model has made available to us to meet the specific needs of our community.

The State of Oregon participates in the 10-State demonstration of the Excellence in Mental Health and Addiction Treatment Act that this committee helped to establish in 2014 through the bipartisan leadership of Senators Stabenow and Blunt. The Center for Wellness is one of 12 CCBHCs that operate within our State. We provide high-quality integrated community-based mental health and substance use services to individuals, while also screening for possible co-morbid conditions like heart disease, diabetes, HIV, and AIDs.

Among the most important services that CCBHCs provide, both in Oregon and Nationwide, are immediate access to medication-assisted treatment services for substance use and 24-hour psychiatric services. Please permit me to provide some very brief context of CCBHCs within rural and frontier counties in the State of Oregon.

According to the Oregon Health Authority, our State reports higher rates of mental health conditions, including severe and persistent mental illness and suicidal ideation. The COVID–19 pandemic has only exacerbated an ongoing mental health and substance use crisis in rural Oregon.

OHA also detailed the lack of access to mental health and substance use care, especially in frontier communities. To give you a sense, there is no stop light within this 76-mile radius of Wallowa County. OHA reports an average wait time of as much as 6 months Statewide due to a lack of providers. However, we are the lucky ones, because the CCBHC model helped create an internal reorganization of service delivery which resulted in same-day access to care.

Prior to becoming a CCBHC, the Center for Wellness was heavily reliant upon grants. Grant funding is crucially important, but it carries limitations. Grants typically end every 2 to 3 years. They all have different reporting requirements and different program specifications, which ultimately result in more time spent filling out paperwork rather than treating our patients.

By contrast, the CCBHC prospective payment system allows us to do three major things. First, the Center for Wellness contracts

with more skilled clinicians, including psychiatrists and medical professionals, to prescribe medication-assisted treatment for patients with opioid use disorder. This directly results in decreased wait times and reduced emergency department visits.

Secondly, the CCBHC program is designed to expand access to underserved populations. In our communities, the CCBHC really opened the door for mental health care to veterans. According to our local VSO in our county, there are at least 1,000 community members who have donned the uniform out of 7,000 residents. Becoming a CCBHC has allowed us to increase our services to 23 veterans in our community. This may not seem significant to you, but it is a 300-percent increase in services.

Thirdly, consistent CCBHC resources are a fundamental driver of integrated care. In Oregon, the CCBHC demonstration financing has made it possible to integrate with a local Federally Qualified Health Center, allowing primary care and behavioral health services all under the same roof.

We also share a single electronic health record to permit immediate care coordination. Patients often tell me that it is such a relief to not have to retell their stories with every provider they meet. We are lucky that we have a great neighbor in the State of Idaho when we have no acute psychiatric beds available. This component of care coordination in partnership with primary care in hospitals, even across State lines, is imperative because patients with severe mental illness and substance abuse challenges have shockingly high rates of medical conditions. The CCBHC model allows us to have these partnerships and get patients the services they deserve in a timely manner.

In closing, I strongly believe that this model represents the future of community-based mental health and substance abuse treatment in the United States. This is why I am asking you to make this model available to every State Nationwide. As a Nation, we can do better than first treating mental health and substance abuse in hospitals, homeless shelters, and our county jails. Investing in CCBHCs is streamlining services in efficient ways that drive costs down over the entire continuum of care.

Despite being from a tiny frontier community at the end of the road in northeast Oregon, I hope you can see that CCBHCs make an enormous impact. Again, thank you for the opportunity to testify, and I am happy to answer any questions.

[The prepared statement of Ms. Jett appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Jett. You make Oregonians proud this morning. I would also note you mentioning the Idaho-Oregon alliance. Senator Crapo's ears perked up when he heard that. And on all these incredible efforts, we have talked about a lot of them. And I just want you to know that it is a tremendous honor to really be your wing man in some of these causes, because we have a lot of work to do, and you have laid out a very powerful case about some of the most important elements. So thank you. And thank you for making the long trip.

Okay; next will be Dr. Durham.

STATEMENT OF MICHELLE P. DURHAM, M.D., MPH, FAPA, DFAACAP, ASSISTANT PROFESSOR OF PSYCHIATRY, BOSTON UNIVERSITY SCHOOL OF MEDICINE; AND VICE CHAIR OF EDUCATION, AND PSYCHIATRY RESIDENCY TRAINING DIRECTOR, DEPARTMENT OF PSYCHIATRY, BOSTON MEDICAL CENTER, BOSTON, MA

Dr. DURHAM. Thank you, Chairman Wyden, Ranking Member Crapo, and distinguished members of the Senate Committee on Finance, for holding this hearing and providing me with the opportunity to speak today about the state of the mental health-care system in America—where it is working, where it falls short, and how the Federal Government can play a role in helping to fill the gaps. Thank you, Senator Warren, for the kind introduction.

Boston Medical Center is an academic medical center and the largest safety-net hospital in New England. The patients we serve are predominantly low-income, with approximately half of our patients covered by Medicaid or the Children's Health Insurance Program—the highest percentage of any acute care hospital in Massachusetts, and one of the highest in the country.

Mental illnesses are all too common among the patients BMC treats in our emergency department and across our continuum of mental health-care services, which include outpatient integrated mental health care within our pediatric and adult primary care clinics, and at local community health center partners. A mental health urgent care clinic, a crisis stabilization unit, and our Boston Emergency Services Team (BEST) provide community-based evaluations and a jail-diversion program. At present, BMC does not own or operate a locked inpatient psychiatric unit.

The patients we see at BMC who present with mental illness frequently have co-occurring substance use disorders, homelessness, malnutrition, and other health-related social needs linked to poverty. The current COVID–19 pandemic, structural racism, and economic crisis have further exacerbated the mental illness and trauma experienced by our patients.

In my 10 years at BMC, I have never seen our mental health-care services stretched so far beyond their capacity as they are now. Just the other day we had 25 patients in our psychiatric emergency department, more than triple its capacity, presenting with much higher level of acuity, some waiting for evaluations, and others boarding, awaiting placement in an inpatient psychiatric unit.

It is widely understood and well documented that America has a dearth of licensed mental health professionals in general, and that particular areas of the country, largely rural and outside of the Northeast, are disproportionately impacted. Even where I practice in Boston, which has one of the highest numbers of child and adolescent psychiatrists per capita in the country, the capacity is insufficient to meet the mental health needs of the community.

Increased Medicare graduate medical education funding for psychiatry residency slots can help increase the physician workforce. Increased funding for loan forgiveness programs for those who work in underserved areas can help alleviate the over $250,000 of debt that the average medical student has accumulated by the time their residency education is completed. The need to pay off medical

school loan burdens is also likely to cause physicians to pursue practice in more affluent areas, adversely impacting access to care for low-income populations.

Beyond the shortage of providers, the mental health workforce is not diverse—for instance, only 2 percent of psychiatrists identify as black—and not representative or reflective of the U.S. population. In order to address this, we must understand that the issue at its root is a pipeline issue that requires holistic solutions.

Just as we say in medicine that a person's ZIP code is more influential than their genetic code in determining life trajectory and long-term health, where a person lives, the color of their skin, and the language they speak is highly determinative of quality of education and resources available, the level of exposure to the mental health field, and the stigma associated with mental illness.

In terms of access to mental health services, COVID–19 led to an accelerated adoption of telemedicine. At peak, over 90 percent of our outpatient psychiatric visits were conducted via telehealth, which enabled BMC to maintain and exceed our pre-pandemic volume of service. That said, while telehealth is an important tool for ensuring patient access to mental health care, it does not work for everyone, due to digital inequities that exist related to Internet access and digital literacy, especially among low-income communities.

The social determinants of mental health and structural vulnerabilities inherently involved with treating low-income patients require more dedicated time with patients to provide appropriate care. Insufficient Medicaid reimbursement acts as a deterrent for providers to see Medicaid patients, producing a cascade effect in which the more oppressed, marginalized populations have limited to no access to mental health professionals.

At BMC, we have developed some innovative models to improve access to mental health services, which are ripe for replication and scaling. Transforming and Expanding Access to Mental Health Care in Urban Pediatrics, otherwise known as TEAM UP for Children, a pediatric integrated model in Federally Qualified Health Centers in Massachusetts, builds the capacity of health centers to deliver high-quality, evidence-informed care to children and families. The model includes behavioral health clinicians and community health workers working with pediatric primary care providers to provide timely mental health treatment.

The Wellness and Recovery After Psychosis program is tailored for people experiencing psychotic symptoms using a team-based approach and providing individual, group, and family therapy; medication management; case management; and peer support.

In addition, Massachusetts is home to some other models in which BMC participates. The Massachusetts Child Psychiatry Access Program, known as MCPAP, improves access to treatment for children with behavioral health needs and their families by making child psychiatry services accessible to primary care providers across Massachusetts via remote consultation and education. This model has been expanded to other States such as Connecticut, where I completed my fellowship. The Metro Boston Recovery Learning Community offers peer-to-peer services for people in recovery from mental health and/or substance use issues through peer support, advocacy, and career coaching.

We are at a pivotal time in our country. Over a year into the COVID–19 pandemic, every person's mental well-being has been impacted in some way. The need for a more robust mental health-care system has never been more clear or pronounced.

Treatment for mental health issues should be accessible, no matter who you are, where you live, or your ability to pay. Appropriate investment along the care continuum and for the mental health workforce can improve access to care and retention and recruitment of mental health professionals. The time is now to invest in a 21st-century mental health-care system in America.

Thank you for your time, and I look forward to the discussion.

[The prepared statement of Dr. Durham appears in the appendix.]

The CHAIRMAN. Very good, Dr. Durham. I know that we will have questions for you in just a couple of minutes.

Mr. Betlach, welcome.

STATEMENT OF THOMAS BETLACH, MPA, PARTNER, SPEIRE HEALTHCARE STRATEGIES, PHOENIX, AZ

Mr. BETLACH. Thank you, Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee. Thank you for the opportunity to testify today on policy solutions for addressing mental health.

I had the privilege of serving as the Arizona Medicaid Director for almost a decade and, for a portion of that time, as the Mental Health Commissioner. Medicaid serves over 70 million members, offering comprehensive mental health benefits to some of the country's most complex populations. As you formulate health policy options, State Medicaid programs should be a critical component of the discussion. Understanding the system and the forces prevailing on it should be at the core of the discussion.

The last year brought to light the extreme fragmentation of our health-care delivery system at all levels. Our policy and program structures are in silos. Funding streams to support these populations follow those siloed program and policy structures. Providers gravitate towards these funding streams, creating more complexity at the point of care, and the very beneficiary the system is designed to serve is forced to navigate the maze we have created.

Today's environment has challenges, but States and Medicaid programs now have access to considerable Federal investments to address these challenges. Examples include the 5-percent set-aside for mental health block grants used for crisis, 85-percent enhanced match in Medicaid for the CAHOOTS program, 10-percent increase in Federal funding for home and community-based services for the rehab option services, and the expansion of Certified Community Behavioral Health Clinics.

In February 2021, the National Association of Medicaid Directors published "Medicaid Forward: Behavioral Health," outlining a series of strategies Medicaid programs are pursuing to advance mental health services for members. The strategies vary based on the unique population served by Medicaid. This report highlighted initiatives such as expanding access and improving timeliness to care, integrating physical health and behavioral health, and expanding access for the full continuum of care, including crisis services.

Further, a March 2021 Bipartisan Policy Council report concluded that integrating primary and behavioral health care is necessary and would ensure that individuals with behavioral health conditions and co-morbid physical health problems receive high-quality access to care. Arizona provides a strong example of this. In 2011, we pursued a multiyear strategy to better integrate services for individuals with serious mental illness. This strategy was focused on driving integration at three levels: policy integration, payer integration, provider integration. In 2018, Mercer consulting conducted an analysis of the integration efforts. Their final report for individuals with serious mental illness found that all measures of ambulatory care, preventative care, and chronic disease management demonstrated improvement. Just as important, all indicators of patient experience improved, with 5 of 11 measures exhibiting double-digit increases.

Another opportunity highlighted by NAMD is to strengthen crisis systems. This issue is front and center with the implementation of 988. SAMHSA provided extensive thought leadership with the development of the Crisis Now model to serve anyone, anywhere, at any time.

The Crisis Now model is based on three critical components: call center capability, 24-by-7 community mobile response teams, and 23-hour crisis receiving and stabilization units.

In Arizona, the system has been developed over the past 20 years and serves all Arizonans. The financing for the system comes from creative multiple funding streams, while leveraging Medicaid for support. While we have seen improvement, there is clearly much more to do.

To that end, Congress and the executive branch need to develop and implement strategies holistically by ensuring Medicaid and behavioral health collaborate and partner in a meaningful manner. On several occasions, Congress has leveraged the mental health expertise of SAMHSA to advance policy initiatives. However, there do not appear to be sufficient expectations established by Congress that these important planning and investment dollars are to be linked to the Medicaid program. Unfortunately, the dollars often get siloed, and the opportunity is suboptimal. At the end of the day, Medicaid beneficiaries may or may not benefit from these forward-looking investments.

Congress should provide more flexibility with block grant funds for States to address social determinants of health, as States look at ways to support these investments. Congress should look at legislation to establish parity between Medicare and Medicaid. Where Medicaid has led the way in developing paraprofessional staff such as peer support services and systems to support broader populations like Crisis, Medicare should follow.

Congress should continue to provide financial incentives for States to modernize mental health infrastructure, like the investments made in CAHOOTS and CCBHCs. Congress should continue to evaluate the impact of the IMD 16-bed limit. While there have been efforts made to allow for some payments in select instances, some States have not been able to avail themselves of these opportunities.

Congress should rectify the fact that behavioral health providers were excluded from the electronic health record incentive program provided through the HITECH Act. And finally, as was mentioned by Dr. Durham, Congress should revisit the GME funding that is made available through Medicare and the 1996 caps.

We are at a critical moment in time to advance the delivery of mental health services, not only with Medicaid, but for our entire country. Thank you for your time and interest in these topics.

[The prepared statement of Mr. Betlach appears in the appendix.]

The CHAIRMAN. Thank you very much, Mr. Betlach.

We will start with you, Ms. Jett. I think what you and your colleagues are saying is, you cannot expand mental health care without expanding a trained workforce. And this is especially true in rural areas. And your eloquent words, I believe, spoke for a lot of providers from rural areas. And it seems to me you have a big challenge filling key slots like licensed clinical social workers who serve Medicare and Medicaid patients, nurses who do so many things well, starting with health screening and recovering patients, who play a key role in terms of peer support. In listening to you over the years, you have convinced me the professionals are essentially the glue holding the mental health system together.

Now I would like to get your thoughts with respect to the workforce, and particularly on the question of having enough people, and then preventing burnout. Because my understanding is that the pandemic just made things a lot more treacherous for so many professionals who just wanted to step up and help people.

Deaths from opioids are 30 percent higher than last year. The number of emergency department visits for suicide and drug overdoses are up more than 25 percent. Three to four times as many people are identifying as facing depression today than before the pandemic.

Why don't you tell the committee—because I have heard you speak to this in the past. It was always a challenge before the pandemic. Tell us what you think is really happening now with how the pandemic has made it much harder for you and your colleagues to do the terrific advocacy you do.

Ms. JETT. Sure. I am happy to speak to that. Crisis burnout is at an all-time high. Every single one of our crisis clinicians will—well, clinicians in general that we hire have to take a crisis rotation. The crisis numbers since the pandemic started have tripled. And the acuity level of those crises has gone from a very simple "I have a lot of anxiety"; "my cat is stuck in a tree for the past 2 days, and I am not sure what to do"; "I am having a panic attack"; to the most recent crisis call that we had, which was, "I have a loaded shotgun, and I intend to use it as soon as we get off this call."

I have never, in my 15 years of being part of a mental health system, ever experienced the acuity level of crises, the burnout with clinicians, and crisis acuity levels with the patients that we see now.

The CHAIRMAN. Well, thank you for giving us a case example. I have heard you speak to this challenge of facing cases that are so much more serious—I guess the technical lingo is the greater level

of acuity—but what a wake-up call, to go from having lots of calls where people are facing anxiety with cats in the trees and the like, to people with loaded shotguns saying that they are prepared to use them. So, thank you very much for that, and for coming.

Dr. Durham, I want to talk to you about our challenges with parity. As you know, we got a Government Accountability Office report documenting all the barriers people face in trying to get behavioral health. The Federal laws have been on the books. I remember the day my Dad and I talked about the parity law. We said, "This could help Jeff Wyden, a schizophrenic." We rejoiced. And yet, what I hear is that there are still all kinds of barriers to patients getting the care they need.

And I would like to have you describe what you think is really going on out there with the parity law. And I gather your patients are facing a lot of barriers, and you still do not think the spirit of the law that would treat mental health like physical health is being honored.

I would like to hear your words.

Dr. DURHAM. Thank you for the question, Senator Wyden. I completely agree that we have not made any headway with parity for mental health and physical health. We have a long way to go.

A really concrete example is that I work in the psychiatric emergency room at Boston Medical Center. As I mentioned in my oral testimony, we have people who—we have like tripled, quadrupled the capacity during the pandemic. One of the things that slows the process for us as a team of psychiatrists, licensed clinical social workers, psychologists, is that we evaluate the patient, we decide that they need inpatient psychiatric level of care, and then we start talking to the insurer.

And that takes a lot of time, where we could be seeing other patients that are acutely in need of services by us, and we have to go back and forth faxing paperwork. Then you have to do a bed search and see what psych unit will accept your patient. And if it is Medicaid or Medicare, generally they want to know for Medicare, "Well, have they met their capacity of days they can be in a psych unit?" And then if they have, total lifetime days, then we are stuck with a patient boarding with us until we can figure out what else we can do.

And for Medicaid, it is a lot of back and forth for our folks. And around 50 percent of our patients are on Medicaid. So that is a huge amount of time when we are in the emergency room spent going back and forth for, essentially, a prior authorization.

And I like to use the example that when a patient comes into the emergency room in acute stroke, or having a heart attack, the physician in that moment makes a decision that they need inpatient hospitalization, and they go to the medical floor without having to go back and forth with an insurer deciding if that is actually the appropriate level of care.

The CHAIRMAN. Thank you. And you know, obviously it was not the spirit of this bipartisan law from Senator Wellstone and Senator Domenici, to have patients and providers having to go into what is almost armed battle to try to navigate just a fair shake for patients and their providers. So I really appreciate your being here.

I am over my time.

Senator Crapo?

Senator CRAPO. Thank you, Mr. Chairman.

This question is for you, Mr. Betlach. There is bipartisan interest in expanding opportunities for integration of physical and mental health services across all payers. While some approaches prioritize payment, others use co-location services, or the use of case managers under a medical home model, to achieve this goal.

What are some of the examples of integration that could be a road map for Medicare or Medicaid in the near future? And how could waivers be used in State Medicaid programs to enhance access to care?

Mr. BETLACH. Senator, thank you for the question. I think there are a lot of different approaches States can take, and certainly it depends upon the ecosystem of each unique State.

I think the first thing it starts with is, States need a strategy. What is your integration strategy? So as States think about this, they should be able to develop a plan in terms of a multiyear strategy that they are going to be implementing around integration.

And as I mentioned in my testimony, there are really three levels to integration. There is how you think about it at the policy level. And for us in Arizona, it was thinking about some simple things like, what are the regulations that we have in place for providers to help build integration? Do we require some silly things like—we had two separate entryways and challenges around billing; and so making sure that, as a State, we were clearing out some of those regulatory burdens that existed for integration.

States may or may not want to integrate and braid funding sources like we did in Arizona at the payer level, but States should certainly have a strategy around maximizing care coordination between payers. So if you are going to have a carve-out of behavioral health services, how are you going to ensure that there is care coordination for individuals who require both physical health and behavioral health services?

And then finally, States need a strategy in terms of how they are supporting providers in terms of integration. It may be opening up things like the collaborative care model codes in terms of being able to pay for services that are done at the primary care site, like Dr. Miller talked about. There may be other incentives.

We leveraged, in Arizona, an 1115 waiver to create provider payments for milestones that were achieved in terms of advancing integration strategies like connecting to our health information exchange and other areas like that.

So States need a plan, and the plan needs to address each of those three critical areas: policy, pay integration, and provider support of integration.

Senator CRAPO. Thank you.

Ms. Jett, you have very well described the issues that you face in a rural community in providing the needed services we are discussing today. Unfortunately, the stigma around receiving mental health treatment can be even higher in rural areas.

Can you speak to these challenges? And what approaches has your clinic taken to combat them?

Ms. JETT. I can. Thank you for the question.

We have been integrated with primary care since 2012 through a series of SAMHSA and HRSA grants. We are partnered, as I said in my testimony, with a local Federally Qualified Health Center. And together we have built a 20,000-square-foot building to provide primary care, dental services, VA services, and behavioral health, all under one roof.

We are moving in, hopefully in August, and we are hoping that this destigmatizes your car from being in the parking lot, because people will not understand why you are there or what services you are receiving. So this is one way that we thought, in a frontier community, we could reduce the stigma of people receiving services.

Senator CRAPO. Well, thank you very much.

And, Dr. Durham, one of the positive outcomes of the pandemic has been, as we have discussed here, the significant expansion of telehealth, which is an important tool to expand access.

Have you found any limitations to tele-mental health for treating your patients, and particularly the younger ones?

Dr. DURHAM. Thank you for the question. Absolutely, I think telehealth has been critical to meeting our patients' needs during this time. But there is a subset of the population where I think we need more research and understanding of how it is going to work fundamentally.

I am a child psychiatrist who practices in a child clinic, and we went to telehealth pretty quickly as well. And I think it was difficult with some of our families too, because when we practice, we want a place where someone can speak to us directly. We want the parents to be separate from the room so that we can engage with the kid, whether that is a 5-year-old, or a 12-year-old, or a 16-year old.

And it was very hard for some of the families who are in low-income communities, who are in multigenerational homes, to have that private place to have a session. And so that was some of the difficulty we saw.

I think for little ones, especially kids who have early intervention services as well, so that 0 to 5 age range, we are also thinking about how we come back now to the office space again. And some of those kids we probably will need to see in person at some point and then maybe go back to telehealth once we have established a relationship. For the little ones, it is a little bit more challenging.

And I think for the adult population, some of our folks who have substance use disorders in particular, and are homeless, really did not have the technology necessary to always engage with that support. So throughout the pandemic as well, what we did was, every day of the week we always had somebody who was there in person in our clinics to make sure that people could get the care they needed and did not have to rely on tele-technology to get the services they wanted.

So I think there is work to do. And I would also say that the audio-only was critical during this time as well. And so, any way we can expand that and make sure post-COVID, if you will, that we still get reimbursement for that, especially in some of our integrated care models—it was critical to have the audio-only be reimbursed at the same rate.

Senator CRAPO. Thank you. I am out of time.

The CHAIRMAN. Thank you, Senator Crapo.

Senator Stabenow?

Senator STABENOW. Well, thank you very much, Mr. Chairman and Senator Crapo. I really want to thank you for this hearing. It has been a while since we have had a hearing focus on mental health and substance abuse services, and I really appreciate your leadership. And to all of you, you have all raised issues that are so incredibly important.

I want to speak specifically to what I think is foundational in the community. And, Ms. Jett, you were talking about the Certified Community Behavioral Health Clinics that go to the core of integrating funding and really treating mental health and substance abuse as part of the health-care system. I always say we should treat health care above the neck the same as health care below the neck, and not just through a focus on grants that stop and start. It needs to be integrated in Medicaid, and it needs to be prospective payment so we can have the full opportunity for professionals being funded.

So today I am really pleased to say that Senator Blunt and I—along with our chairman, Senators Daines, Cortez Masto, Smith, and Tester—welcome all the members of the committee to be cosponsors in the next step. We have 10 States that have been doing a demonstration of how this can work with high-quality standards, and today we introduced legislation that would allow States across the country to be able to do this, which is incredibly important.

We have, through our startup grants, through the COVID process, we have been able to bring in dollars, as has been indicated, to over 300 communities across the country, 40 States plus DC, to do startup grants. But what we need is comprehensive community care. And this all really started, I have to say, because Senator Blunt and I worked together on Federally Qualified Health Centers, which are widely supported on a bipartisan basis. And the idea, as you said, is quality standards. If the community clinic can meet the high quality standards, they get full reimbursement in the health-care system. And so that is what this is. The idea is to integrate those payments.

So, Ms. Jett, no surprise, I have a question for you to expand on CCBHCs. You really were one of the very first in the country and have done just a marvelous job in showing what can be done. But I wonder if you could expand more on the issue of permanent funding.

You know, I have always said to colleagues that it is like having someone having a heart attack, and they go to the hospital and they are going to immediately get treated. Right now, in too many places around the country, if somebody walks into a mental health center, it is the equivalent of saying, "I am sorry, the grant ran out, can you come back in a few months?" when somebody is in crisis, which obviously is ridiculous.

So, could you talk a little bit more about the importance of integrating funding and permanent funding in the mental health and substance abuse system?

Ms. JETT. Of course. I would like to give a couple of examples first about how the system is currently funded, which presents a variety of challenges for us.

For example, on the Medicare side, only licensed clinical social workers or medical doctors can treat Medicare patients for mental health services. What this means in a frontier county is, if we only have one or two licensed clinical social workers on staff, then the remainder of those services being delivered to Medicare patients are being written off.

In our CCBHC, we write off upwards of $500,000 a year for Medicare-delivered services. Our growing population is over 65 and under 17. We have the under-17 covered, but the over-65 population is underserved. And really the reason is, we do not have the licenses available to treat those people.

So the funding for CCBHCs allows that wrap-around payment to bridge the gap of services not being currently financed. It is vital, and it is important that we fund the business of mental health. People just want to fund the services, but there is an actual infrastructure that is required to provide this high level of integrated care.

Senator STABENOW. Thank you so much. And in the limited time I have left, let me ask you to speak a little bit more to integrating care. Again, the financing model really is about integrating primary care for individuals. It is a whole person, and we segregate them when we are talking about various ways to provide health care. But could you talk about the delivery of behavioral health services and what you do in the context of providing primary care for people?

Ms. JETT. Sure. Well, the CCBHC model in Oregon allows for 20 hours or more of primary care to be delivered, as we say, on our turf in the behavioral health system. This building, co-located with our local FQHC, works both sides of that equation, right? Because we understand that there are many people who want to access behavioral health services—specifically those with persistent and severe mental illness—on the behavioral health side.

Conversely, there are people on the primary care side who only want to access behavioral health services from their primary care doc. And so, having both an FQHC and a CCBHC in one location allows for multiple access to services in the integration.

Senator STABENOW. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague.

Senator Crapo and I will be working very closely with you and Senator Daines as we go forward on these issues in a bipartisan way.

Let's see. What we are going to do, because I think a couple of our hearings have been a challenge with so many Senators having hectic schedules, I am just going to call the names in order of appearance.

So, Senator Grassley would be next. I am not sure he is available, but I thought we ought to check. Senator Grassley?

[No response.]

The CHAIRMAN. Okay. Senator Cantwell is of course here and has been a longstanding leader in terms of health-care advocacy, so let's recognize Senator Cantwell.

Senator CANTWELL. Thank you, Mr. Chairman. And thank you and the ranking member for holding this important hearing, and my colleague Senator Stabenow for her leadership on this.

Many of you have mentioned—well, a big theme this morning is the integration of mental and physical health. I appreciate everybody honing in on what we could do about that. To me, this is—you know, when I look at 20 to 25 percent of the homeless population having mental health problems, I think there are costs. These are just continued costs to the system that we have not taken care of. And if we had an integrated system, and I think even better case management, because—who is managing the situation? If the person has mental health problems, who is managing the situation? And if no one can talk to any of the people, how could you possibly integrate the physical and mental health?

I am sure I am not telling you anything. The drugs that people are taking for mental health cause a lot of physical problems. So this has to be fixed.

So what do you think we can do to get our colleagues to understand that we are losing money that we could save now if we would just fix this integration? So either Dr. Miller, since you were very big on this, or Dr. Durham—either one.

Dr. MILLER. Well, Senator, thank you for the question. I will just begin by saying that I think you put your finger right in the center of the biggest problem that we have, which is how we have bifurcated, trifurcated, and split apart health. When you talk about services for the unhoused, or you begin to look at our children versus adults, we have fragmentation in almost every level. So to integrate requires us to have really thoughtful strategies that look at the issue at multiple levels simultaneously. And I will give you one example of that.

If we simply look at how we clinically integrate care, without paying attention to how we financially support that integration, it usually falls apart. If we do not look at the administrative or operational functions that also provide oversight, it means that a lot of well-intended folks out there trying to bring these integration services together usually fall apart because there is not a structure for them to ultimately be grabbed by and supported.

So, when we look at health, it is an opportunity to really think about that integration at multiple levels. So thank you for the question.

Senator CANTWELL. Dr. Durham?

Dr. DURHAM. Sure. Thank you for that question. I am very aligned with what you said about case management and those services needed for families that present with a lot of issues besides just the mental health issue.

In our model for TEAM UP for Children, which is in FQHCs in the greater Boston area, we have a community health worker as part of the model for just that: to do some of that care coordination not only between the schools, but thinking about housing insecurity, food insecurity, and what other services are needed.

I think what happens many times, though, is that the case management service, the community health worker, or even a peer coach, are not usually reimbursed by the system. And so it does end up being a lot of grant funding. And I appreciated what Ms.

Jett said as well, that the grant funding ends and then all those services that helped support families and patients also go away.

And so, ways that we can embed that more into the system from a reimbursement perspective would be fantastic.

Senator CANTWELL. Well, I just go back to an example of the—as the chairman knows, I am a big supporter of affordable housing too, but hospitals are now helping to finance affordable housing so you can have a roof over somebody's head so that they do not keep coming to the emergency room. And while you are talking about helping families, I am talking about the cost to the system when people have no support or no help.

I do not think we have a clue about how much we are running up the bills that we could do a better job with if we just had integration and case management for these people. Then we could make better decisions and lower the costs.

And so, I hope we come to understand this, because a lot of our—I think what we are seeing in homelessness is people who just literally fall through the cracks. They do not have anybody advocating for them. They have bounced in between these things. They do not have the issue taken care of, and the next thing you know, they are out on the street.

This is then costing all of us in all sorts of other ways. So to me, let's understand that this is a task certainly about helping people, but it is also a task about fixing the system that is costing us way more than it needs to cost us at this point.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cantwell. And as usual, you go right to the heart of the case, which is, who manages a lot of these cases? Who is, in effect, in charge? And as I saw with my late brother, as he suffered from schizophrenia, he got good care in a number of instances, but too often we could not figure out who was in charge. And I said to myself continually through this odyssey, if this is what an elected official who has tried to specialize in health care faces—and I spent years and years in those communities playing basketball—what is it like for the typical person? So, thank you. Thank you for hitting the question of who is going to manage these cases, and Senator Cantwell said it so well, as always.

Senator Thune, I believe you are out there on the web.

Senator THUNE. Yes, I am.

The CHAIRMAN. Are you available?

Senator THUNE. Yes, sir. Thank you, Mr. Chairman. And thanks to our panelists for being with us today.

I think most everyone can agree that telehealth has proven to be an important tool on our tool belt for increasing access to mental health services. And once we get past this pandemic, I have concerns about a policy enacted last year that will require an in-person visit for Medicare to pay for tele-mental health.

One of the things I hear everywhere in South Dakota is, it does not matter what the provider setting is, whether it is Indian Health Service or the VA or our public hospitals in South Dakota, our schools, we cannot find, recruit, and retain providers. And so, as we are talking about the need to increase access, it seems to me that this arbitrary and inconsistent barrier does not make sense.

In fact, in rural America it stands to make access even more inequitable.

Ms. Jett, can you share some perspectives on how telehealth has helped rural patients overcome the stigma of seeking mental health services and the potential challenge an in-person requirement can have moving forward?

Ms. JETT. Of course. Thank you for the question. Of course, there are both pros and cons to receiving telehealth services. I am happy to say that our clinic provided services nearly seamlessly through the pandemic because of the use of telehealth.

However, as Dr. Durham has pointed out, those in underprivileged or underserved communities often struggle with technology, as well as appropriate hot spots or Wi-Fi capability.

And so, what we have done as a community is, we took some of the FEMA crisis money that we received, and we bought 10 iPads and 10 hot spots to deliver to children and families and community members who were without Wi-Fi or technology services that were available to them.

We would often have them drive into the clinic and park in the parking lot. We would walk out an iPad, and they would hook up to our system right there in the parking lot and have their psychiatrist appointment or therapist appointment right there in the parking lot.

So, telehealth services have certainly expanded the access, but also have prevented some people from accessing services too, specifically the population with severe and persistent mental illness. This has been a great barrier to them, unfortunately.

It is very difficult to explain to someone with severe and persistent mental illness that their therapist is on the TV. That is a little odd. So it has been a bit of a challenge with that particular population. But overall, I think it has improved access.

Senator THUNE. Well, thank you. And I guess I would direct this to anybody on the panel. The in-person requirement passed last year is not consistent with multiple telehealth policies previously enacted by this committee, like the eTREAT Act for substance use disorder, and the FAST Act for stroke.

Would you support legislation to remove the face-to-face requirement for mental health, like Senator Cassidy has introduced along with Senators Cardin, Smith, and I? And keep in mind that there is nothing to stop an individual provider from requiring their patient to have an in-person visit. And to Ms. Jett's earlier comment, I serve on another committee, the Commerce, Science, and Transportation Committee, which is working on the Wi-Fi issue and trying to make those services available to more people across the country.

But with respect to this issue, this piece of legislation that Senator Cassidy is leading, and some of us are co-sponsoring, does anybody want to talk about that particular legislation, whether or not you think that is something that you all could support and that makes sense as we look at better solutions to deal with mental health challenges facing this country?

Dr. DURHAM. Yes, I can take that. I think that having a 6-month in-person provision will really be an unnecessary barrier to folks getting care. And I think it should be at the discretion of the clini-

cian or physician seeing the patient whether or not they need to see them again for an in-person visit. And I think we would go down this road again of, it is a parity issue of why, for certain illnesses or disorders you do not need it, and for mental health you would need it.

So I would be very aligned with not having this provision and just using the discretion of the clinician on whether or not they need an in-person evaluation.

Senator THUNE. Great. Anybody else?

Ms. JETT. Well, I think the bottom line is, we just have to be a flexible system that is amenable to serving all people of all populations at any time they request access for services.

So, requiring these barriers seems sort of silly to me. And I hope that we can think twice about something like that.

Mr. BETLACH. Especially if the beneficiaries have now seen the value in receiving services through this mode of treatment.

Senator THUNE. Okay. Great. My time has expired.

Thank you, Mr. Chairman. Thank you, panel.

The CHAIRMAN. Thank you, Senator Thune. And I think you are making very important points with respect to these various issues requiring a previous appointment in order to get to telehealth. We have to work through those issues, and we are going to do it in a bipartisan way

Senator Grassley would be next.

Senator GRASSLEY. Thank you, Mr. Chairman.

In 2019, I passed the bipartisan ACE Kids Act, with the help of Senator Bennet, that will align Medicaid rules and payments to incentivize coordination and improve health outcomes. This Congress, I am working with Senator Bennet to build onto the ACE Kids Act with the Accelerating Kids Access to Care Act. A key aspect of this effort is to enable the pediatric health home to coordinate care with children, including the prevention and treatment of mental illness and substance abuse.

So, for Mr. Betlach and Dr. Durham, you both discussed in your written testimony the importance of care coordination to addressing fragmentations in the health-care system. The ACE Kids Act requires States to ensure mental health-care coordination is included when establishing a pediatric health home. What lessons can be learned from both your experience as a provider and a State Medicaid Director with upcoming implementation of the ACE Kids Act in 2022?

Dr. DURHAM. Thank you for the question, Senator Grassley. I think the more we can coordinate care for kids and families, the better, at any opportunity. Kids are in many different systems: school systems, their community, their family network, and all of their providers, especially as kids have more complex medical conditions. And so, I would be in great support—any time we can provide the services to coordinate care, the better it is. And I think what we have seen in some of our models that have focused on pediatric and mental health integration in FQHCs is that, the more members of the team that are involved with every system that the kid is in, the better it is for the kid. Their mental health gets better. Their physical health gets better. And then of course, where

they thrive is at school and at home, ultimately. So, thank you for that question.

Mr. BETLACH. Senator Grassley, what we have seen in Arizona is that States need to have a strategy around the different silos that exist in terms of where complex kids may be, whether it is working with the foster care system, whether it is working with kids who may be receiving services through a waiver for individuals with developmental disabilities. Really, the State needs to be looking at the delivery of behavioral health services holistically and how it is going to serve those populations and reduce the fragmentation.

And so, it is leveraging the investments that SAMHSA has made, for example, with first-episode psychosis to make sure that Medicaid is plugging into the infrastructure that is being created, and looking at that. So, if it is using managed care or fee-for-service, the State needs a plan in terms of how it is going to take kids with these complex needs and get them the services that they need.

Senator GRASSLEY. In the last Congress, we made mental health services via telehealth a permanent benefit of Medicaid. So, for Dr. Durham and Dr. Miller: as health-care providers, how best can Congress support this expansion of mental telehealth while ensuring improved health outcomes for individuals served by the expansion of access?

Dr. DURHAM. Access has been greatly improved with telehealth. We have seen that throughout the pandemic, and with our patients. You know, as we discussed previously, I do think there are certain populations where it is more difficult.

And so, audio-only has been very helpful throughout the pandemic. We have seen that a lot in some of our integrated care settings, whether that is pediatric integrated care, or internal medicine integrated care for primary care—at least at Boston Medical Center.

And so, I hope that the provision would still continue to allow audio-only visits at the same reimbursement rates, because it has significantly impacted and helped many of the homeless population, folks who do not always have access to the technology.

Dr. MILLER. I agree with Dr. Durham. And, Senator Grassley, thank you for the question.

The uptick in telehealth utilization for mental health has been a very helpful sign. The people like it when care is able to come to them. And if we are really going to put the patients and families first, we do have to consider policies like the in-person requirement we just discussed and consider whether or not these things are good or bad for people. Does it restrict their access? Does it restrict where they are going to be able to ultimately use these services?

So, making permanent the audio-only, having payment parity, and allowing this for all forms of outpatient care, is a tremendous benefit for so many people across our country.

Senator GRASSLEY. I will yield.

The CHAIRMAN. Thank you, Senator Grassley.

Next would be Senator Carper. Is he available on the web?

Senator CARPER. Senator Carper is right here.

The CHAIRMAN. Okay, and we can hear you. Go ahead.

Senator CARPER. Thank you, sir. I welcome each of our witnesses today.

My staff and I have heard from pediatricians from across the country, including in the Nemours Children's Hospital, the fabled children's hospital that we are very proud of. And we hear from any number of sources that our country is experiencing a mental health crisis among our children. And I do not think it is just in Delaware, I think it is throughout our country.

But during the pandemic, children have experienced major disruptions as a result of public health safety measures, including school closures, social isolation, financial hardships, and gaps in health-care access. It has become clear that COVID–19 has significantly exacerbated the health stress on our children and youth, highlighting our Nation's acute shortage of mental health services and the need to reinforce and expand the pediatric mental health delivery systems and infrastructure.

A question for Dr. Durham, if I could. Dr. Durham, what more can those of us in the Congress do to address root causes and support effective approaches to prevention and early identification of mental and behavioral health issues? Dr. Durham?

Dr. DURHAM. Thank you very much for that question. As you mentioned, many of our kids have experienced a lot of loss. And when we think of loss, it is not only death within their family, but also thinking of not being able to see their friends or do the social activities and other things that fulfill and support their livelihood.

I do think one thing that we need to think through from a prevention/promotion standpoint is that many of our schools, even in the Boston area, do not have school therapists that they have access to. So, we do not want people to always get treatment once there is a severe level of illness and they need to be in a hospital or an emergency room, but how can we start thinking in a prevention and promotion framework of just touches, if you will? So, meaning that something is going on. A teacher notes it, or a principal, or someone in the school or the family, and they have the services right there within the school system before we get to the point where you are calling the emergency services or a crisis line.

There are not enough supports within the school system to do any of that sort of prevention and promotion framework. Teachers are doing a lot. They are doing their job. But we do not have therapists embedded in many of our schools, even when we think about a resource-rich place like Massachusetts. And so, I think it is critical that we think about it in that framework.

I do think pediatric integrated care is another way to think more about prevention and promotion; so, seeing children and families at their well-child visit, which we do in Massachusetts, and start thinking and asking those questions about what stresses are happening in their lives and getting care for immediate needs—whether it is a mild behavioral health need, depression or anxiety that is not to the point where maybe they are thinking about harming themselves or harming anyone else.

So, using that framework of prevention and promotion, I think, is critical. And sometimes that is not necessarily reimbursable from a mental health standpoint as it is for physical health. Kids are supposed to go get their visits quite early in life for a check-in. And

the more we can think about even like a mental health check-in with their primary care provider or therapist in the school, I think the better we would all be in the long run.

Senator CARPER. Thanks.

A question for the record, if I could, for all of our witnesses. Several months ago I was in the Bay Area in California visiting a number of promising technology companies. One was called Ginger, G-i-n-g-e-r, in the Bay Area. And they focus on coverage for—or they focus on mental health screenings, and behavioral health coaching. And I have a question regarding the coverage for those screenings and coaching. And I would just ask you if any of you find virtual behavioral health coaching to be an efficient means of preventing serious mental illness? And if so, should Congress consider mandating coverage for virtual mental health screenings and behavioral health coaching in plans offered on the health insurance marketplace? That is a question for the record for each of you.

Thank you, very much. Thank you, Mr. Chairman and Ranking Member.

The CHAIRMAN. Thank you, Senator Carper.

So, colleagues, we are going to keep this going. Our guests will, I am sure, find this somewhat entertaining, because we have all these votes, and Senators are coming in and going, but we are going to keep it going.

The next four questioners from the committee will be Senator Cardin, Senator Cassidy, Senator Bennet, and Senator Daines.

So, Senator Cardin, if he is available on the web, would be next. And as I say, we are just going to keep this going.

Senator Cardin, are you out there in cyberspace?

[No response.]

The CHAIRMAN. Okay. Senator Cassidy has been sitting here all morning.

Senator CASSIDY. Thank you, Mr. Chairman.

Dr. Durham, I think I may have given you a lecture in medical school.

Dr. DURHAM. I think you may have. [Laughter.]

Senator CASSIDY. You may recall, it was on diarrhea and hepatitis. I was famous on those lectures. There will be a quiz as to hepatitis A and how it is transmitted, but we will do that off the record. Thank you, very much.

It is incredibly gratifying to me to see you and how your career has gone.

Dr. DURHAM. Thank you very much.

Senator CASSIDY. Let me echo Senator Thune's endorsement of the bill that we have introduced as regards telehealth, tele-mental health. And, Mr. Chair, I would like to submit two letters which support this legislation that we are putting forward with Senator Thune, as you mentioned, but also Senators Smith and Cardin—and I have lost the list. And so this letter is from the American Telemedicine Association, and this is a group of folks with the Health Innovation Alliance of the American Telemedicine Association.

The CHAIRMAN. Without objection, so ordered, Senator Cassidy. And Senator Crapo and I will be working very closely with you and the coalition on this very important idea.

[The letters appear in the appendix on p. 54.]

Senator CASSIDY. Thank you.

Mr. Betlach, good to see you.

Mr. BETLACH. Senator Cassidy, good to see you, sir.

Senator CASSIDY. Your hair is a little longer—— [Laughter.]

Listen, several questions for you. You and I both know, in fact we all know, dual-eligibles are just a terrible mess, very expensive to care for, with terrible outcomes. We are spending incredible amounts of money to get terrible outcomes. It is the worst of all.

Now SAMHSA has a lot of grants out there in order to address the issues of the mentally ill, as well as those who have substance abuse, and yet there seems to be poor coordination with Medicaid. You have experience. Can you give some ideas as to how we could better coordinate those programs?

Mr. BETLACH. Sure, Senator Cassidy. That is an incredibly important question. In Arizona, roughly 40 percent of the population of individuals with serious mental illness are dual-eligible members, which actually leads to incredible fragmentation, as you described.

When I first became the Medicaid Director, if you were an individual with a serious mental illness, you had a plan for physical health for Medicaid, a plan for behavioral health for Medicaid, Medicare fee-for-service, Medicare Part D—four different organizations that were potentially involved in paying for your services, none of them coordinated.

As you said, it has led to just terrible results. On average, an individual with serious mental illness dies 25 years younger than peers, and oftentimes it is from untreated chronic diseases.

And so in Arizona, it all comes back to the system design issue. Who is accountable in this? And it is very challenging with dual-eligible members. But we created and built off some of the Federal regulations that exist that said the managed care organization that was responsible for providing services for individuals with serious mental illness not only had to deliver Medicaid services but Arizona Medicaid programs, the third largest housing authority, so there were rental subsidies that were flowing through the Medicaid program—employment support services. Very importantly, the plan had to be a dual special needs plan, which meant that it offered the Medicare services, which meant it was then accountable for delivering Medicare services to that population.

Senator CASSIDY. Let me stop you.

Mr. BETLACH. Yes.

Senator CASSIDY. Great ideas: aligning incentives, a point of authority, everything that checks the boxes. What were your outcomes? Were you able to improve outcome for the duals?

Mr. BETLACH. Yes. In the independent third-party study that was done by Mercer, we saw an increase in terms of all the HEDIS scores for ambulatory and chronic management, and an increase in all of the CAHPS scores.

Senator CASSIDY. Now let me ask, because sometimes those are process-oriented as opposed to outcomes-oriented——

Mr. BETLACH. Right.

Senator CASSIDY. And so, to what degree did you see emergency room visits decrease? Return to workforce? Longer life span, et cetera?

Mr. BETLACH. We do not have the indicator yet on longer life-span. We are only a few years into this, right? So that is going to be a lagging measure as we look at the different indicators. But we did see a decrease in emergency department utilization and an increased use of primary care. Again, not necessarily outcome measures, right, but it is a start.

Senator CASSIDY. Well, let me ask, then—because I am almost out of time—specifically, integrating SAMHSA grants in there, were you able to do that as well?

Mr. BETLACH. We did. We flowed all of the SAMHSA block grant dollars to that organization. They were responsible for those as well. So again, a single accountable organization that had all those dollars braided in it.

Senator CASSIDY. Gotcha. I thank you all for your good work. I really appreciate it.

And again, Dr. Durham, it is great to see your success.

Dr. DURHAM. Thank you.

Senator CASSIDY. And I yield back.

The CHAIRMAN. Thank you, Senator Cassidy. We are going to be working very closely with you as we go forward on this committee effort.

Senator Bennet is next.

Senator BENNET. Thank you, Mr. Chairman. And again, thank you very much for holding this hearing. I hope that it is only the start of a larger effort to address the mental health issues in our country. I, like my colleagues, am deeply concerned about the issue of parity and how insurance companies and providers often erect barriers to adequate mental health coverage.

Senator Kaine and I were working on developing our Medicare-X Choice Act to create a public option, and mental health access was at the top of our mind. We viewed this as an opportunity to improve access to people, especially in rural areas. And a key provision in this proposal provides primary care to patients with a public option without cost sharing—and this should absolutely include mental health care.

Dr. Miller—and anybody else on the panel who would like to answer—can you speak to how a public option could be designed to integrate mental health and primary care? How should this elevate the standards on parity that currently do not exist in the private health insurance market?

Dr. MILLER. Thank you for the question, Senator Bennet, and thanks for your ongoing leadership in this space.

First, from a coverage perspective, any public option should incorporate some of the key lessons that we are learning from landmark Federal cases like *Wit vs. United Behavioral Health.* This includes things like requiring coverage to be consistent with generally accepted standards of care that ensure the inclusion of civil enforcement provisions.

Second, a public option can actually create a standard for integrating care. A public option can determine the scope of services, and it can actually raise the bar on expectations for integrated

practices. This is needed, and overnight it could create a new mechanism to support integrated primary care.

And then finally, a public option could expand the scope of services and the range of providers to make sure that it pays for critical services that augment the onsite delivery, like peer support specialists. Hence really, if you bake it into a public option, you are beginning to change the game from how people have experienced mental health and primary care on the ground.

Senator BENNET. Anybody else?

[No response.]

Senator BENNET. I am deeply concerned with the increased rates of mental illness that young people are experiencing, leading to death by suicide, substance use, or other mental and behavioral health challenges.

In Colorado, it has been 5 years since suicide became the leading cause of death for kids aged 10 and older. And at the same time, we have seen a reduction in beds for youth suffering from mental illness. We have seen that decreased by 1,000 in the past decade.

A few weeks ago, our children's hospital declared, quote, "a pediatric mental health state of emergency," as emergency mental health visits were up 90 percent in April of 2021 compared to April 2019.

What gaps exist in the tools needed to address the mental health challenges facing our children and young adults across the continuum of mental health care, particularly for the Medicaid population? I know a lot of our colleagues are working on improving home and community-based services. How can we ensure that kids and families are receiving mental health services at home or in their communities? I don't know, Dr. Durham, whether you might want to get us started?

Dr. DURHAM. Sure, I can get us started. I think it is a fantastic and great question, so I appreciate it. I think it also has a lot to do with the care continuum. I think what we have seen is, everything has been exacerbated. What we knew pre-pandemic was that we do not have enough services for kids. I think a State like Massachusetts has done a good job. Senator Cassidy is from Louisiana, which is my home State, which is very different. And my family and friends are still there, and I can compare Massachusetts and Louisiana.

And so we do have a continuum for care. We have in-home services for kids on State Medicaid in Massachusetts with different language capacities. And I think that model should be replicated in other States similar to the State of Louisiana, where I come from, where there are very limited resources for kids on the State Medicaid.

And that care continuum has day programs in Massachusetts. We have crisis units for kids so we do not have to go all the way to the highest level of care, which is a locked psychiatric unit for kids. And you know, as previously stated, I do think we need to do something to expand school-based therapists at schools.

We do not have enough. That is where kids are most of the day. That is what gets noticed quickly by teachers and other people who see them day in and day out. And so these are ways that we can work from a prevention and promotion framework. Kids as young

as 12, 13, and 14 will tell you when they are in their early 20s, "I knew when I was 12 that something was going on." And either maybe a parent or a caregiver did not recognize, but also there was no one to go to.

So, the more that we can invest in that, all the way from prevention and promotion along the care continuum, I think the better for all of our kids.

Senator BENNET. Thank you, Mr. Chairman.

I am out of time, but I appreciate that answer very much.

Senator CRAPO [presiding]. Thank you, Senator Bennet. The chairman has gone over to vote. I don't know if it has been explained that we have two votes going right now, so we are kind of rotating back and forth. Plus, we have a lot of members who may or may not be available because of that. But I am just going to go down the list.

I am told that Senator Daines is on his way here, but let me just ask. Is Senator Daines on the Internet?

[No response.]

Senator CRAPO. All right. I am just going to call out some names, and if nobody answers, I am going to—did I just hear somebody? If nobody answers, I will ask a few of my own additional questions.

Senator Casey?

[No response.]

Senator CRAPO. Senator Young?

[No response.]

Senator CRAPO. Senator Warner?

[No response.]

Senator CRAPO. Senator Whitehouse?

[No response.]

Senator CRAPO. Senator Hassan?

Here is Senator Daines. You are up.

[Pause.]

Senator DAINES. Mr. Chairman, thank you. And truly, I am very glad that we are holding this hearing today on such an important topic.

Last month, Senator Stabenow and I hosted our first Finance Health Care Subcommittee hearing of the year, since May was mental health month. We focused on the importance of improving access to mental health services and how the COVID crisis has impacted patients as well as providers.

We were fortunate to have Lenette Kosovich as our Montana witness. She is the CEO of the largest behavioral health organization in Montana, and she was able to highlight the challenges our rural communities face when it comes to accessing mental health care. She also discussed the benefits of the Certified Community Behavioral Health Clinic model, known as the CCBHC model, which brings the reimbursement for behavioral health services on par with that for physical health-care services.

In fact, following that hearing, Senator Stabenow and I decided to team up in this legislation to allow States, including Montana, to adopt the CCBHC model. In fact, we are introducing it today. Our bipartisan bill will integrate the physical and the mental health care and provide patients with access to treatment more quickly.

Ms. Jett, how can the CCBHC model help rural communities like those in Montana that face access challenges and have a shortage of mental health professionals?

Ms. JETT. Thank you for your question. We really believe in the CCBHC model. In fact, we have been one of the first to adopt it and have been using the model for about 4 years now.

We find that integrating the services, or creating what we like to call the neck in between the head and the body, really helps improve outcomes for patients that we serve. It also improves access to underserved populations, specifically veterans in our community who have really benefited from us becoming a CCBHC, primarily because Oregon wrote a waiver with the CCBHC model that would allow veterans to access care from non-veteran clinics.

So where we live in northeast Oregon is about a 2-hour drive for any veteran receiving any sort of services, medical or mental health services. And so by becoming a CCBHC, and along with that Oregon waiver, we are able to treat local veterans for behavioral health issues. It has been really powerful.

Senator DAINES. As the son of a veteran, thank you.

I recently introduced legislation with Senator Cortez Masto to make permanent a CARES Act policy that I championed allowing first-dollar coverage of virtual care under these high-deductible health plans. Our bipartisan bill would allow Montanans and Americans across our country to continue accessing essential care like mental health and primary care services, without the burden of first meeting a deductible. With more than 50 percent of American workers now receiving their health-care coverage through the high-deductible health-care plans, I believe this policy should be made permanent.

A question for Dr. Miller. Do you agree that limiting barriers to telehealth services, after the public health emergency, would benefit patients seeking mental health services?

Dr. MILLER. Senator Daines, thank you for the question. As we have discussed today, there is such power in being flexible with how we are able to deliver services to where people are. And so what we need to do is continue to explore how these services have added value to people's lives, and how they have improved outcomes.

Many of the changes that we have seen through the emergency order have made a difference in countless lives. And I think to take that away would not only be to the detriment of those families that have become dependent on it, it would also hurt our Nation's overall health.

And so, we have to be very thoughtful and very considerate when it comes to these issues of telehealth. I would recommend that this group, this committee and this Congress, really consider ways to either make some of these changes permanent, or to consider an extension that goes on for the next year to 2 years to allow for us to continue to maximize on what many folks have benefited from.

Senator DAINES. Thank you.

I want to shift gears and talk about a problem we are facing in Montana, and that is meth. In Montana, meth is taking a devastating toll on our families and our communities. I had a briefing with our Guard in Montana on Friday, their Counter-Drug Task

Force, and we were talking about significant increases year over year in 2020 versus 2019 on drug seizures in our State—meth and heroin.

In fact, in 2020 drug overdose deaths hit a record high. We are now looking at a disturbing increase in meth-related violent crime. While medications can be effective in treating some substance use disorders, there are currently no FDA-approved medications to help meth addiction.

According to the National Institute of Drug Abuse, contingency management, which involves giving patients incentives to not use drugs, is an effective treatment for some individuals suffering with addiction. Mr. Betlach, in your experience, are there any Federal barriers that prevent States from implementing effective contingency management?

Mr. BETLACH. Senator, thank you for the question. I would say, I am not aware of any, but we can do some further research and get back to you.

Senator DAINES. Okay. Thank you.

Thanks, Mr. Chairman.

Senator CRAPO. Thank you very much.

And I do understand that Senator Young is on the web. Senator Young, are you there?

Senator YOUNG. I am, Mr. Chairman. Thank you so much for holding this hearing. I think this is a really important topic.

The coronavirus outbreak has created an unprecedented mental health challenge for our country. I know it has certainly created challenges back home for many of my Hoosier constituents. While we do not yet know the full impact of the coronavirus pandemic on mental health, we do know it has forced Americans to isolate from their loved ones and other support systems, causing a troubling spike in mental health and substance abuse problems.

A Kaiser Family Foundation poll found that 45 percent of adults say that the outbreak has affected their mental health, almost half of adults. Among adults in Indiana who reported experiencing symptoms of anxiety or depressive disorder, almost 20 percent, one out of five, reported needing counseling or therapy but not receiving it, in the past 4 weeks.

I have a few questions related to this directed towards Dr. Durham. Dr. Durham, access has long been a barrier to adequate behavioral health care. The public health emergency is only exacerbating the existing challenges and increasing the need for providers and treatment.

How are providers responding to this increased need?

Dr. DURHAM. Thank you for the question. I think that you are absolutely correct that we have seen a lot of people, and a lot of uptake in services because of what we have all, I think, noted today, which is that there has been an increase in flexibility when we have added audio and video telehealth capability to all of our clinics throughout the country.

And like most have said previously, I do not think we should change that moving forward. We need to meet people where they are and whenever they can access the technology without having to necessarily come and drive in to appointments, or if you are in

a rural community where you may not have access in your community to a mental health provider.

So, what has happened is that our clinics are full. We are seeing people back to back with telemedicine and our audio appointments. And what it leads to is that, you know, we have a workforce issue. And we need to figure out ways that we can expand on who is able to provide care, as Ms. Jett mentioned earlier. There are certain insurers that do not allow for certain services to be provided. And so we need to look at that more deeply, the issue of who can provide services and be reimbursed for the services.

I am a firm believer that whatever you trained for and went to school for, you should be able to practice and get reimbursed appropriately for it. So I think that telehealth has expanded so much for our communities, and I think there is more research to be done as well about which patient populations it works for and how we need to pivot in some other ways to make sure it is accessible for them too, due to other digital inequities, and maybe a lack of digital literacy as well. But it has definitely aided that process of engaging and reducing stigma, I think, in mental health. Not having to physically come in to see a mental health provider, I think, has helped substantially.

Senator YOUNG. Well, I agree that these additional flexibilities, based on my consultation with providers back home, have just been essential. So I think it is really important that we continue to maintain these flexibilities.

If time remains, I will briefly touch on social determinants of health. Because we know that these are the economic and social conditions in which people live and learn and work and play. And they also impact one's ability to access transportation and stable housing. And by extension, these factors can positively impact the health and well-being of the most vulnerable Americans.

So, Dr. Durham, once again, just briefly, how might we better leverage existing programs and address the barriers to coordination between mental health and some of these social service programs that I alluded to? Is there anything that comes to mind that you see as a real opportunity for us in Congress?

Dr. DURHAM. So, I can talk based on my experience, just as a clinician and as someone who works in outpatient child psychiatry. We have folks at Boston Medical Center with exactly what you mentioned. They are struggling with food insecurity, housing insecurity, transportation issues—all of the social determinants. But what is lacking, most times from a Medicaid perspective, is we are not necessarily reimbursed for that time that we take to coordinate the care. It is very difficult to get case management as a psychiatrist, or as a social worker in our clinic, or we have LMHCs in our clinic—the time dedicated to coordinate all of those services that family may need from a case management standpoint are not necessarily reimbursed.

And so that happens but is carved out at other times during the day when maybe we have a gap, if you will, in our schedules. And I wholeheartedly agree that a person's mental health is affected by all of those social determinants. And the more that we can think about how we provide care and get reimbursed so that we can talk about all the social determinants, get them the services they need

and also, as a provider, focus on their mental health, I think the better, you are right, our families would be. And then the communities would be as well, ultimately.

So many times that mechanism is funded by grants, and grants go away. And then we are stuck with, how do we help our families with all of the needs that they need in order to focus on the mental health issue at hand?

Senator YOUNG. Thank you so much. Yes, sustainable reimbursement for transportation to a primary care provider, and in underserved populations, so that we do not end up paying, as taxpayers, for something that becomes far more costly in the longer term, and certainly costly to that person's health, reimbursement to replace an air conditioning unit—or a heater—so that somebody does not become incredibly ill. It is the whole ounce of prevention notion. And we have just got to get better at that.

So thank you so much.

Senator CRAPO. We will have to move on to the next Senator, which is Senator Casey, who I understand is on the web.

Senator CASEY. Thank you, Senator Crapo. Thanks very much.

I just have one question, and I know this may be plowing ground that has been plowed during the hearing, but I want to reiterate some of it.

I will direct my question to Dr. Durham and Dr. Miller. We know that, even before the COVID–19 pandemic, children were facing both behavioral and mental health crises all across the country. This need obviously is much greater because of the pandemic. And now kids are waiting weeks to months to get mental health care, both in the evaluation and the treatment. So it is highly unlikely to get markedly better even as the pandemic is receding.

We have heard a lot today about telemedicine and the benefit it provides. But used alone, it does not help us with the question of increasing the number of trained professionals who can help both children and teens access the mental and behavioral health care that they need.

Primary care docs and nurses are often the first point of contact for kids, and for teens and their families, whether they are struggling with anxiety or depression or substance use disorder issues. Yet too often, many of these primary care providers believe they are not prepared to respond appropriately.

So there is not a lot in the way of incentives to provide to child health providers to either engage in or expand their provision of mental or behavioral health care. So we know that that lack of incentives can contribute to both racial and ethnic health-care disparities, both in terms of care and outcomes.

So to both Doctors, Dr. Miller and Dr. Durham, how do we better support or incentivize health-care providers, advanced practitioners, and other therapists to increase or enhance their ability to respond to these mental health needs?

Dr. MILLER. Thank you for the question, Senator Casey. And I will just begin by briefly saying that I think you have your finger right at the center of this issue, which is that people, families, children, have to work too hard to get access to care. So how do we incentivize the places where the kids show up to make sure that they are providing adequate onsite mental health care?

And I think it begins with the flexibility of funding. One of the most profound barriers as to why people do not adopt integrated mental health care is because of the up-front startup costs. If they had flexible funding, what they could do is be a little more creative with how they were able to onboard a clinician to make sure that they were there in that pediatric setting to help that family and that child.

The second thing is that we have to provide some level of technical assistance. Integrating care, as powerful and potent as it is, can be difficult. And so an added incentive beyond just the flexible funding is helping practices make that change, make that transformation. Without that, sometimes we see people start and stop because of the difficulty of it.

Senator CASEY. Thanks.

Dr. Durham?

Dr. DURHAM. Yes, thank you for the question. I will echo everything Dr. Miller said, and I will just add to it in that our TEAM UP for Children model, which is at FQHCs in Boston, the greater Boston area, did exactly that. You have to have some funding in order for those health centers to start doing some of that work. And so that is what some of the grant initiatives did.

But then on top of that, I would say that what we have also added to that care team—and make sure that it is a true team—is that the pediatrician or the pediatric primary care provider does not feel alone, that there is a behavioral health clinician and community health worker as a part of that model to get at kids that have the most needs—these are kids on our State Medicaid—to make sure, as the previous Senator mentioned, that we are tucking away housing, and food insecurity, and all of those other things so that we are not continuing to cost the system, but helping with that as well.

But I do think that that team effort, so that the pediatric primary care doc does not go at it alone, we have also integrated training within that, so they learn more about mental health conditions at the primary care level, which has been instrumental. And then also clinical work flows, because it is different, when we decide to start shifting from just physical health to both mental and physical health, that they have to shift their practice in some way. So the technical assistance aspect, I think, is also very key.

Senator CASEY. Thanks very much.

Thanks, Senator Crapo.

Senator CRAPO. Thank you.

And I understand Senator Warner is now with us. Senator Warner?

Senator WARNER. Thank you, Senator Crapo. And I thank the panel and the chairman for holding this hearing.

I know we have been talking about a variety of mental health issues. I want to talk about one that is quite close to home with me in terms of my own family, and that is some of the challenges around eating disorders.

We have seen from the *Journal of Eating Disorders* that about 62 percent of the individuals with eating disorders have seen an increase in stress due to COVID–19. We have seen a dramatic increase in binge eating as well.

I have seen around Virginia—again both on a personal basis and on a more global basis—how this disease can really challenge not only the afflicted, but whole families. As a matter of fact, eating disorders have the highest incidence of mortality of any mental health issue.

Dr. Durham, given your experiences as a physician specializing in pediatric and adult psychiatry, what do you think, both COVID-related and non-COVID-related, we can do to get ahead of this issue around eating disorders, from anorexia to bulimia to a host of other kinds of manifestations of this challenge?

Dr. DURHAM. Thank you for the question. This is not necessarily my area of expertise, but what I will say is that I understand, and can understand how eating disorders, among many other disorders that we treat during the pandemic, are on the rise. I think what happens when you are in a position of high stress, social isolation, lots of loss, is that you do not have all those reserves, those emotional reserves, that you had prior to the pandemic, and lack all the social connectedness that we all want and strive for.

And so, I think that is why we have seen rates rising in depression, anxiety, and folks maybe going back to some restrictive or binge-eating behavior. And we have also seen that for folks with substance use disorders, who had a period of sobriety for maybe years and now unfortunately have relapsed during this time because it has been stressful for everyone, and you sort of fall back to maybe things that felt more comfortable, or that were habit-forming at some point.

And so now, we have talked a lot too today about thinking about this critical time. But I do not think we have seen—you know, we need that year or two to see the devastating consequences of this pandemic, because I think it is going to take time for people to get back to their normal level of functioning, if you will, and to their own baseline.

And so whatever we can do to extend services for telehealth and other services, and increase that flexibility, I think will be key moving forward.

Senator WARNER. I agree with you. I do think it is going to take us that time. What is the new baseline going to be? I mean, Dr. Miller, in your testimony you noted the need to integrate mental health within the primary care field and to modernize the workforce. The National Center of Excellence for Eating Disorders trained primary care practitioners on screening, brief intervention, and referral to treatment called SBIRT.

Do you view these cyber-trainings for primary care practitioners as helpful in addressing some of these workforce issues around mental health; not just eating disorders but more broadly?

Dr. MILLER. Yes. Thank you for the question, Senator Warner. And I think any time we do not ask, we do not know. So we have to be able to screen to detect if there are issues that are under the surface that our patients and families are not necessarily raising on their own.

So I think it is a positive thing to screen. However, I have to point out that screening alone without treatment is insufficient. We need to be providing incentives, as we have discussed today, to onboard experts, clinicians who can help when those individuals do

come forward with a positive screening, if it is an eating disorder, if it is anxiety, and if it is depression. This is a very positive thing for us. It not only normalizes how people begin to talk about issues like eating disorders, but it also creates a team-based environment so that we can provide the most comprehensive care necessary for that patient.

Senator WARNER. Well, this is an area—I wish, Mr. Chairman, I was not as much of an expert as I have become over the last 12 or 14 years, but I appreciate the comments.

I want to go to Dr. Durham again. You know, when we are talking about practitioners, we had an enormous tragedy with Dr. Lorna Breen in Charlottesville, VA, who was a solo practitioner. In many ways the stress and overwhelming nature of COVID–19 unfortunately led her to, with the level of depression—she took her own life. Along with Senator Kaine and others in Congress, we introduced the Lorna Breen Health Care Provider Protection Act that would address professionals in terms of trying to make sure that we train folks on how to deal with these high-stress circumstances.

Dr. Durham, I know we are down to the last couple of seconds. Do you want to comment on how we make sure that we take care of patients, but also our providers?

Dr. DURHAM. Yes, in the last couple of seconds, I appreciate that. And I appreciate that that is happening, because we do need to take care of all of our providers. It has been an equally stressful time for all of us, no matter if you are a physician or a social worker, an LMHC, nurses; we have been working really hard. And I think that at a place like BMC, a lot of things have happened where they were even just doing wellness check-ins for all of our staff, from people that deliver food to patient rooms, to physicians, to the nurses. And I think that that is important.

And any time we can integrate more initiatives for the workforce, I think the better. We are going through this equally, as all of our patients are.

Senator WARNER. Thank you, Mr. Chairman. Thank you, Dr. Durham.

The CHAIRMAN. Thank you, Senator Warner.

Our next three are Senator Whitehouse, Senator Hassan, and Senator Warren.

Senator Whitehouse, are you out there?

Senator WHITEHOUSE. Thanks, Mr. Chairman. I am out here. I appreciate this hearing very much.

First, one of the things that I have gotten for feedback from my mental health community in Rhode Island is that the increase in telehealth during COVID had kind of a hidden benefit, very hard to quantify, but I heard it repeatedly, and that was the sense from practitioners that the qualitative input that they were getting through telehealth was actually better, more meaningful, than beforehand when people had to find their way across town, wait in the waiting room, fill out the stupid clipboard, go into an unfamiliar room, and then have a chat with the practitioner. To be able to do it from a place of safety at home seemed to bring out better interaction, better substantive qualitative interaction.

And I am wondering if any of you have had that experience, or if you have seen any—I know it is hard to quantify, but has anybody tried to quantify it in any way?

Mr. BETLACH. Thank you for the question, Senator. The only thing I would add to that is that, in talking with providers, not only have they heard that from an impact, but also a lower notional rate. So, definitely——

Senator WHITEHOUSE. Yes, definitely a lower notional rate.

Mr. BETLACH. So, in addition to being able to have a better impact, you also have people showing up more for appointments. They have not had conflicts. They have not had transportation issues. So a number of those factors have been taken out of the equation, and as a result, more people have accessed services.

Senator WHITEHOUSE. So let me leave it at that. And if anybody else wants to expand on that for the record, please let me know. But I am going to take it as the agreement of the panel that there were those two improvements, both in showing up and in being engaged and getting better engagement as a result of telehealth.

The other topic I wanted to go into was the interface between law enforcement and mental health, which plays out first directly on the street with law enforcement and then, depending on how the individual engaged with law enforcement, maybe at the local police station or jail; and if not, then usually a ride over to the emergency room, where they get dropped on the unhappy ER docs to cope with.

So, Senator Cornyn and I are working on a bill to improve the engagement of law enforcement in this space so that there is an accredited curriculum and training programs for people so that they know they are getting the real deal in terms of training to improve crisis intervention teams and their engagement with law enforcement, to figure out how to improve the referrals to community-based mental and behavioral health service folks, and to improve de-escalation tactics. All of this, I think, is pretty important.

And I just wanted to get your sense—anybody who would care to respond—on the extent to which law enforcement today is the entry point for people who are in need of and have not received adequate mental health and behavioral health services and the extent to which it is a successful entry point.

Mr. BETLACH. Senator, thank you for the comments. In terms of the interaction between the mental health delivery system and law enforcement, I guess I would invite you to come out to Arizona and see what is going on with regards to the crisis system in our State in which, not only do we have robust mobile response teams but also crisis stabilization facilities to be able to work with law enforcement. There are thousands of drop-offs that occur annually within a 5-minute time span oftentimes.

There is also a lot of training in terms of the CIT model that you mentioned. So clearly there is a role, from my perspective, that Medicaid should be playing in helping to support the interaction and support of law enforcement, mental health providers, through a stabilization crisis infrastructure. And really, there has been a lot of discussion and a lot of new resources for States to be able to establish more robust systems.

There is also going to be an expectation from individuals as they dial 988 in the future in terms of what types of infrastructure will be available for individuals.

Senator WHITEHOUSE. Thanks. And I think my time is running out. So, if anybody else has best practices or really good local examples that you would like to share with us, if you could please get that information into the committee, both Senator Cornyn and I would be very grateful.

Thanks, all, for your terrific work and for helping get us through the COVID situation.

The CHAIRMAN. Thank you, Senator Whitehouse.

Senator Hassan, and then Senator Warren.

Senator HASSAN. Well, thank you, Chair Wyden and Ranking Member Crapo, for this hearing. And to all of our witnesses, thank you so much for taking the time to be with us today.

Dr. Miller, I want to start with a couple of questions to you, and then I will move on to the other panelists. The demand for mental health and substance use disorder treatment and services skyrocketed during the COVID–19 pandemic, as millions of Americans grappled with grief, isolation, and economic uncertainty. We have helped meet that demand by providing new means to access mental and behavioral services such as telehealth, and there has been a lot of discussion about that this morning. Unfortunately, even as we move to make it easier to access some services, the stigma still associated with substance misuse prevents too many people from getting the behavioral health services they need.

Dr. Miller, how does the stigmatization of substance use disorder impact access to treatment and services, and what steps can Congress take to better integrate substance use disorder treatment into primary care settings?

Dr. MILLER. Well, thank you for your question, Senator, and thank you for your ongoing passion and views in this space.

You know, to your point on stigma, we know that only about 10 percent of individuals with substance use disorders receive care. And that tells me a lot about stigma. It says both socially that we do not talk about it as much as we should but, more importantly however, structurally we have these fragmented ways of individuals being able to get access to care.

One of the views that I think you are very familiar with, and that we have discussed today, is that we need to make it easier for individuals who are identified with a substance use disorder to be able to get access to care. That means bringing that care to where people are.

We have to train up our providers to identify it, and we have to train up our clinicians to treat it, and we have to recognize that undergirding all of the substance use disorders is also mental health. The reasons that we provide gold standard treatment for things like substance use disorders is because we need to provide counseling at the same time. This is how we begin to destigmatize substance use disorders and, hopefully, encourage more people to seek care.

Senator HASSAN. Thank you. I am also continuing to work on trying to change the X-waiver requirement as we move forward, be-

cause I think that stigmatizes the provision of treatment for some health-care providers too.

Dr. Miller, I want to turn to another devastating public health crisis that we have to work on, which is the issue of suicides. A report published yesterday—and Senator Wyden mentioned it earlier—by the CDC found that, earlier this year, emergency department visits for suicide attempts by adolescent girls increased 51 percent on average when compared to 2019.

And I have heard directly from New Hampshire students about the mental health concerns that they have. That is why I have introduced the bipartisan STANDUP Act with my colleague, Senator Ernst, that is going to encourage the implementation of evidence-based policies and training in schools and communities across the country that will help to prevent suicide.

Dr. Miller, can you speak to the importance of providing kids and teenagers with the tools that they need to recognize if they, or someone they know, is at increased risk of suicide?

Dr. MILLER. Thank you again for the question, Senator. As the father of two children, I can tell you this is the one that I really want to make sure that we get right. We teach our youth, our kids, all about aspects of physical health. We even teach them things like how to drive a car, and even how to save someone's life with CPR. And so, yes, we have to be able to equip our youth and our schools, frankly, where our youth are basically a lot, with the ways to identify issues related to suicide.

In fact, there was one survey that came out from Mental Health America that showed how youth are talking more to each other around the issues of mental health, which includes suicide, rather than their parents.

So, because our youth are the front lines, we need to equip them with those skills necessary to know how to be there for one another. This could be the way to augment the workforce that we have discussed today. If we simply depend on our clinical workforce to address the demand, especially with our youth, we will fail.

We have to be more creative, more thoughtful, and most importantly, we have to have the youth at the table and with us as we design the solution to work with them on ways that they can better help each other.

Senator HASSAN. Thank you.

Mr. Betlach, I want to move on with a question for you. We increased Federal funding for home and community-based Medicaid services under the American Rescue Plan. This funding helps ensure that older adults and individuals with disabilities, including those with mental health conditions such as bipolar disorder and schizophrenia, can access mental health services outside of institutional settings.

Can you, from your experiences as Director at the Arizona Medicaid program, speak to the important role that home and community-based mental health professionals play in delivering care for individuals who experience severe mental health disabilities? And what can we do in Congress to expand access to home and community-based care for those struggling with mental health conditions?

Mr. BETLACH. Senator, the investment that you have made is really a once-in-a-generation investment in terms of where States are at in the ability to leverage that 10-percent home and community-based bump. And it is really broader, I think, than a lot of people appreciate. It is also on behavioral health services that States deliver through the rehab option as well. And those are incredibly important.

So States are right now developing their plans. I am working with a number of States, and they are generating their options that they want to invest in. So it is an exciting time for States. But States are feeling like there is a very significant time crunch here in terms of being able to establish this investment and do it in the right way.

So I think those plans will be evolving. But there is clearly a unique opportunity, and these services are so important to be able to deliver services in the communities that serve these populations.

So it is an exciting time for States to have these resources to be looking at workforce issues, to be looking at being able to deliver more services in the community.

Senator HASSAN. Thank you.

And thank you, Mr. Chair.

The CHAIRMAN. I thank my colleague.

Senator Warren?

Senator WARREN. Thank you, Mr. Chairman.

COVID–19 is the worst public health crisis that our Nation has tackled in over a century, but it does not exist in a vacuum. The pandemic has exacerbated every preexisting public health problem facing our Nation. And that is especially true for substance use disorder, which often co-occurs with other mental health conditions.

Dr. Durham, I am sure that you are familiar with the data. Did substance use disorder and drug overdoses increase or decrease during the pandemic?

Dr. DURHAM. Thank you, Senator Warren. They definitely increased during the pandemic. I think DPH in Massachusetts reported, for black Americans in particular, a 69-percent increase over the pandemic——

Senator WARREN. Sixty-nine percent increase?

Dr. DURHAM. Yes, in Massachusetts, specifically. That could have been from various, you know—this is usually fentanyl-laced substances. Many times, cocaine use disorder is pretty prevalent in some of the black patients that we see, specifically at BMC. And so we can think of lots of things that happened during this period. What happened to everyone happened also to the folks we see with substance use disorders: job loss, economic insecurity, housing insecurity, the loss of social supports. You know, substance use disorders are a remitting and relapsing disease. People sort of think of one moment in time you are sober, and then that's it. But it is not. And so, it is a chronic medical condition, and we should treat it as such.

Senator WARREN. So let me just push on this a little bit and let that sink in a little bit, that we saw a 69-percent increase in opioid deaths in Massachusetts.

You know, we were already, Nationwide, losing tens of thousands of Americans to drug overdoses. And the problem has only gotten

worse. And I think this is where you were headed. It has gotten worse—differently in different communities.

So you were serving on the front lines of this pandemic at Boston Medical Center, which serves many low-income patients and communities of color. As the coronavirus spread through Massachusetts and substance use disorder worsened, what patterns did you see in terms of the types of patients you saw at BMC, the types of communities that were affected? Can you just say a little more about that? I think that is where you were headed.

Dr. DURHAM. Yes, sure. Well, we predominantly serve about 70 percent black and Latinx at BMC, people who identify as black and Latinx, and about 30 percent do not speak English as their first language.

Just like many, I think many people were scared to come into the hospital at the beginning of the pandemic. And so I think what happened, though, is that we got high acuity as we hit December and January, where people were coming in with severe—whether that be mental illness, but also severe relapse on whatever substance that they may have been previously using and maybe had stopped. I think poverty and job loss, like I mentioned earlier—you know, health, access to health care in general, there was a change in that. We have talked a lot about telehealth, but it does not work for everybody.

And so this is the particular population where I do not think it worked well. You needed to be on a Zoom link with your recovery coach. Did you have access to a computer and to get the Zoom link, and then have a smartphone? So I will pause there.

Senator WARREN. That is very helpful. So you have told us about the scope of the problem. You have told us about how it hits different communities differently. Let's talk a little bit about the solution.

In recent years, Congress has taken some steps, like passing the SUPPORT Act, to expand access to addiction treatment services. But it is clear that more resources are needed.

So let me ask you. Boston Medical Center is a national leader in addiction and substance use disorder treatment, research, and training. Would a significant Federal investment in substance use disorder prevention help lower overall deaths, reduce these disparities, and help support providers like BMC?

Dr. DURHAM. Absolutely. I think that we need parity in mental health and substance use treatment. I think we also silo substance use disorders from mental health disorders from physical health. The more we can combine all of that, because it is one person that presents, the better we will all be.

I do think that we need to start early with community outreach and more investment in the community. I think when we speak about black and Latinx communities in particular, we need more research that allows us to partner with community-based services to do some of that research, because we are not targeting that population well, and we need to invest dollars to do that.

Senator WARREN. Well, I really appreciate it. You know, we have an opportunity here not just to build back to where we were before the pandemic, but to drastically improve our public health infrastructure.

I was very happy to see President Biden's commitment back as a candidate to invest $125 billion over 10 years in substance use disorder and the opioid crisis. And that is why, in the coming weeks, I will be reintroducing my Comprehensive Addiction Resources Emergency Act, or the CARE Act. This legislation would provide State and local governments the resources to combat substance use; to invest in biomedical research, public health surveillance, and professional training; and to expand access to naloxone.

I am looking forward to working with my colleagues to get this done. I appreciate all the work that all of you are doing. I hope you can get better support from Washington to continue to do it.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren. And I believe what you and Dr. Durham have just done in terms of laying out the 69-percent increase in substance abuse in your State really conveys the urgency of what this committee has to do. So I thank you very much, and I thank you, Dr. Durham, because that is what this is all about.

Senator Warren and I talk about this all the time. The committee has a lot of stuff we have to deal with. We have all kinds of issues. But when you hear about a 69-percent increase in substance abuse, you say, "This is something that cannot wait." So I really thank you, Senator Warren.

And I am just going to wrap up with a couple of comments. I want to thank our witnesses. You all have been terrific. And I think you have seen from the Senators the very strong feelings about how important it is that we work on this, and we do it coming together in a very polarized political environment.

I do not know if any of you are aware of the Wyden story. My father wrote a book called "Conquering Schizophrenia." It was about my late brother. And for years and years on end, my brother had schizophrenia and would be out on the streets in California, and the Wyden family went to bed at night worried that he was going to hurt himself or somebody else. And I think that is pretty typical of what families are facing when they are dealing with mental illness. And you all have described how many people fall between the cracks—the incredible stigma of this.

Chantay, thank you so much for describing what you are trying to do in rural Oregon, the part of the State I love so much, to try to reduce the stigma. And you all have laid out a lot of solutions here. You have laid out a lot of solutions, and I have been talking with Senator Crapo. We think that this is an issue where the committee can come together and do better.

We have currently reviewed the committee records. This is the second-ever hearing of the Senate Finance Committee on the issue of mental health care in our over 100-year history. Senator Stabenow and Senator Daines are doing good work in the subcommittee, and I think now both Democrats and Republicans understand that we have to bring a greater sense of urgency and commitment and resources into this issue so that mental health is really in line with physical health, which of course was the dream of Senators Wellstone and Domenici,

And I think I touched on it. I remember opening up the paper the next day, and I said to myself, "Hallelujah; there is hope for

Jeff Wyden and all the families who have suffered." And as you said very eloquently, Dr. Durham, in a lot of instances, the commitment to parity is honored more in the breach than in the observance.

So I thank you all very much for your excellent testimony. It is a great kickoff to the committee's work in this area. I think you have heard from my Republican colleagues—they were raising important issues. I looked at the comments made by my Republican colleagues and my Democratic colleagues, and there was not an offbase idea in the house today. You can literally go up and down both sides of the dais and see Senators with great sincerity offering concrete ideas.

So we are going to wrap up for today. But for all of you and your colleagues who are out there on the web, we are wrapping up for today, but make no mistake about it: we are going to be consulting with you. This is a "to be continued" discussion.

Members know that questions have to be produced, what we call QFRs, within a week. And I want to thank our witnesses again.

And with that, the Senate Finance Committee is adjourned.

[Whereupon, at 12:30 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF THOMAS BETLACH, MPA, PARTNER, SPEIRE HEALTHCARE STRATEGIES

Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for the opportunity to testify today on policy solutions for addressing mental health. I had the privilege of serving as the Arizona Medicaid Director for almost a decade and for a portion of the time, as the Mental Health Commissioner.

Medicaid serves over 70 million members, offering comprehensive mental health benefits to some of our country's most complex populations. In 2020, the Medicaid and CHIP Payment and Access Commission (MACPAC) published mental health statistics that showed, for non-institutionalized adults, 27.6 percent of the Medicaid population had an indicator of mental illness compared to 18.7 percent of the commercially insured population. And for individuals with Serious Mental Illness, the numbers were 8.2 percent for Medicaid, and 4.3 percent for commercial populations.[1]

As you formulate health policy options, State Medicaid programs should be a critical component of the discussion. Understanding the system and the forces prevailing on it should be at the core of discussion.

The last year brought to light the extreme fragmentation of our healthcare delivery system at all levels. Our policy and program structures are in silos. Funding streams to support these populations follow those siloed program and policy structures. Providers gravitate towards these funding streams creating more complexity at the point of care. The very beneficiary the system is designed to serve is forced navigate the maze we created.

Fragmentation is often discussed, so I would like to explain how that fragmentation manifests in our system. When I became Medicaid director, individuals with serious mental illness had up to four different payers to navigate. Forty percent of that population were Medicaid and Medicare dual-eligible members. An individual had a Medicaid plan for physical health, a Medicaid plan for behavioral health, traditional Medicare and a Part D plan or a Medicare Advantage plan. Unfortunately, this level of fragmentation is common. The result is misaligned incentives and the bureaucracies of Medicare and Medicaid spending considerable time and resources creating payment rules and refereeing rather than focusing on improving care for our populations.

Now, in addition to fragmentation, Medicaid leaders are contending with the impact that the pandemic has had on an individual's mental health. It has been well documented that the pandemic has had a more negative impact on individuals with less means, both in terms of health and financial stress.

This last year has brought important issues such as social justice and health equity to the surface and at the same time there was rapid innovation. For example, the use of telehealth and the deployment of the 988 crisis hotline. Both will require much work ahead to ensure long-term success.

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[1] Behavioral Health in Medicaid Presentation, MACPAC, September 2020.

Today's environment has challenges. But States and Medicaid programs now have access to considerable investment resources to address these challenges and advance the delivery of mental health services.

1. Congress has authorized a 5-percent set-aside funding from the Mental Health Block Grant to be used for Crisis Systems.
2. Congress has authorized an 85-percent enhanced match in Medicaid for community mobile response teams.
3. Additional resources are now available for States that use the rehabilitation option to cover behavioral health services, which was included in the 10-percent increased Federal funding for home and community-based services.
4. Finally, additional resources are available for expanding Certified Community Behavioral Health Clinics.

In February 2021, The National Association of Medicaid Directors (NAMD) published "Medicaid Forward: Behavioral Health," outlining a series of strategies Medicaid programs are pursuing to advance mental health services for members. The strategies varied based on the unique populations served by Medicaid. This report highlighted initiatives such as, expanding access and improving timeliness to care, integrating physical health and behavioral health, and expanding access for the full continuum of care including crisis services.

Populations identified included children with complex needs, individuals experiencing homelessness, older adults, individuals with intellectual and developmental disabilities, and individuals involved in criminal justice.

The NAMD report provided proof that when implemented, the highlighted strategies make a difference.

Further, a March 2021 Bipartisan Policy Council report concluded that "integrating primary and behavioral health care is necessary and would ensure that individuals with behavioral health conditions and comorbid physical health problems receive high-quality access to care. Comorbid behavioral and physical health diagnoses are common. Addressing them together through integration can provide a patient-centered approach that can be cost-effective for payers and providers, reduce health disparities, and improve patient outcomes."[2]

Arizona provides a strong example of this, in 2011, we pursued a strategy to better integrate services for individuals with serious mental illness. This strategy was focused on driving integration at three levels.

1. Policy integration—Arizona merged behavioral health policy expertise into the Medicaid program and reviewed all policies that limited integrated services.
2. Payer integration—Arizona braided multiple funding streams including Medicaid, SAMHSA block grants, and local dollars to support housing and other non-Medicaid compensable services.
3. Provider integration—Arizona created new incentives and supported providers in developing more coordination and integration at a provider level. This included opening up new codes to support the collaborative care model. This model has been shown to improve clinical outcomes and reduce costs by further integrating care at the primary care provider.

In 2018, Mercer consulting conducted an analysis of the integration efforts. Their final report for individuals with serious mental illness found that all measures of ambulatory care, preventive care, and chronic disease management demonstrated improvement. For example, Medication management for people with asthma (75-percent compliance) increased 35 percent. Just as important, all indicators of patient experience improved, with five of the 11 measures exhibiting double-digit increases. For example, shared decision-making improved 61 percent.[3]

Another opportunity highlighted by NAMD is to strengthen crisis systems. This issue is front and center with the implementation of 988. SAMHSA provided extensive thought leadership with the development of the Crisis Now model and the publication of the National Guidelines for Behavioral Health Crisis Care Best Practice

[2] Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration. Bipartisan Policy Council, March 2021, page 8.
[3] Independent Evaluation of Arizona's Medicaid Integration Efforts, Mercer, 2018.

Toolkit. This document provides the details on how to establish a system to serve anyone, anywhere at any time.

The Crisis Now model is based on three critical components.

1. Call center capability.
2. Twenty-four by seven Community Mobile Response Teams.
3. Twenty-three hour crisis receiving and stabilization units.

In Arizona, this system was developed over 20 years and serves all Arizonans. The call centers answer thousands of calls every month, meeting the State's expectations of three rings or less. Mobile response teams located throughout the State serve individuals in the community. Stabilization facilities provide services for individuals experiencing severe crisis episodes and offer continuous support for law enforcement to drop off individuals and to return to the field within 5 minutes. The financing for this system comes from creatively braiding multiple funding streams while leveraging Medicaid for support.

While we have seen improvement, there is clearly much more to do. We stand today at a unique moment with the power to address complex issues and continue the momentum of innovation by making strategic policy changes. To that end:

1. Congress and the executive branch need to develop and implement strategies holistically by ensuring Medicaid and behavioral health collaborate and partner in a meaningful manner. On several occasions Congress has leveraged the mental health expertise that lives at the Substance Abuse and Mental Health Services Administration (SAMHSA) to advance policy initiatives. This includes set-aside funding for first episode psychosis and crisis system planning. However, there does not appear to be sufficient expectations established by Congress that these important planning and investment dollars are to be linked to the Medicaid program. Unfortunately, the dollars often get siloed and the opportunity is suboptimal. SAMHSA traditionally works directly with its network of mental health commissioners, and Medicaid programs sometimes lack the expertise or bandwidth to leverage these opportunities. At the end of the day, Medicaid beneficiaries may or may not benefit from these forward-looking investments.
2. Congress should provide more flexibility with block grant funds for States to address social determinants of health as States look at ways to support these investments. As coverage has expanded, there may be opportunities for States to leverage block grants to support select social determinants for specific populations and improve outcomes.
3. Congress needs to legislate to establish payment parity between Medicare and Medicaid. Where Medicaid has led the way in developing paraprofessional staff such as peer support services and systems to support broader populations like Crisis, Medicare should follow. To achieve parity, Congress must act to have Medicare cover these and similar services.
4. Congress should continue to provide financial incentives for States to modernize the mental health infrastructure. Programs like Money Follows the Person worked well for home and community-based services. I am excited to see Congress using similar approaches for behavioral health services like community mobile response teams and CCBHCs. Congress should consider lending financial support towards models that improve care and access. This approach should also be expanded to dual eligible members as well.
5. Congress should continue to evaluate the impact of the IMD 16-bed limits. While there have been efforts made to allow for some payments in select instances, some States have not been able to avail themselves of these opportunities. A good place to start the policy discussion is looking at select settings like crisis stabilization.
6. Congress should rectify the fact that behavioral health providers were excluded from the electronic health records incentive program provided through the HITECH Act. Data aggregation and analytics are an important component of improved care coordination. This is an investment that should be made to advance integration.
7. Finally, Congress should evaluate how graduate medical education financing policies negatively impact the ability to attract specialists, such as child psychiatrists, to meet the needs of the Medicaid population. Many States, like

Arizona, are punished as a result of the Medicare formulas that are locked in at 1996 allocations.

We are at a critical moment in time to advance the delivery of mental health services, not only within Medicaid but for our entire country. Thank you for your time and interest in these topics.

QUESTIONS SUBMITTED FOR THE RECORD TO THOMAS BETLACH, MPA

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. Arizona has been a leader in behavioral health crisis services as the State's crisis now model has been incredibly successful in supporting individuals experiencing crisis, and creating a safety net for folks who have slipped through the cracks of our mental health system for far too long. Senator Cornyn and I have introduced legislation that seeks to empower communities across the country to build crisis services. The crux of our bill is insurance coverage—these are services that should be covered, no matter where people get their insurance.

What kind of difference would insurance coverage make as States look to build crisis services similar to the Arizona model?

Answer. Having all insurers provide coverage for crisis services would greatly benefit States. True parity would enable additional resources to be made available to support important crisis infrastructure. If all plans (*e.g.,* commercial insurers and Medicare) covered a broad continuum of behavioral health services, it would reduce stigma, educate consumers on the importance, and improve access to behavioral health resources.

Question. What else can Congress do to facilitate the delivery of crisis services across the country?

Answer. Congress can continue to provide financial incentives like the block grant set-aside funding for crisis services and the additional funding for mobile response teams. Additionally, Congress can work closely with the administration to ensure appropriate coordination is occurring at the Federal level to maximize collaboration between agencies, including SAMHSA and Medicaid.

Question. In your testimony you also highlighted a recent report from the Bipartisan Policy Center on behavioral health integration.

What does that look like in practice and how easy or difficult would it be to implement this kind of integration into risk-based payment models such as Accountable Care Organizations, Medicaid Managed Care Organizations, and Medicare Advantage?

Answer. It is challenging to implement integration well with managed care. States should be thoughtful purchasers and make sure that appropriate contracts and policies are in place to support payer and provider integration. However, as more States have adopted integrated purchasing models, lessons learned and best practices are available to other States to enable them to successfully design and implement structures. State experience tells us that while it is challenging, if done correctly there are positive impacts associated with payer integration.

Question. What difference would that make in boosting access to services?

Answer. The Arizona experience shows that for individuals with serious mental illness there has been an increase in access when measured based on HEDIS scores. When done appropriately, integration results in additional providers being able to deliver behavioral health services.

QUESTIONS SUBMITTED BY HON. JOHN BARASSO

Question. The health-care professionals, along with all front-line workers, deserve our gratitude and appreciation. Their dedication to our communities during this pandemic is something we must recognize and never forget.

A top concern of Wyoming mental health facilities is making sure there are enough staff to care for their patients. It is especially challenging to attract and keep health-care providers in rural communities. Can you discuss solutions related

to workforce development you believe will improve the ability of mental health facilities to attract and maintain staff in rural areas?

Answer. Medicaid has done some excellent work expanding the behavioral health workforce through the use of peer supports. By leveraging individuals with lived experience, Medicaid has been able to expand access and better engage patients. Medicaid (and other payers) need to continue to expand the use of peer and family supports for behavioral health. In addition, the significant growth of telehealth, in response to COVID, expanded access and should continue to improve workforce capacity particularly in rural areas.

Question. Can you specifically discuss changes to GME policy you believe would improve the pipeline of mental health physicians?

Answer. There are a range of policy changes that Congress should consider with regards to GME. Three GME policy changes that would have a strong positive impact and improve capacity are:

- Change the Medicare formula to recognize the growth that has occurred especially in States like Arizona that are at an extreme disadvantage based on the Medicare formula being frozen for the past 25 years.
- Provide incentives for GME programs that specialize in behavioral health training.
- Increase expectations and create incentives so that more training can be done in outpatient clinics and in rural settings.

Question. As a doctor, I strongly support increasing access to mental health services, especially in rural communities. Senator Stabenow and I have previously introduced legislation for many years that would allow mental health counselors and marriage and family therapists to receive reimbursement from Medicare.

Can you discuss how the Department of Health and Human Services can improve access for mental health services, especially for those on Medicare?

Answer. Access will be improved when Medicare improves the overall benefits for behavioral health by expanding who can deliver services and where those services may be delivered.

Question. In particular, can you comment on the merits of allowing licensed professional counselors and marriage and family therapists to receive reimbursements from Medicare?

Answer. Some State Medicaid programs have determined that covering these codes are valuable in increasing access for members. Given the limited benefits within Medicare today for behavioral health services, especially in comparison to the robust Medicaid benefits, this is an important area for Congress to evaluate.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. The toll that union-sponsored excuses for "virtual learning" has taken on actual kids is extraordinarily sad, especially for our Nation's most vulnerable children. In October 2020, a survey conducted by the Jed Foundation showed that 31 percent of parents said their child's mental or emotional health was worse than before the pandemic. Private insurance data also shows that while all health care claims for adolescents ages 13–18 were down in 2020 compared to 2019, mental health-related claims for this age group increased sharply. Additionally, the Centers for Disease Control and Prevention (CDC) reports 25 percent of parents whose children attended school virtually were more likely to report an overall worsened mental or emotional health compared to only 16 percent of parents of children attending school in-person.

What strategies and collaboration efforts would you recommend to encourage the infrastructural changes and technical assistance necessary to promote school safety and proactive approaches to mental health challenges?

Answer. We need to continue our efforts to train and support parents, teachers, staff, and students about the importance of behavioral health. Programs like mental health first aid have shown benefits towards reducing stigma and providing individuals with important tools on how to have challenging conversations.

Question. What programs within the Department of Health and Human Services' (HHS) purview are best poised to support children and schools as they return to complete in-person learning?

Answer. See above.

Question. How can we integrate more telehealth opportunities to expand access to mental health services in schools?

Answer. Medicaid and other purchasers should work with insurers and schools to leverage telehealth and other mobile technologies to engage students. These opportunities extend beyond just K–12 into higher education. Some States are evaluating policies that will expand the capacity to use schools as sites for delivering telehealth services.

Question. Telehealth has expanded rapidly as a result of the COVID–19 pandemic. Numerous studies have demonstrated the effectiveness of telehealth for behavioral health services. As telehealth becomes more common among health-care providers, what can Congress do to ensure that patients do not suffer from unnecessary bureaucratic delays?

Answer. States with support from the Federal Government greatly expanded access to telehealth services for programs like Medicaid. Post-COVID, States will need to monitor access to ensure that inappropriate barriers are not being placed on the delivery of services. Access to care and the quality of the services being delivered are ultimately what Congress may want to consider evaluating as the telehealth evolution moves forward.

Question. There is a well-researched connection between unemployment and mental health. As recently as April 2021, despite billions of dollars of COVID–19 stimulus, aggregate employment remained 7.9 million jobs below its pre-recession level.

What impact will this failure to get people back to work have on mental health?

Answer. Recent surveys and studies indicated that individual stress levels are higher today than pre-COVID. There are many factors in place that have resulted in increased stress, including employment status. There will need to be continued efforts to provide education to individuals and families on the importance of mental health along with information on how individuals may access care in a timely matter.

Question. Last November, an article published in the *Journal of the American Medical Association* noted that multiple studies indicated that older adults may be less negatively affected by certain mental health outcomes than other age groups. Are these study outcomes consistent with your own professional experiences working with older adults?

Answer. This in not my area of expertise, and I do not feel comfortable commenting on this.

Question. Current network adequacy standards often allow networks of specialists who aren't taking new patients or who have long waiting lists. That means that many people needing treatment must go out of network to get care, and only those who can afford the high cost get it. One of the biggest challenges to access to behavioral health care services is that many behavioral health specialists don't participate in health plan networks.

Why is that, and how can we change that?

Answer. Market dynamics often drive provider utilization. It is clear that the country needs more specialists and a broader workforce to meet the increased demand. Congress should evaluate the impact of Graduate Medical Education funding and how that has resulted in constraints in behavioral health specialists. Medicaid has overcome some of the constraints by establishing a para-professional workforce of Peer supports.

Question. Outside of the public health emergency, telehealth services are restricted to certain geographic and clinical settings. Beneficiaries must live in a rural area and have an initial face-to-face visit with the distant-site provider. Once a relationship has been established, periodic in-person visits are also required. With few exceptions, patients must be located in a clinical setting and may not receive care from their homes. In addition, the distant- site provider cannot be located in a rural health clinic or FQHC.

Telehealth has been used broadly during the pandemic to expand health-care access to individuals throughout the country. During the pandemic, Medicare significantly expanded the coverage of telehealth services. A recent Bipartisan Policy Center poll suggests that people receiving mental health and substance use services

want a combination of in-person, video, and telephone services even after the pandemic has passed.

What telehealth expansions should remain after the pandemic?

Answer. I believe that consumers will expect all telehealth expansions to remain in place after the pandemic and purchasers and payers will need to ensure appropriate oversight is in place to drive the level of quality required from this platform.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. Could you please explain why utilizing the primary care physician as the coordinator for a patient's mental health will result in better access to care and, ultimately, better patient outcomes?

Answer. Primary care physicians in many instances can serve as an initial access point for individuals with behavioral health needs. Like other acute or chronic issues, more serious cases may require a referral to specialists. However, a primary care provider may in fact be well-positioned to deal with the behavioral health needs of the patient in that moment. For many patients, the relationship with the primary care provider is already established and there will be more interactions. There also may be an ability to deal with stigma and educational issues around behavioral health diagnosis. Like many other cases that are more complex, primary care providers may not ultimately be the only provider involved with a patient but we need to do more to leverage and incentivize our primary care providers to meet the behavioral health needs of patients.

Question. Do you foresee any differences in integrating care with pediatricians and perhaps geriatricians as well?

Answer. Yes. Integration will look different for subsets of populations. Pediatricians need support for certain diagnosis and subpopulations. For example, children with more severe cases of autism may need to be referred to other providers for specialty services. More complex cases like children involved with the foster care system may require additional behavioral health supports. Populations served by geriatricians may require more robust specialty home and community-based services. Coordination between providers, patients and families are critical and pediatricians and geriatricians should be able to lean on insurers and managed care organizations to support and enhance service coordination.

Question. As COVID–19 closed down our society, health-care providers still cared for patients. And with the pandemic came increased isolation, loneliness, anxiety, and depression.

Sadly, nearly 40 percent of American adults reported struggling with mental health or substance use. Anxiety and depression rose by 31 percent and serious suicidal ideation increased by 11 percent.

Points of access for those in crisis is a high priority for me. Last Congress I, alongside my colleague Senator Bennet, introduced the Suicide and Crisis Outreach Prevention Enhancement Act. This bill would reauthorize the National Suicide Prevention Lifeline for 5 years and collect more data on outcomes, providing a feedback loop of perfecting best practices. We think this legislation could save lives and help breakdown the stigma of seeking mental health care.

Can you describe the impact that you see this pandemic having on the need for access to mental and behavioral health services?

Answer. The pandemic has resulted in an increased need for behavioral health services. It has also increased expectations that these services be delivered through a full continuum of platforms including in-person, telehealth, and the ability to have individuals receive services in-home.

Question. What gaps do you continue to see in access to mental and behavioral health care?

Answer. Consistent with my testimony, we need to continue to support integration so that more patients can access behavioral health services in more settings. We need to continue to create incentives for a full continuum of services. The Lifeline program is a great start, but there is significant work to be done to enable success.

With the advent of 988, we need to make sure States are creating the infrastructure to respond to the expected increased demand. We also need a full continuum

of crisis services. While Lifeline call center capacity is critical so are community services like mobile response teams and stabilization centers who handle more complex cases that cannot be resolved by call center teams. We need to create alternatives to emergency department boarding and short-term incarceration for those in crisis. We need to have Medicare and commercial carriers provide more financial support for behavioral health services and follow the lead Medicaid has established with broader services and provider access. We need to incentivize GME programs to create more specialists to support the behavioral health needs of patients.

Question. You mention in your testimony the National Association of Medicaid Director's recommendation of Crisis Systems. These are teams that are mobile, in the community and respond to individuals who may be experiencing a mental health crisis.

I am honored to work with my colleague from Nevada, Senator Cortez Masto, on the Behavioral Health Crisis Services Expansion Act. This bill would help communities establish a continuum of care for those undergoing a mental health crisis and support first responders and care providers by making such services reimbursable under Medicare and Medicaid.

This model would transform the way communities care for individuals in crisis and, in turn, it would help those who are most in need. I know you outlined the Crisis Now model in your testimony, but could you reemphasize the potential impact of such a crisis care system?

Answer. In Arizona, the Crisis Now model has been a critical part of the behavioral health continuum. It has provided robust call center teams that support individuals experiencing behavioral health crisis. Consistently, Arizona has one of the highest answer rates of any State for calls made to the Lifeline that originate from Arizona area codes. These call centers are able to support those in crisis by activating robust mobile response teams that serve all Arizonans (not just Medicaid members) in both urban and rural parts of the State. For the most complex cases, individuals may be served by short-term stabilization units. These stabilization units have also supported tens of thousands of law enforcement drop-offs that often occur in under 5 minutes. A robust crisis system can serve anyone anywhere at any time. Unfortunately, Arizona is somewhat unique in having this level of infrastructure. The overall impact is that people experiencing a behavioral health crisis are served in their time of need by individuals trained to deal with those in need. Crisis Now offers an appropriate array of vital services as an alternative to how people were treated previously through Emergency Department bed holds and incarceration.

Question. Do you see these teams as part of a larger strategy for addressing mental health?

Answer. Yes. The Crisis Now model serves individuals experiencing a crisis. We need to continue to expand access to prevent individuals from moving into crisis. We need to expand educational efforts around the importance of behavioral health and reduce stigma. We need to look at creative ways to deliver engaging behavioral health services through various platforms. We need to continue to improve culturally appropriate services and expand behavioral health access to address health equity issues. Crisis is an important step for improving behavioral health services but it is not the only policy focus that needs to be addressed to meet the needs of our country.

SUBMITTED BY HON. BILL CASSIDY, A U.S. SENATOR FROM LOUISIANA

American Telemedicine Association
901 N. Glebe Road, Suite 850
Arlington, VA 22203
T 703–373–9600

June 15, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Telemedicine Association (ATA), I commend you for holding an important and timely hearing entitled, "Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions." This hearing presents an excellent opportunity for members of your committee to thoughtfully consider the future of mental health care and how Congress can act to expand access to quality care for patients across the country. One such way you can accomplish this goal is to support the Telemental Health Care Access Act of 2021, bipartisan legislation championed by Senators Cassidy (R–LA), Smith (D–MN), Cardin (D–MD), and Thune (R–SD). The ATA enthusiastically endorses this important legislation and asks that you give it every possible consideration as you work together to identify policy solutions to improve mental health services.

As the only organization exclusively dedicated to expanding access to care through telehealth, the ATA appreciates and commends your committee's continued work to thoughtfully consider sound health care policies, including those impacting Medicare beneficiaries' access to telehealth services. Telehealth allows patients to receive safe, affordable, and quality care where and when they need it and has been a lifeline for millions of Americans during the COVID–19 pandemic. Before COVID–19, 65% of patients felt hesitant about telehealth, but now 87% want to continue using telehealth services post-pandemic.[1] Behavioral health services lend themselves particularly well to remote care, both because physical presence is not always clinically necessary for care and because of the great need for more access to mental health services.

We appreciate Congress's acting swiftly at the beginning of the COVID–19 Public Health Emergency (PHE) to ensure patients could safely access health care services from their homes. As you know, should Congress fail to act before the end of the current PHE, millions of Medicare beneficiaries will lose the choice to use these telehealth services. We look forward to continuing to work with you and your dedicated staff on policies that ensure these beneficiaries are not pushed off the telehealth cliff. Further, we commend you for already recognizing this looming cliff by including in the Consolidated Appropriations Act, 2021, Pub. L. 116–260, a provision to ensure Medicare beneficiaries can access telemental services moving forward. However, one well-intentioned part of this policy provision, the in-person requirement, could have unintended negative consequences on Medicare beneficiaries.

In-Person Requirements for Telehealth Are Clinically Inappropriate

There is no clinical evidence for an arbitrary in-person requirement before a patient can access telehealth services. In fact, evidence has demonstrated that telemental services like telepsychology are just as effective as in-person visits.[2] Further, there is clear consensus that a provider can establish a relationship with a patient via a telehealth visit. The association of state regulators who oversee standards of medical care, the Federation of State Medical Boards, states that ". . . the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient."

In-Person Requirements Exacerbate Provider Shortages

The United States has a deficit of 6,000 mental health providers, and this shortage is expected to grow to a quarter of a million by 2030.[3] As we saw in 2020 and 2021, telehealth increases the capacity of the providers we do have to see more patients by removing geographic and other physical barriers. We must work together to increase the number of mental health providers to ensure all Americans get the care they need. However, explicitly denying a patient's access to mental health services based on his or her inability to find a scarce mental health provider is simply unreasonable.

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[1] How Americans Feel About Telehealth: One Year Later, SYKES' 2021 Telehealth Survey Report, April 9, 2021.
[2] How well is telepsychology working?, American Psychological Association, July 1, 2020.
[3] Triple-Tree: A New Era of Virtual Health Q2, 2021.

In-Person Requirements Increase Barriers and Worsen Health Inequities

The ATA strongly opposes statutory in-person requirements as they create arbitrary and clinically unsupported barriers to accessing affordable, quality health care. Requirements such as these could negatively impact those in underserved communities who may not be able to have an in-person exam due to provider shortages, work, lack of childcare, and/or other resources. Recent CDC data demonstrate that 23% of American adults do not have an existing relationship with a health care provider, and that statistic is alarmingly high in minority populations.[4] We cannot ignore the importance of providing all Americans, regardless of whether they have an established relationship with a medical provider, the opportunity to access life-saving health care.

Federal In-Person Requirements Unnecessarily Preempt State Laws

The in-person requirement for telehealth services is at odds with the direction telehealth policy has moved over the last decade. It disrupts Medicare's historical approach, which is to remain deferential to state laws on professional practice requirements and clinical standards of care. Today, no state practice of medicine law in the U.S. requires a prior in-person visit. The ATA urges Congress to ensure telemental health services continue post-pandemic but to recognize federal laws restricting these services are inappropriate. Instead, Congress should defer to states and individual payers to determine telehealth prerequisites. For the Medicare program, instead of codifying service-specific restrictions in statute, Congress should work with HHS to ensure the Secretary has the authority at the regulatory level to implement any appropriate health care requirements. By explicitly limiting care in statute, legislators will unnecessarily stifle innovation and tie the hands of regulators, providers, and patients.

For each of the reasons listed above, the ATA is proud to strongly support the Telemental Health Care Access Act and applauds the leadership of Senators Cassidy, Smith, Thune, and Cardin in introducing this essential legislation. We ask that you, too, consider the importance of this legislation and how we can work together to identify commonsense policies to not only expand access to care but also ensure beneficiaries and federal taxpayers are protected. Thank you for your consideration, and please feel free to contact the ATA policy director Kyle Zebley should you have any questions about our support for thislegislation or ATA's broader federal policies.

Kind regards,

Ann Mond Johnson
CEO
American Telemedicine Association

CC: The Honorable Bill Cassidy
The Honorable Tina Smith
The Honorable John Thune
The Honorable Ben Cardin

HEALTH INNOVATION ALLIANCE ET AL.

June 22, 2021

Senator Bill Cassidy
520 Hart Senate Office Building
Washington, DC 20510

Senator Tina Smith
720 Hart Senate Office Building
Washington, DC 20510

Senator Ben Cardin
509 Hart Senate Office Building
Washington, DC 20510

Senator John Thune
511 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Cassidy, Smith, Cardin, and Thune:

We write to thank you for your support of patients and providers in the mental health community by introducing the Telemental Health Care Access Act. We endorse your bill and applaud your efforts to ensure consistent coverage of mental health services furnished through telehealth.

[4] Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity, KFF, Accessed June 8, 2021.

Congress and the Administration have done much to utilize telehealth in response to COVID–19, and the results have been impressive. Prior to the pandemic just one percent of primary care visits were delivered via telehealth. Immediately after COVID–19 came ashore, primary care visits were delivered via telehealth more than 40 percent of the time. Telehealth improved access to care without generating cost increases for many, and at the exact time it was needed to help safeguard patients and prevent additional infections. It is a solid investment.

We were glad to see language pass through the Consolidated Appropriations Act of 2021 to remove Medicare restrictions on the mental health services delivered through virtual means, but we believe the inclusion of the in-person requirement every six months was unnecessary and a step in the wrong direction. Your legislation seeks to rectify that issue and we appreciate your leadership. Over the past 10 years, all 50 states and the District of Columbia have removed in-person requirements as a prerequisite to treatment through telehealth. In-person requirements on telehealth services create unnecessary barriers to care and can be especially harmful for those seeking mental and behavioral health services. The Health Resources and Services Administration reports a shortage of over 6,500 providers in the mental and behavioral health specialty. The scarcity of providers, particularly in rural and underserved areas makes lifting the in-person requirement even more critical. Those seeking care should not, and in many instances cannot, travel for hours to see an in-person provider.

By removing the automatic application of an in-person requirement for telemental health services in Medicare, Congress can improve health and lower costs while increasing access and utilization. This is where health care must head to become consumer-focused and responsive in the 21st century. We strongly urge Congress to pass the Telemental Health Care Access Act and continue increasing patient access to convenient at-home telehealth services. Thank you for considering our comments and for your leadership on this important issue.

Sincerely,

Health Innovation Alliance
American Telemedicine Association
STCHealth
CoverMyMeds
HIMSS
PCHAlliance
National Council for Mental Wellbeing
athenahealth
Alliance for Connected Care
eHealth Initiative
Doctor On Demand
Hims & Hers
Association for Behavioral Health and Wellness
GO2 Foundation for Lung Cancer
Partnership to Advance Virtual Care
Teladoc Health
Centerstone
American Psychiatric Association
3M Health Information Systems
American Foundation for Suicide Prevention
American Psychological Association
The Michael J. Fox Foundation for Parkinson's Research
American Medical Association
College of Healthcare Information Management Executives
Connected Health Initiative
American College of Physicians
Federation of American Hospitals
American Heart Association
Greenway Health
Marshfield Clinic Health System
Association of American Medical Colleges
American Medical Group Association
Vanderbilt University Medical Center

PREPARED STATEMENT OF HON. MIKE CRAPO,
A U.S. SENATOR FROM IDAHO

Thank you, Mr. Chairman. Ensuring access to high-quality mental health services has been—and must continue to be—a priority.

Far too often, individuals with mental health, addiction, or substance use disorders find themselves isolated from their communities and separated from their providers. While Congress has taken decisive steps to address addiction, bolster behavioral health care, and curb substance use disorders, challenges remain. This committee has the ability to turn the tide.

We can begin by empowering States to craft innovative, targeted solutions. Medicaid functions most effectively when States have the flexibilities they need to address patients' unique care needs and adapt to unforeseen crises. As the Nation's largest payer of mental health and substance use disorder services, Medicaid must support, rather than subvert, State efforts to serve communities in need.

Unfortunately, the COVID–19 pandemic has highlighted—and exacerbated—the mental and behavioral health challenges we continue to confront. Loss of loved ones, increased isolation, and delayed treatment prompted a spike in anxiety, depression, and other debilitating conditions.

While many are returning to their pre-pandemic lives, we should not be content to allow our mental health-care delivery system to revert to its pre-pandemic ways. Whether for rural communities, urban areas, or tribes, telehealth has undoubtedly increased access to care. Through emergency flexibilities and permanent legislation authored by this committee late last year, we have taken crucial first steps toward modernizing telehealth coverage.

I look forward to working with you, Mr. Chairman, and with other members of this committee to build on those efforts in the months ahead. Further, by partnering with State and local leaders, we can spur care coordination, strengthen the mental health workforce, and drive value through delivery system reforms.

While there is no silver bullet here, I am confident we can tackle all of these challenges while upholding core principles of fiscal responsibility and program integrity.

Before concluding, it bares emphasizing that we must continue to make progress in improving understanding of mental health so that people in need are not afraid or ashamed to seek treatment. We cannot discount the impact of stigma on preventing those in need of treatment from receiving care. I look forward to hearing our witness testimony today to learn more about the solutions they have identified.

PREPARED STATEMENT OF MICHELLE P. DURHAM, M.D., MPH, FAPA, DFAACAP, ASSISTANT PROFESSOR OF PSYCHIATRY, BOSTON UNIVERSITY SCHOOL OF MEDICINE; AND VICE CHAIR OF EDUCATION, AND PSYCHIATRY RESIDENCY TRAINING DIRECTOR, DEPARTMENT OF PSYCHIATRY, BOSTON MEDICAL CENTER

Thank you, Chairman Wyden, Ranking Member Crapo, and distinguished members of the Senate Committee on Finance, for holding this hearing and providing me with the opportunity to speak today about the state of the mental health-care system in America—where it's working, where it falls short, and how the Federal Government can play a role in helping to fill the gaps.

My name is Dr. Michelle Durham. I am a pediatric and adult psychiatrist at Boston Medical Center, and vice chair of education in the Department of Psychiatry, where I also trained for my residency, and now have the distinct honor of serving as the psychiatry residency training director. I hold a joint appointment at the Boston University School of Medicine as an assistant professor of psychiatry. Boston Medical Center (BMC) is an academic medical center and the largest safety-net hospital in New England. The patients we serve are predominantly low-income, with approximately half of our patients covered by Medicaid or the Children's Health Insurance Program (CHIP)—the highest percentage of any acute care hospital in Massachusetts.

The BMC emergency department, which includes 8 adult psychiatric emergency beds, is among the top ten busiest in the country. Mental illnesses are all too common among the patients BMC treats in our emergency department and across our continuum of mental health care services, which include outpatient integrated mental health care within our pediatric and adult primary care clinics and at local community health center partners, a mental health urgent care clinic, a crisis stabiliza-

tion unit, and our Boston Emergency Services Team (BEST) provides community-based evaluations and a jail diversion program. At present, BMC does not own or operate a locked inpatient psychiatric unit.

To give you a sense of who BMC serves, 70 percent of our patients identify as black or Latinx, approximately one in three (32 percent) speak a language other than English as their primary language, and over half live at or below the Federal poverty level. The patients we see at BMC who present with mental illness frequently have co-occurring substance use disorders, homelessness, malnutrition, and other health-related social needs linked to poverty. The current COVID–19 pandemic, structural racism, and economic crisis has further exacerbated the mental illness and trauma experienced by our patients. In my 10 years at BMC, I have never seen our mental health-care services stretched so far beyond their capacity as they are now. Just the other day, we had 25 patients in our psychiatric emergency department—more than triple its capacity—presenting with a much higher level of acuity, some waiting for evaluation and others boarding awaiting placement in an inpatient psychiatric unit.

A severe lack of capacity in our country's mental health-care system existed long before the COVID–19 pandemic. The reasons for this are multifactorial; however, for the sake of my remarks today I will broadly categorize them into issues related to the mental health-care workforce and patient access to care.

It is widely understood and well-documented that America has a dearth of licensed mental health professionals, in general, and that particular areas of the country—largely rural and outside of the Northeast—are disproportionately impacted.[1] Even where I practice in Boston, which has one of the highest number of child and adolescent psychiatrists per capita in the country, the capacity is insufficient to meet the mental health needs of the community.[2] Increased Medicare graduate medical education (GME) funding for psychiatry residency slots can help increase the physician workforce. Increased funding for loan forgiveness programs for those who work in underserved areas can help alleviate the $250,000 of debt that the average medical student has accumulated by the time their residency education is completed. The need to pay off medical school loan burden is also likely to cause physicians to pursue practice in more affluent areas, adversely impacting access to care for lower-income populations.[3]

Beyond the shortage of providers, the mental health workforce is not diverse—for instance, only 2 percent of psychiatrists identify as black—and not representative or reflective of the U.S. population.[4, 5] In order to address this, we must understand that the issue at its root is a pipeline issue that requires holistic solutions. Just as we say in medicine, that a person's ZIP code is more influential than their genetic code in determining life trajectory and long-term health, where a person lives, the color of their skin, and language they speak is highly determinative of the quality of education and resources available, the level of exposure to the mental health field, and stigma associated with mental illness.

In terms of access to mental health services, COVID–19 led to an accelerated adoption of telemedicine. At peak, over 90 percent of our outpatient psychiatric visits were conducted via telehealth, which enabled BMC to maintain and exceed our pre-pandemic volume of service. That said, while telehealth is an important tool for ensuring patient access to mental health care, it does not work for everyone due to digital inequities that exist related to Internet access and digital literacy, especially among low-income communities.

Additional barriers to care exist as a result of disparate insurance coverage, lack of mental health parity, and insufficient insurance uptake by licensed mental health

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[1] U.S. Health Resources and Services Administration. Health Professional Shortage Areas Data Dashboard. Last Updated: June 10, 2021. *https://data.hrsa.gov/topics/health-workforce/shortage-areas.*

[2] American Academy of Child and Adolescent Psychiatry. Practicing Child and Adolescent Psychiatrists Workforce Maps by State. Last Updated: March 2018. *https://aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx.*

[3] Zimmerschied C. How med student loan burdens can deepen health disparities. American Medical Association. April 27, 2017. *https://ama-assn.org/education/medical-school-diversity/how-med-student-loan-burdens-can-deepen-health-disparities.*

[4] Lin L, Stamm K, Christidis P. How diverse is the psychology workforce? American Psychological Association. 2018; 49(2). *https://apa.org/monitor/2018/02/datapoint.*

[5] American Hospital Association (2016). The State of the Behavioral Health Workforce: A Literature Review. *https://aha.org/system/files/hpoe/Reports-HPOE/2016/aha_Behavioral_FINAL.pdf.*

providers (especially for Medicaid). The social determinants of mental health and structural vulnerabilities inherently involved with treating low-income patients require more dedicated time with patients to provide appropriate care. Insufficient Medicaid reimbursement acts as a deterrent for providers to see Medicaid patients, producing a cascade effect in which the more oppressed, marginalized populations have limited to no access to mental health professionals.

I welcome the Senate Finance Committee's involvement in exploring ways for Federal policy to improve mental health care across various settings, as well as incentivize and seed the development and scaling up of innovative models of mental health care delivery in order to improve access. A few such examples include:

- Transforming and Expanding Access to Mental Health Care in Urban Pediatrics (TEAM UP) for Children, a pediatric integrated model in Federally Qualified Health Centers in Massachusetts, builds capacity of health centers to deliver high-quality, evidence-informed care to children and families. The model includes behavioral health clinicians and community health workers working with pediatric primary care providers to provide timely mental health treatment.
- The Massachusetts Child Psychiatry Access Program (MCPAP) improves access to treatment for children with behavioral health needs and their families by making child psychiatry services accessible to primary care providers across Massachusetts via remote consultation and education. This model has been expanded to other States such as Connecticut where I completed my fellowship.
- The Wellness and Recovery After Psychosis (WRAP) Program is tailored for people experiencing psychotic symptoms using a team-based approach and providing individual, group and family therapy, medication management, case management, and peer support.
- The Metro Boston Recovery Learning Community (MBRLC) offers peer-to-peer services for people in recovery from mental health and/or substance use issues through peer support, advocacy, and career coaching.

We are at a pivotal time in our country. Over a year into the COVID–19 pandemic, every person's mental well-being has been impacted in some way. The need for a more robust mental health care system has never been more clear or pronounced. Treatment for mental health issues should be accessible—no matter who you are, where you live or your ability to pay. Appropriate investment along the care continuum and for the mental health workforce can improve access to care and retention and recruitment of mental health professionals.

Mental health is health and should not be thought of or managed separate or apart from physical health in the ways it historically has been. The time is now to invest in a 21st-century mental health-care system in America.

Thank you for your time. I look forward to the discussion.

QUESTIONS SUBMITTED FOR THE RECORD TO MICHELLE P. DURHAM, M.D., MPH, FAPA, DFAACAP

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

Question. During your testimony and conversations with my staff, you mentioned that telehealth flexibilities were not enough to fully capture people with substance use disorder that encountered BMC providers (for example, it was harder to connect individuals that entered the emergency room with SUD services that were online, as opposed to available in person and in the moment). Congress should take steps to expand telehealth flexibilities beyond the pandemic, but it should also identify and seek to mitigate gaps that emerge when telehealth is the default.

What additional barriers, if any, did virtual telehealth services pose to patients in need of SUD services, and what specific steps should Congress take to address those barriers in advance of future pandemics?

Answer. Telehealth video was difficult for patients who didn't have reliable access to the needed technology (phones with video, computers, Internet, etc.) and a confidential place to have an appointment. Patients who need certain medications still were required to come into the clinic (*e.g.,* methadone and injections for naltrexone or extended-release buprenorphine). Reimbursement for audio-only appointments al-

lowed clinicians to connect with folks who did not have access to technology with video capabilities and should be continued beyond the pandemic. Expanding mobile services for methadone and injectable medications would also help to reduce barriers to treatment. The infrastructure proposals before Congress that seek to expand broadband access would also be beneficial to enable more of the population to reliably access telehealth services. In addition, the Federal Government could work with local communities to establish centralized locations in the community where people can attend telehealth appointments.

Question. During your testimony, you raised the alarming statistic that black men in Massachusetts saw a 69-percent increase in overdoses and overdose deaths during the pandemic.

As Congress seeks to develop future legislation that responds to overdoses and overdose deaths through a health equity lens, what types of questions should members ask to ensure they are identifying challenges facing communities of color in SUD policy development?

Answer. I really appreciate this question. I think it's important for members of Congress to ask, "Who is not at the table?" It is important to include people with lived experience with addiction, including persons of color, in the conversation as they are so often left out, and ask them directly, "What are the challenges you personally faced in getting the care you needed to get better?" In addition, using a health equity lens, Congress could ask, "How does SUD treatment offered to white patients differ from what is offered to persons of color, in terms of where services are offered, how they are advertised, and what specific treatment are offered to individuals? Data suggest that racial disparities exist in each of these arenas.

It is also important to acknowledge that stigma related to addiction and mental health is very real and differs by community and culture. Stigma is a challenge for ensuring access to care and stigma is a challenge for policymaking. Members of Congress can help reduce stigma by validating the experiences of persons of color with substance use disorders by inviting them to have a seat at the table in the development of SUD policy. Congress could seek to learn more about why stigma exists against seeking help, including the particular stigma associated with receiving medications for addiction, and what added stigma exists for persons of color who use drugs.

The Federal response to addiction should not focus on a specific class of substances like opioids at the exclusion of others as use patterns oftentimes cuts across racial/ethnic lines. In addition, use of more than one substance (or polysubstance use) is common and government policies and funding would do better to reflect that reality. As members of Congress are likely well aware, fentanyl is increasingly being mixed into other substances like cocaine, which users may ingest unknowingly, and may influence overdose and overdose death rates. The Congress could inquire, "How does the availability of drugs and presence of fentanyl in the drug supply create further disparities in overdoses and overdose deaths for persons of color?"

There are numerous historical policies related to drug use that have resulted in the systematic exclusion of people of color from addiction treatment services. Reviewing past policies through a health equity lens can help to correct past inequities in order to create a more equitable and accessible SUD treatment system for persons of color. In particular, decriminalizing drug possession can help individuals get the treatment they need and avoid incarceration where comprehensive addiction services, including medications for addiction treatment, are rarely available. Additionally, a health equity lens should be applied to examining racial disparities in access to different medications for opioid use disorder, like methadone, which is more commonly prescribed to persons of color, and buprenorphine, which is more commonly prescribed to white patients, as well as the disparate regulations pertinent to these treatments. Research is necessary to better characterize the needs of people of color and to design addiction treatment programs that may be more responsive to their goals and expectations—the Federal Government can play a role in catalyzing and seeding this research. Additionally, Congress can create sustainable funding and additional incentives for integrated mental health and primary care services, which especially for low-income populations, like those served at BMC, should incorporate the capacity to address social determinants of health.

Question. In your experience as a provider, how do you see these communities left out of SUD conversations, and what preemptive steps should policymakers take to center these communities in policy discussions?

Answer. The one-size-fits-all approach of the American health care system does not work for all communities—*i.e.,* expecting patients to show up to clinic to get care, instead of bringing care to places and people that communities trust. For example, care provided in houses of worship, community centers or home visits. In general, there's not a lot of focus on prevention and promotion in our addiction and mental health-care system. Greater investment in community-based organizations and support services, such as case management focused on psychosocial needs, would help reach more people that the current system fails to catch. It also could help to create a seat at the table in SUD policy discussions for community health workers (CHWs) and recovery coaches.

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. In your testimony you touched on the continuum of crisis services that are provided by Boston Medical Center.

If you were to be able to expand the capacity of programs like the behavioral health urgent care clinic or the crisis stabilization unit, would you expect to see changes in ER volume or even hospital readmissions?

Answer. Expanding the continuum of crisis services at Boston Medical Center (BMC) would probably not realistically impact the volume of patients we see presenting with behavioral health issues in the emergency room (ER) or inpatient setting. A regional approach to expand the full continuum of care services, not just crisis services, including an emphasis on prevention and moving upstream to address health-related social needs, behavioral health integration in primary care settings, and other means of enabling individuals to access outpatient mental health services when they need it, would be more likely to reduce reliance on ER and inpatient mental health services. Timely response is key and can potentially avoid requiring ER or inpatient-level care.

Question. You spoke about the workforce challenges that we're seeing across the country, and the lack of diversity among providers that seems to exacerbate access issues among LGBT populations, communities of color and underserved communities.

Do you think expanding the types of clinicians who can practice behavioral health services would help to build the pipelines of providers who can meet the needs of diverse communities?

Answer. Increased use of behavioral integration in primary care and allowing mental health professionals to work to the full extent of their license within scope of practice could help address workforce shortages and improve access to behavioral health care. Including CHWs and peer support in care models, and reimbursing them for their time is crucial to better serving the needs of diverse communities.

Question. How else can Congress develop a provider workforce that is able to serve diverse communities most effectively?

Answer. As I mentioned in my testimony, I see the provider workforce shortage as a pipeline issue. Additional education and training opportunities writ large and for communities of color in particular would go a long way. Increased resources should be targeted to historically disinvested communities. Barriers to education and training can be addressed with additional funding for scholarships for people of color and individuals from low-income communities to complete their primary education and higher education, as well as loan repayment programs to reduce the financial burden/barriers to getting people into the field. Addressing stigma in the community—what it means to work in the mental health profession, and what it means to get mental health care—is imperative as well. In terms of legislation before Congress, the Pursuing Equity in Mental Health Act (S. 1795)—which you've cosponsored and has passed the House as H.R. 1475—if passed by the Senate would help provide additional resources to recruit and sustain a diverse mental health workforce. BMC is very much in support of S. 1795/H.R. 1475.

QUESTIONS SUBMITTED BY HON. JOHN BARASSO

Question. The health-care professionals, along with all front-line workers, deserve our gratitude and appreciation. Their dedication to our communities during this pandemic is something we must recognize and never forget.

A top concern of Wyoming mental health facilities is making sure there are enough staff to care for their patients. It is especially challenging to attract and keep health-care providers in rural communities.

Can you discuss solutions related to workforce development you believe will improve the ability of mental health facilities to attract and maintain staff in rural areas?

Answer. The mental health burden in some communities, rural, urban, and suburban, is tremendous, and requires significantly more resources to adequately support the mental health workforce and address the need. Overtaxing the limited mental health resources that exist in high need areas contributes to high churn among mental health professionals. A model like the Massachusetts Child Psychiatry Access Program (MCPAP), which I referenced in my testimony, is one way to stretch existing resources and increase access to psychiatric consults for primary care providers in rural areas.

Question. Can you specifically discuss changes to GME policy you believe would improve the pipeline of mental health physicians?

Answer. Increased funding for GME slots in general, as proposed in the Resident Physician Shortage Reduction Act (S. 834/H.R. 2256), and targeted to a particular specialty, such as addiction medicine and addiction psychiatry, as proposed in the Opioid/SUD Workforce Act (S. 1438/H.R. 3441), would help significantly improve the pipeline of mental health physicians.

Question. As a doctor, I strongly support increasing access to mental health services, especially in rural communities. Senator Stabenow and I have previously introduced legislation for many years that would allow mental health counselors and marriage and family therapists to receive reimbursement from Medicare.

Can you discuss how the Department of Health and Human Services can improve access for mental health services, especially for those on Medicare?

Answer. One way HHS could help improve access to mental health services is by removing the Medicare cap on the number of inpatient psychiatric days a beneficiary can have in their lifetime—this is a lack of parity with physical health care. People under age 65 who are chronically or severely mentally ill and on Medicare, who need inpatient mental health care, end up stuck in the hospital emergency department because of this restriction.

Question. In particular, can you comment on the merits of allowing licensed professional counselors and marriage and family therapists to receive reimbursements from Medicare?

Answer. People should get reimbursed for what is in their scope of practice, so I don't see any reason why licensed professional counselors (LPCs) or marriage and family therapists (MFTs) should not receive reimbursement from Medicare for the services they are trained to provide.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. The toll that union-sponsored excuses for "virtual learning" has taken on actual kids is extraordinarily sad, especially for our Nation's most vulnerable children. In October 2020, a survey conducted by the Jed Foundation showed that 31 percent of parents said their child's mental or emotional health was worse than before the pandemic. Private insurance data also shows that while all health care claims for adolescents ages 13–18 were down in 2020 compared to 2019, mental health-related claims for this age group increased sharply. Additionally, the Centers for Disease Control and Prevention (CDC) reports 25 percent of parents whose children attended school virtually were more likely to report an overall worsened mental or emotional health compared to only 16 percent of parents of children attending school in-person.

What programs within the Department of Health and Human Services' (HHS) purview are best poised to support children and schools as they return to complete in-person learning?

Answer. I'm not sure of the particular programs within HHS that may best support children and schools as they return to in-person learning, but either way more therapists are needed in schools. Kids spend most of their waking hours in school so it is best to make mental health services and supports available to them there.

In addition, mental health support for school teachers, staff, administrators, and parents of school-aged children will be vitally important as kids look to adults for modeling especially during times of transition and uncertainty. The Federal Government can and should play a role in helping to facilitate connections to care within the community in instances when it is beyond the capacity of school (*e.g.,* funding and supporting crisis management services in the community). All of this should be integrated into a prevention and promotion framework, which includes psychoeducation and group intervention, in order to help kids and adults connect the dots of what they have experienced and identify how trauma may manifest and when to ask for help.

Question. How can we integrate more telehealth opportunities to expand access to mental health services in schools?

Answer. I think it would be very impactful if students could access telehealth in schools. Schools or community health center partners should be outfitted with the technology to enable access for kids who may not have the necessary technology or private space at home, assuming the location of the child is no longer relevant for reimbursement. Parents will have to be involved to a certain extent with the care of minors, particularly with respect to prescribing medication, so it will be important for schools and communities to set up systems and processes to engage parents without creating additional barriers.

Question. Telehealth has expanded rapidly as a result of the COVID–19 pandemic. Numerous studies have demonstrated the effectiveness of telehealth for behavioral health services.

As telehealth becomes more common among health care providers, what can Congress do to ensure that patients do not suffer from unnecessary bureaucratic delays?

Answer. Congress can help to ensure parity for mental health services with physical health services. In my experience, prior authorization for behavioral health services is not level with physical health and should be addressed to reduce unnecessary barriers to care.

Question. There is a well-researched connection between unemployment and mental health. As recently as April 2021, despite billions of dollars of COVID–19 stimulus, aggregate employment remained 7.9 million jobs below its pre-recession level.

What impact will this failure to get people back to work have on mental health?

Answer. Engaging people with meaningful work, financial security, and structure is helpful for maintaining and supporting mental health. In places where insurance is more closely tied to work, rising or stagnant unemployment could reduce access to health care for people facing unemployment.

Question. Last November, an article published in the *Journal of the American Medical Association* noted that multiple studies indicated that older adults may be less negatively affected by certain mental health outcomes than other age groups.

Are these study outcomes consistent with your own professional experiences working with older adults?

Answer. N/A.

Question. Current network adequacy standards often allow networks of specialists who aren't taking new patients or who have long waiting lists. That means that many people needing treatment must go out of network to get care, and only those who can afford the high cost get it. One of the biggest challenges to access to behavioral health care services is that many behavioral health specialists don't participate in health plan networks.

Why is that, and how can we change that?

Answer. Low reimbursement and administrative burden, including dealing with prior authorization, act as deterrents to providers accepting health insurance. Improving reimbursement and expanding team-based care models that support integration of behavioral health into primary care settings could help.

Question. Outside of the public health emergency, telehealth services are restricted to certain geographic and clinical settings. Beneficiaries must live in a rural area and have an initial face-to-face visit with the distant-site provider. Once a relationship has been established, periodic in-person visits are also required. With few exceptions, patients must be located in a clinical setting and may not receive care

from their homes. In addition, the distant-site provider cannot be located in a rural health clinic or FQHC.

Telehealth has been used broadly during the pandemic to expand health care access to individuals throughout the country. During the pandemic, Medicare significantly expanded the coverage of telehealth services. A recent Bipartisan Policy Center poll suggests that people receiving mental health and substance use services want a combination of in-person, video, and telephone services even after the pandemic has passed.

What telehealth expansions should remain after the pandemic?

Answer. Particularly for the patients that I see at Boston Medical Center, a majority of whom are low-income, maintaining coverage and reimbursement for audio-only telehealth is essential. Insurers should also not require an in-person visit for mental health visits in order to permit continued telehealth use (*e.g.,* requiring one in-person visit within 6 months of the first telehealth appointment). The decision of whether to see a patient in person or virtually should instead be up to the discretion of the clinician.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. Your testimony outlines the collaborative care model and integrated care. I can appreciate the benefit of this collaboration between practitioners, and I too am concerned about the education and support our primary care physicians receive for addressing mental health.

The Massachusetts Child Psychiatry Access Program, as you claim, "improves access to treatment for children with behavioral health needs and their families . . . via remote consultation and education." Telehealth is a tool that delivered positive results during the pandemic and is largely here to stay. And I look forward to working with my colleagues on ensuring patients have access to care through telehealth, including mental health care.

What type of education regarding mental health is offered to primary care physicians in collaborative care models?

What about outside of those care models?

Do you have any recommendations for Congress to consider regarding disseminating mental health best practices or education items to primary care physicians?

Answer. Congress could play a role in funding a national technical assistance program for collaborative care models, including access to start-up capital to get behavioral health clinicians, managers, and systems in place. Training and education works best when built into clinicians' workflow/time. Additional research funding is needed in order to learn more about the best forms of integrated care for different patient populations.

PREPARED STATEMENT OF CHANTAY JETT, MA, MFT,
EXECUTIVE DIRECTOR, WALLOWA VALLEY CENTER FOR WELLNESS

INTRODUCTION/BACKGROUND

Good morning, Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee. Thank for you for the opportunity to appear before the committee to discuss policy solutions to address both the mental health and substance use crises impacting the United States and in particular the rural and frontier areas of our percent. My name is Chantay Jett, and I am executive director of Wallowa Valley Center for Wellness (WVCW), which provides community-based mental health and substance use treatment services in the most remote region of the great State of Oregon.

We represent a truly frontier area of our Nation where the cows outnumber the people and our closest major airport is in Boise, ID—nearly 4 hours away. We are literally at the end of the road where everybody knows everybody, which unfortunately contributes to both stigma and lack of access for people seeking treatment services. I am here to tell you that the Certified Community Behavioral Health Clinic (or CCBHC) model has truly made a difference in our frontier community. I hope

every State in the near future has the opportunity to use the resources this model has made available to us to meet the specific needs of our wonderful community.

The State of Oregon participates in a 10-State demonstration of the Excellence in Mental Health and Addiction Treatment Act that this committee helped to establish in 2014 through the bipartisan leadership of Senators Stabenow and Blunt. The Center for Wellness is one of 12 CCBHCs that operate in our State. We provide high-quality, integrated, community-based mental health and substance use services to individuals, while also screening for possible co-morbid conditions like heart disease, diabetes, and HIV/AIDS. Among the most important services that CCBHCs provide—both in Oregon and nationwide—are immediate access to Medication Assisted Treatment (MAT) for substance use and 24-hour emergency psychiatric care.

PREVALENCE OF BEHAVIORAL HEALTH CONDITIONS IN OREGON/ MENTAL HEALTH PROFESSIONAL SHORTAGES

Please permit me to provide some very brief context of CCBHCs within rural and frontier counties in the State of Oregon. According to the Oregon Health Authority (OHA), our State reports higher rates of mental health conditions, including severe and persistent mental illness and suicidal ideation. The COVID–19 pandemic has only exacerbated an ongoing mental health and substance use crisis in rural Oregon.

OHA also details a lack of access to mental health and substance use care, especially in frontier communities which face greater distances for referral to outpatient and inpatient services. To give you a sense, there is no stoplight within a 76-mile radius of Wallowa County. The OHA reports average wait times of as much as 6 months Statewide due to a lack of providers. However, we are the lucky ones, because the CCBHC model helped created an internal reorganization of service delivery which resulted in same day access to care.

WALLOWA VALLEY CENTER FOR WELLNESS: THE CCBHC EXPERIENCE

Prior to becoming a CCBHC, The Center for Wellness was heavily reliant upon grants. Grant funding is crucially important, but it carries limitations. Grants typically end every 2 to 3 years; they all have different reporting requirements and different program specifications, which unfortunately results in more time spent filling out paperwork, rather than treating our patients.

By contrast, the CCBHC prospective payment system permits us to do three big things. First, The Center for Wellness is able to contract with more skilled clinicians—including psychiatrists and medical professionals to prescribe Medication Assisted Treatment for patients with opioid use disorder. This directly results in decreased wait times and reduced emergency department utilization.

Secondly, the CCBHC program is designed to expand access to underserved populations. In our case, becoming a CCBHC really opened the door for mental health care to veterans as it requires the staffing of services specifically for veterans. According to the Veterans Service Organizations (VSO) in our county, there are at least 1,000 community members who have donned the uniform out of 7,000 residents. One of our CCBHC funded clinicians has been invited to the weekly PTSD groups at the Veterans of Foreign Wars (VFW) for veterans and their families. Becoming a CCBHC has allowed us to increase our services to 23 veterans in our community. This may not seem significant to you, but it's an increase of 300 percent—a big deal for us here in rural Oregon.

Thirdly, consistent CCBHC resources are a fundamental driver of integrated care. In Oregon, the CCBHC demonstration financing has made it possible to integrate with a local Federally Qualified Health Center (FQHC) allowing primary care, specialty medical services, and behavioral health services to be accessible under the same roof. We also share a single Electronic Health Record with our partner FQHC and local critical access hospital to permit immediate care coordination. Patients tell me that it is such a relief to not have to retell their story with every multidisciplinary provider they see. I will add that if there is no open acute psychiatric bed in our hospital or an acute bed is too distant in time traveled, we are lucky to have a great neighbor and partner across the State line in Idaho to access acute care psychiatric hospitalization. This component of care coordination and partnership with primary care and hospitals even across State lines is imperative because patients with severe mental illness and substance use challenges have shockingly high rates of chronic conditions, encompassing everything from cirrhosis to emphysema to heart disease. The CCBHC model allows us to have these partnerships and get patients the services they deserve in a timely manner.

In closing, I strongly believe that this model represents the future of community-based mental health care and substance use treatment in the United States. This is why I am asking you to make this model available to every State nationwide. As a percent, we can do better than first treating mental health and substance use in hospital emergency departments, homeless shelters, and the county jails. Investing in CCBHC's is streamlining services in efficient ways that drive costs down over the entire continuum of care. Despite being from a tiny frontier community at the end of the road in northeastern Oregon, I hope you see that CCBHCs make an enormous impact.

Again, thank you for the opportunity to testify, I am happy to answer any questions you may have.

QUESTIONS SUBMITTED FOR THE RECORD TO CHANTAY JETT, MA, MFT

QUESTION SUBMITTED BY HON. RON WYDEN

Question. I understand you employ a range of physician and non-physician providers.

Can you tell the committee more about the clinical staff you employ who can and cannot receive Medicare reimbursement? In rural and frontier counties it is very difficult to find licensed providers in this workforce shortage landscape.

Answer. Many of the service providers, such as peer support, case management, skills training, Supported Employment, Early Assessment Support Alliance (EASA), Assertive Community Treatment Team (ACT), med management, and Substance Use Providers (SUD) are not compensated at all by Medicare. The Licensed Clinical Social Workers we employ along with psychiatrists are compensated less than the value of the service they provide.

Question. In a typical year, about how much does Medicare's provider policy cost your clinic?

Answer. Wallowa Valley Center for Wellness writes off more than $500,000 per year in uncovered Medicare services.

QUESTIONS SUBMITTED BY HON. JOHN BARASSO

Question. The health-care professionals, along with all front-line workers, deserve our gratitude and appreciation. Their dedication to our communities during this pandemic is something we must recognize and never forget.

A top concern of Wyoming mental health facilities is making sure there are enough staff to care for their patients. It is especially challenging to attract and keep health-care providers in rural communities.

Can you discuss solutions related to workforce development you believe will improve the ability of mental health facilities to attract and maintain staff in rural areas?

Answer. Attracting and retaining a highly qualified workforce requires easier loan repayment programs and equalizing the requirements for school BH, primary care BH and community BH. We currently see the other sectors being able to pay more for less requirements and we cannot compete with this. The solution is to create an environment of equal parity in base salary for behavioral health workers as well as parity with the paperwork administrative burden placed only on the community mental health programs, as well as primary care providers sharing the risk for acute care hospital placements. I believe these three practices would remove a significant barrier to workforce development and the inability to offer competitive employment for a spouse/partner of a master's level clinician.

Question. Can you specifically discuss changes to GME policy you believe would improve the pipeline of mental health physicians?

Answer. As a community mental health program, we do not deal specifically with the guidelines and policies related to GME programs on the primary health-care side. I do not feel like I could offer an educated answer to your question.

Question. As a doctor, I strongly support increasing access to mental health services, especially in rural communities. Senator Stabenow and I have previously intro-

duced legislation for many years that would allow mental health counselors and marriage and family therapists to receive reimbursement from Medicare.

Can you discuss how the Department of Health and Human Services can improve access for mental health services, especially for those on Medicare?

Answer. Medicare reimbursement for Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) would vastly improve access to care. Currently, a consumer has to either wait for an available (and scarce) LCSW or pay full fee for services, both of which are unacceptable. The ability to conduct telephonic and video sessions has addressed some barriers to care and these services must continue to be reimbursed/billable regardless of the status of COVID.

Question. LMFTs and LPCs are as qualified or more to serve our community members, and the alliance between Medicare and LCSWs is purely an outcome of effective lobbying not good practice. In particular, can you comment on the merits of allowing licensed professional counselors and marriage and family therapists to receive reimbursements from Medicare?

Answer. Please see above.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. The toll that union-sponsored excuses for "virtual learning" has taken on actual kids is extraordinarily sad, especially for our Nation's most vulnerable children. In October 2020, a survey conducted by the Jed Foundation showed that 31 percent of parents said their child's mental or emotional health was worse than before the pandemic. Private insurance data also shows that while all health care claims for adolescents ages 13–18 were down in 2020 compared to 2019, mental health-related claims for this age group increased sharply. Additionally, the Centers for Disease Control and Prevention (CDC) reports 25 percent of parents whose children attended school virtually were more likely to report an overall worsened mental or emotional health compared to only 16 percent of parents of children attending school in-person.

What programs within the Department of Health and Human Services' (HHS) purview are best poised to support children and schools as they return to complete in-person learning?

Answer. Regardless of the location of the instruction, a global event like COVID impacts the mental health of students. DOE and HHS need to partner on grasping the impact of collective trauma. Educators and school-based counselors need to recognize and support the lasting effects that COVID has had on our Nation and world and help students gain an understanding and normalize the emotional response to a life changing event.

Question. How can we integrate more telehealth opportunities to expand access to mental health services in schools?

Answer. A barrier to tele-health BH services is ensuring IT systems have the necessary permissions to "talk" to teach other. Our experience is that the school's Internet blocks our access.

Question. Telehealth has expanded rapidly as a result of the COVID–19 pandemic. Numerous studies have demonstrated the effectiveness of telehealth for behavioral health services.

As telehealth becomes more common among health care providers, what can Congress do to ensure that patients do not suffer from unnecessary bureaucratic delays?

Answer. Unnecessary bureaucratic delays are often due to the payment structure and how Medicare and private insurance will not pay for less expensive evidence-based services such as IPS-supported employment, case management, skills training, etc.

Question. There is a well-researched connection between unemployment and mental health. As recently as April 2021, despite billions of dollars of COVID–19 stimulus, aggregate employment remained 7.9 million jobs below its pre-recession level.

What impact will this failure to get people back to work have on mental health?

Answer. Like students, the entire Nation has experienced collective trauma, and employers need to recognize that status quo employment practices and some of the

barriers to things like affordable housing and child care have a ripple effect across the employment rate.

Question. Last November, an article published in the *Journal of the American Medical Association* noted that multiple studies indicated that older adults may be less negatively affected by certain mental health outcomes than other age groups.

Are these study outcomes consistent with your own professional experiences working with older adults?

Answer. Actually, older adults identify "not needing" MH support but that does not correlate with overall health outcomes and behaviors (such as obesity, smoking, gambling, alcohol abuse, and suicide). Our older community members cite stigma and rugged individualism as factors in avoiding MH services. This is also relevant to accessing/pursuing preventative medical care. "I'm not sick, so why should I see a doctor?"

Question. Current network adequacy standards often allow networks of specialists who aren't taking new patients or who have long waiting lists. That means that many people needing treatment must go out of network to get care, and only those who can afford the high cost get it. One of the biggest challenges to access to behavioral health care services is that many behavioral health specialists don't participate in health plan networks.

Why is that, and how can we change that?

Answer. In my opinion, this problem is specific to the failure of health plan networks. The most common feedback I hear is that "the network is full and not accepting any new providers." This is something providers in private practice face; this is not generally an issue in a community mental health program which employs a wide range of behavioral health specialists within their own programs.

Question. Outside of the public health emergency, telehealth services are restricted to certain geographic and clinical settings. Beneficiaries must live in a rural area and have an initial face-to-face visit with the distant-site provider. Once a relationship has been established, periodic in-person visits are also required. With few exceptions, patients must be located in a clinical setting and may not receive care from their homes. In addition, the distant-site provider cannot be located in a rural health clinic or FQHC.

Telehealth has been used broadly during the pandemic to expand health care access to individuals throughout the country. During the pandemic, Medicare significantly expanded the coverage of telehealth services. A recent Bipartisan Policy Center poll suggests that people receiving mental health and substance use services want a combination of in-person, video, and telephone services even after the pandemic has passed.

What telehealth expansions should remain after the pandemic?

Answer. All of them! We are finding greater engagement to care by being offering an array of access points for folks. Even in the pandemic our yearly hours of service only fluctuated by about 60 hours from the previous year. However, the number of visits nearly doubled due to shorter encounters made possible through a variety of video, telephonic and in-person visits.

PREPARED STATEMENT OF BENJAMIN F. MILLER, PSY.D.,
CHIEF STRATEGY OFFICER, WELL BEING TRUST

Chairman Wyden, Ranking Member Crapo, and members of the committee, my name is Dr. Benjamin F. Miller, and I am the chief strategy officer for Well Being Trust, a national foundation started in 2016 through a gift by the Providence Health System that is focused on advancing the mental, social, and spiritual health of the Nation.

I am a clinical psychologist by training and have spent most of my adult life pursuing strategies that can advance mental health to a place of priority within our society. This goal has guided much of my work during my time as the founding director of the University of Colorado's Farley Health Policy Center and continuing today in my capacity as an adjunct professor at Stanford School of Medicine and at Well Being Trust.

It is an honor to be able to speak to you today about an issue that every American is experiencing—an issue that we need to aggressively pursue, and which COVID–

19 has all but exacerbated especially among communities of color and other marginalized people: our mental health. Several government reports highlight how broken our mental health system is. The 2020 DoD Inspector General report that found over 50 percent of service members and their families who needed mental health care did not receive it.[1] SAMHSA found that over 56 percent of adults with mental illness did not receive any treatment in the past year, nor did 35 percent of those with serious mental illness.[2] And a recent GAO report highlighted a multitude of issues at multiple levels for mental health, including ongoing challenges with health insurance, enforcing laws like mental health parity, and finding the right clinician who can help.[3] In one survey, almost 30 percent of people reported not seeking care because they did not know where to go.[4]

The need to solve for these and other existing problems is real and immediate. Clear pathways do not exist for people seeking mental health care—there are not obvious doors to enter, and we have no system that routinely is able to identify and treat people in a timely manner. This is perhaps our greatest challenge as we emerge from the devastating COVID–19 pandemic.

With broad majorities in both parties now understanding the importance of addressing mental health, I believe it is the time to enact immediate fixes for people in need, as well as begin to lay the foundation for a reimagined mental health system—a mental health system that is grounded in community and an integral part of our broader health-care infrastructure.

There are three key priorities I believe this committee should consider as it pursues both short- and long-term reforms for mental health.

First and foremost, we need to bring mental health care to where people are. This includes schools, and even our workplaces, but to most immediately meet this moment, the best place to start is in primary care, the largest platform of health-care delivery. In one poll, 70 percent of adults agreed that it would be more convenient if their mental health and substance use services were integrated into their primary care doctor's office.[5]

To do this, we must create more global and flexible funding mechanisms for primary care practices who are working to integrate mental health. Our payment mechanisms often reinforce a siloed delivery model, and this must change.

By first using existing payment structures like those found in Medicaid Managed Care Organizations, Medicare Accountable Care Organizations, and Medicare Advantage plans to expand mental health integration work, primary care practices would have the flexible financial resources to onboard mental health clinicians as a part of their integrated care team.

Second, we must reconsider the design and capabilities of our workforce. Demand for care has far outpaced the supply of mental health clinicians, and it is inconceivable to rely upon clinician recruitment strategies alone to meet our ever-growing need. There are two things we can do simultaneously to address this workforce issue.

First, we can map out mental health utilization and gaps to better determine where services are needed and for whom.[6] Without this we run the risk of widening disparities or putting money into places or programs people are not using for their mental health.

Second, we invest in our community workforce—those like peer support specialists, community health workers, or more broadly, lay people in our communities. We train them in mental health skills to help become the first line of mental health support, complementing our clinical enterprise and enhancing the overall capacity for communities to address mental health needs.[7]

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[1] *https://www.dodig.mil/reports.html/Article/2309785/evaluation-of-access-to-mental-health-care-in-the-department-of-defense-dodig-2/.*

[2] *https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect10pe2018.htm.*

[3] *https://www.gao.gov/products/gao-21-437r.*

[4] *https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/.*

[5] *https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC-MC-FINAL-Slide-deck-on-Mental-Health-Analysis-Poll.pdf.*

[6] *https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00073-0/fulltext.*

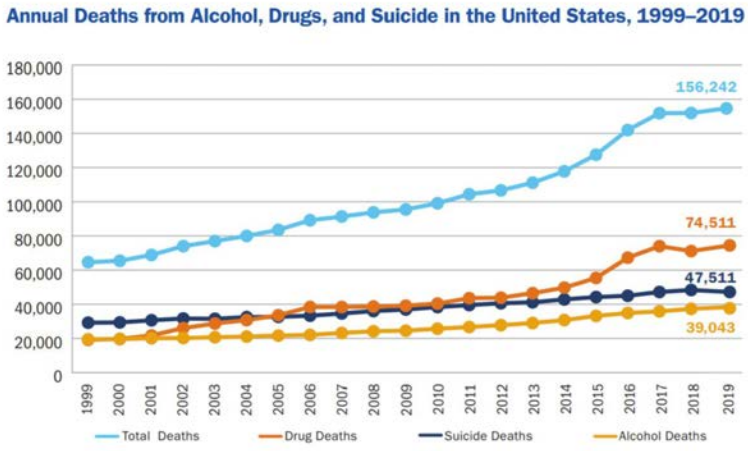
[7] *https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12229.*

Finally, we must modernize and connect our Federal programs and systems to collaboratively solve for common mental health problems. I realize it is hard to ask committees to work across jurisdictional boundaries, but so many aspects of our mental health need to be understood together and implemented together—at the State and community level. Because there are multiple agencies, funding streams, and programs that support mental health, performing a landscape analysis can create a strategy for synergistic efficiencies by breaking down silos across Federal agencies and departments and allow for a more cohesive plan for mental health.

In closing, I thank the committee again for holding a hearing on mental health. This is our moment to be bold in what we can do to boost our Nation's well-being, and ultimately save lives.

CONTEXT

In 2019, 156,242 Americans were lost to alcohol, drugs, or suicide—one person every 3½ minutes. 39,043 of those deaths were tied to alcohol misuse—a 4-percent increase over 2018—and drug-induced deaths in 2019 increased by 5 percent to account for 74,511 of the totals.[8]



Source: TFAH and WBT analysis of National Center for Health Statistics data

A few things to note. First, this data represents societal behaviors before COVID–19. While we do not have all the data from 2020 yet, preliminary CDC data suggests a 27-percent increase over 2019 in drug overdose deaths offering a glimpse into how much worse it could be.[9] In addition, between 2003 and 2018, the age-adjusted suicide rate reported by the CDC increased by more than 30 percent—and early data indicates that this number will continue to grow in the face of COVID–19.[10]

Second, the data highlight our ongoing problems with health disparities. In these data, we saw a 2-percent increase in drug overdose deaths in whites but a 15-percent increase in blacks and Latinos, an 11-percent increase in American Indians, and a 10-percent increase in people of Asian descent. These are statistically significant differences that highlight how even dominant legislative responses to major issues like our opioid crisis can work well with some populations but not all. These ongoing disparities require a level of attention in system design that is currently missing. Simply decreasing the supply of opioids overall without addressing the demand and its underlying causes leaves us in a place where unintended consequences are likely to occur, such as increases in deaths from synthetic opioids or some sub-

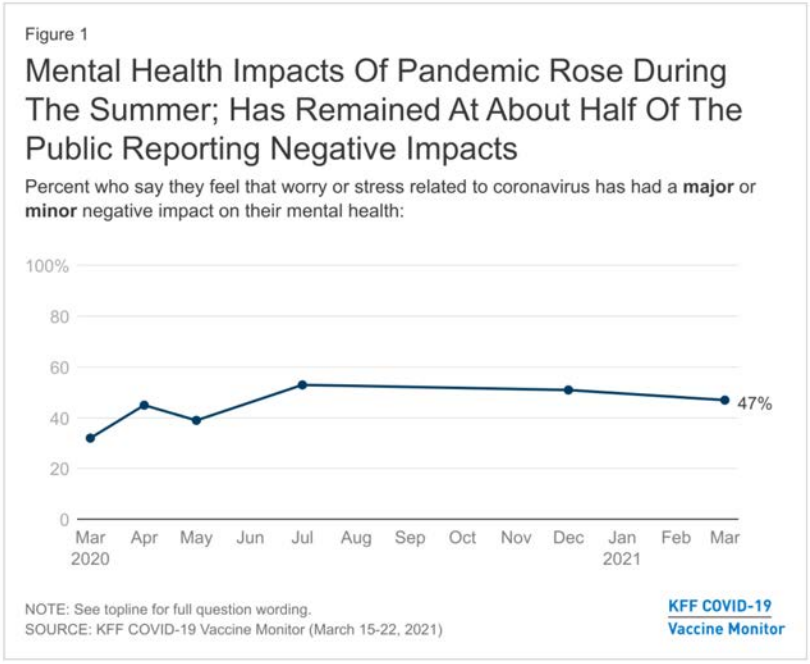
[8] *https://wellbeingtrust.org/news/pain-in-the-nation-annual-deaths-due-to-alcohol-drugs-or-suicide-exceeded-156000/.*
[9] *https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html.*
[10] *https://stacks.cdc.gov/view/cdc/100479.*

populations failing to sufficiently benefit from even the most well-intentioned reforms.

Finally, it's important to see these data points for what they are—a macro trend line going in the wrong direction. While the calculations are ongoing, the projections informed by the CDC data and others suggest that our problems are only getting worse and are overwhelming communities. We must stop trying to see substance us disorder and mental, physical and behavioral health as separate issues—they are all interconnected. Assessing and addressing all is essential to achieve the outcomes and well-being we want for individuals and society as a whole. But in order for us to do this, and do this well, we need a system that can take care of all aspects of our health and not just the pieces. In fact, COVID–19 has given our Nation an opportunity to see mental health for what it is—a foundation to our overall health and well-being.

As seen below, Kaiser Family Foundation has tracked the mental health impact of COVID–19 throughout the pandemic. This is truly an issue that impacts us all.

In early 2020, the number of adults who said worry and stress related to the coronavirus was having a negative impact on their mental health increased from about one-third (32 percent) in March 2020 to roughly half (53 percent) in July 2020.[11] While the impact appears to have normalized, data from March 2021 finds thatalmost half of adults report negative mental health impacts due to COVID–19.



In another survey conducted in the fall of 2020, almost 80 percent of surveyed registered voters described how COVID–19 had impacted their mental health. In the same survey, 9 out of 10 people believed that elected officials should be doing more for mental health.[12] And when compared to the rest of the world, the U.S. has a much higher mental health burden from COVID–19 than other high-income countries.[13]

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[11] *https://www.kff.org/coronavirus-covid-19/poll-finding/mental-health-impact-of-the-covid-19-pandemic/*.
[12] *https://wellbeingtrust.org/news/viacomcbs-well-being-trust-2020-mental-health-survey/*.
[13] *https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries.*

Perhaps most concerning is the impact that COVID–19 has had on our kids and younger adults. Thirty-one percent of 18–29-year-olds report stress has had a major impact on their mental health. Schools are overwhelmed by the mental health needs of students but must make difficult decisions on where to invest their limited resources.

Some of these issues are the expected result of a national health emergency; however, our Nation's fragmented approach to mental health and addiction impedes treatment and has exacerbated these problems. In addition, some facets of society, like our Nation's jails and prisons, are full of people with mental health and addiction needs. Many of these people had significant unmet need for mental health and addiction services before they were incarcerated. And too often, these needs unaddressed by the time they move back into community settings—further stressing the ability of local systems to adequately respond.[14] These national problems and others are a constant threat against the well-being of our communities until comprehensive reforms are embraced.

It should be no surprise that when people don't have any place to go, they show up in the emergency department—but these are often some of the worst places for people to go who are in a mental health crisis as they are often ill-equipped to manage acute psychiatric crises potentially exacerbating an already existing problem. Data from the CDC found that compared with 2019, the proportion of mental health-related visits to emergency departments for children aged 5–11 and 12–17 years old in 2020 increased approximately 24 percent and 31 percent, respectively.[15]

To make this crisis even more challenging, two commercial payers[16,17] have stated that they will retroactively review why a person went to the ED, and if they determine it wasn't warranted, they can restrict or deny these Americans coverage. Imagine showing up thinking you are having a heart attack only to be told it's a panic attack, and then have to pay out of pocket after the cause of the emergency was diagnosed. This could further discourage American families from seeking out help, and while one payer has temporarily walked back this policy,[18] it remains something that could reemerge.

In summary, unaddressed mental health and addiction needs will negatively impact the collective spirit and well-being of individuals, families, and communities. The 116th Congress passed landmark legislation establishing streamlined crisis hotlines (988 crisis hotlines), which could very well overwhelm an already fragile system without support. I am hopeful that this committee might take the opportunity afforded by this legislative effort to begin laying the foundation for a truly modern system of care that works to integrate mental health through delivery, financing, and policy.

Below I outline the three areas that I believe hold the most promise for mental health.

1. Reimagine Care Delivery

Mental health is local. We need to consider all the places that people show up with need and be prepared with a mental health response. From community settings like schools, and workplaces to health delivery settings like primary care, one of the best ways we can begin to enhance access and more proactively address mental health needs is to integrate mental health.

What does this look like? At a high level it means that the location—whether it's a primary care office or a school—has the resources to have an onsite mental health professional who can help identify, treat, and coordinate. This approach helps us begin to better distribute mental health services throughout the community in an effort to better be responsive to needs. Below I outline a few specific policy ideas that can support this reimagined approach to mental health.

Primary Care

Care for those seeking mental health services is fragmented in many of today's local systems, leaving even the most connected of people waiting for help. The issues that contribute to the problems in our current care delivery systems include: (1) un-

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[14] *https://www.mhanational.org/issues/access-mental-health-care-and-incarceration.*
[15] *https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm.*
[16] *https://www.uhcprovider.com/en/resource-library/news/2021-network-bulletin-featured-articles/0621-ed-facility-commercial-claims.html.*
[17] *http://file.anthem.com.s3-website-us-east-1.amazonaws.com/04591CAEENABC.pdf.*
[18] *https://www.nytimes.com/2021/06/10/health/united-health-insurance-emergency-care.html.*

necessary care limitations restricting where and how a person can get access to care; (2) referrals being the dominant intervention for mental health in most healthcare settings; and (3) care approaches remain fragmented with team-based interventions remaining an aspirational goal in most settings. Integrating mental health into primary care addresses all three of these issues head on.

The Bipartisan Policy Center's report on mental health and primary care integration offers several key recommendations for this committee to consider.[19] And rather than list all of those recommendations here, I would encourage the committee and staff to look into the report at the three major areas the report covers: transforming payment and delivery to advance value-based integrated care, expanding and training the integrated workforce, and promoting technology and telehealth to support integrated care.

Additional integration recommendations include:

- **Creating a definition for mental health and primary care integration.** The definition should allow for local adaptation and flexibility in how practices implement an integrated model of care. There are operational definitions that have been created, which may prove useful in this process.[20] The evidence for integration is that patients like it, clinicians like it, it saves money from total costs, the costs are currently borne by practices and are unsustainable.[21, 22] The National Academies' report on Implementing High Quality Primary Care published last month with support from four Federal health agencies, points to mental health integration in primary are as the team-based intervention most supported by evidence.
- **Fixing the financing of integrated mental health in primary care because practices typically bear the cost, one size will not fit all, and flexible financing options will allow for practices to create a model of care that works best for their community.** I have offered an example below from Colorado.

  Western Colorado's Rocky Mountain Health Plans (RMHP) has pursued a comprehensive approach to mental health integration and found the model necessary to meet the needs of their members, wherever they choose to access care. Specifically, they have implemented enhanced, non-volume-based payment models to promote and sustain integrated mental health clinicians in advanced primary care sites. Their payment models sustain services that are often not recognized in conventional private payer or State programs, such as health and behavioral encounters or care coordination services. These embedded mental health clinicians provide immediate support for the emotional well-being of patients and families and improve the overall capacity of scarce primary care providers to serve the population.

  Additionally, when extended or specialty therapy is necessary, primary care-based providers receive reimbursement for care alongside other provider options in the inclusive network. They admit all willing and qualified providers promptly to their mental health provider network, credentialing over 90 percent of all complete applications within 45 days, often a major rate limiting factor in expanding our workforce.

  Patrick Gordon, RMHP's CEO, attributes the positive performance of their health plans to comprehensive primary care and integrated mental health. They routinely exceed quality benchmarks set by the State of Colorado in their year-to-year agreements and have achieved Commendable accreditation distinction from the National Committee for Quality Assurance, as well as statutory and contractual financial performance requirements that require an annual return of 2 percent savings to taxpayers.

  The key? They have embraced a new model of care that pays for mental health differently in primary care settings. This model begins to take us away from traditional fee-for-service codes and embraces the power of what can happen when we push for flexibility in our financing that supports the concept of a team working in concert to improve health. A recent report from the National Academies reinforces this by recommending paying for primary care

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[19] *https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R02.pdf.*
[20] *https://integrationacademy.ahrq.gov/products/lexicon.*
[21] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5698230/.*
[22] *https://jamanetwork.com/journals/jama/fullarticle/2545685.*

teams to care for people, not doctors to deliver services.[23] A forceful charge to move away from volume-driven payment mechanisms that may reinforce a siloed approach to mental health.

Future Accountable Care Organization efforts and primary care value-based payment models should include specific incentives to promote mental health integration.

In addition, as States move away from carved-out financial models for mental health, new arrangements emerge that better support integrating care. Each decision of how mental health is financed can have an impact on how care is delivered on the ground.[24] We should continue to promote payment models that reinforce the concept of a team and facilitate easier access for mental health services in primary care.

- **Assuring that our mental health workforce is trained and prepared to work in integrated settings.**
  Most mental health clinicians are trained to work in specialty mental health settings. While some training programs have recognized the importance of training their mental health clinicians to work in places like primary care, without proper training, many mental health clinicians may not adapt to a primary care culture, making it difficult to sustain integrated efforts.

  To this end, the Federal Government could consider:

  - Expanding financial support for continuing education programs that prepare providers to work in integrated settings;
  - Increasing financial support for programs that recruit diverse students into primary care and mental health professions and improve access to and affordability of health-care education;
  - Creating learning collaboratives for integrated programs and increasing preference for integration as a quality improvement activity under programs like MIPS; and
  - Funding the incubation of new models of integrated training for primary care and mental health professionals in medical schools/other training institutions.
- **Providing technical assistance to primary care practices looking to integrate mental health.**

  Integrating care requires a change in workflow and overall practice culture. It becomes about the team and not just the individual clinician. Practices could benefit greatly from having some form of technical assistance to help them with this transformation. Recent evidence from the Agency for Healthcare Research and Quality demonstrates that this facilitation is key to enabling transformation and for speeding it up.[25, 26] There are two immediate options to help here:

  - Provide appropriate funding for the Primary Care Extension Program; and
  - Establish grant funding for technical assistance for implementation and the ongoing delivery of integrated care.

Schools

Federal policies, initiatives, regulations, and guidance are important tools for the promotion and widespread adaption of comprehensive school mental health systems. In addition to Federal agencies with responsibility over the well-being of children and youth such as the Department of Education (DOE) and the Department of Health and Human Services (HHS), congressional champions are increasingly leaning into their role in this space.

We have a patchwork of grants at SAMHSA, and elsewhere that either promote school climate or integrate mental health services, and ESSA allows flexibility, but we need an ambitious goal of making sure that our initiatives reach every school and that they're equipped to engage all of the school staff in promoting the mental

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[23] *https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care.*
[24] *https://www.ohsu.edu/sites/default/files/2021-05/McConnell%20et%20al.%20Financial%20Integration%20of%20Behavioral%20Health%20in%20Medicaid.pdf.*
[25] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8118489/.*
[26] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6827672/.*

well-being of the students and addressing the needs of those with mental health conditions.

Before the pandemic, clinicians were seeing alarming trends in adolescent mental health, with increased reporting of depression, anxiety, and suicidal ideation. Unfortunately, those trends were accelerated by the pandemic. Emergency room visits for mental health for adolescents 12–17 rose by 30 percent last year. To put it simply, America's children are in trouble.

The good news is that we know what can be done to help alleviate this mental health crisis in our youth. We want to see strong community and family supports, and importantly we know that one of the best chances we have to get children the mental health care they need is actually in the one place they all have to go every day, and that's in our school systems. The adoption of comprehensive mental health systems in our school systems will help make sure that every child has the opportunity to thrive, while also making sure we offer immediate help to those who might be falling through the cracks.

Congress has a significant role to play in promoting school mental health. Federal policies, initiatives, regulations, and guidance are important and necessary tools for the widespread adaption of comprehensive school mental health systems.

Congress can provide three major lanes of support to comprehensive school mental health programs: providing funding via appropriations, grants, and initiatives; setting up sustainable funding mechanisms and incentives such as increasing the Federal Medicaid matching rate for school-based health services and working with schools to support their ability to bill Medicaid; and scaling up technical assistance centers and programs to provide ongoing support for implementation at the district and school levels.

However, and important to note, promoting school-wide mental health is not a one-and-done program—it's a process of engaging staff, students, and parents to identify needs and continuously improve. And to accomplish this, schools need support.

Making concrete investments in school mental health won't just address the current crisis we find ourselves in, it will pay dividends for generations, giving all children the chance to thrive, and building a next generation resilient and prepared workforce.

2. Reconsider the Design and Capabilities of our Workforce

To make it easier for people to access and pay for mental health care, we need a different way of thinking about workforce—one that helps us respond to mental health needs in a timely manner and do so in a high quality and effective way. Solving these problems goes beyond simply adding more clinicians.

The existing mental health workforce access challenges within our communities are well understood. They result in the following statistics:

- Thirty-three percent of those seeking care wait more than a week to access a mental health clinician;
- Fifty percent drive more than one-hour round trip to mental health treatment locations;
- Fifty percent of counties in the U.S. have no psychiatrist;
- And only 16 percent of active psychologists are from minority populations despite comprising 40 percent of the U.S. population;[27] and
- Only 10 percent of practicing psychiatrists are from underrepresented minorities.[28]

There are two immediate steps we can take to best begin to address our workforce shortage problem.

First, we can map out mental health utilization and gaps to better determine where services are needed and for whom.[29] We should look at where people are showing up for care and who is available to help. Without this important foun-

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[27] American Psychological Association. Demographics of the U.S. psychology workforce: Findings from the American Community Survey. Washington, DC, 2015.

[28] Wyse R., Hwang W.-T., Ahmed A.A., Richards E., Deville C. Diversity by Race, Ethnicity, and Sex Within the U.S. Psychiatry Physician Workforce. Acad Psychiatry. 2020;44(5):523–530.

[29] *https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00073-0/fulltext.*

dational step, we run the risk of widening disparities or putting money into places or programs people are not using.

Second, we need to invest in our community workforce—those like peer support specialists, community health workers, or more broadly, lay people in our communities with no formal role or title. We train them in mental health skills to help become the first line of mental health support, complementing our clinical enterprise and enhancing the overall capacity for communities to address mental health needs.[30] Frameworks have been proposed that offer guidance on how best to enhance our mental health workforce, and much of it begins with strengthening our unlicensed and community-based workforce.[31] Solutions for the mental health workforce can be broken down further into three distinct buckets of improving our current workforce, enhancing the pipeline for the future workforce, and creating a new community workforce.

Current Workforce

We should take the clinicians we have out there in the field and retrain or prepare them to work in new settings. For mental health clinicians, this might be primary care or schools. We should also look to our unlicensed workforce—peer support specialists and community health workers and seek ways to support, finance, and scale their work.

The education, training, and development of new generations of health professionals will be needed to address existing and expected unmet needs in areas such as crisis care and maternal and childhood mental health. The following steps should be taken in the short-term to address immediate areas of unmet medical need and prepare for expected increases in service requests once the 988 community crisis hotlines come online in the near future.

- Increase funding for Medicare residency slots. Without this, it's nearly impossible to increase the number of clinicians like psychiatrists. Of note, parity implementation and enforcement may also help here considering that some clinicians eligible to bill for services may be under-reimbursed making it less desirable to fill a residency slot.
- Make permanent 1135 waiver allowing Medicaid providers in another State to provide Medicaid services (though State licensing laws still apply).
- Promote telehealth and other digital service options to expand the service reach of our existing medical professionals.
- Incentivize providers to take additional Continuing Medical Education (CME) classes on current mental health best practices.[1]
- Focus existing federally funded quality improvement organizations on mental health integration across diverse primary care practices and for serving diverse populations, and finance additional learning collaboratives as necessary.

Future Workforce

We should provide prospective health-care professionals with the appropriate training by making mental health a core curricular component of medical school education. In addition, we should train our future clinicians to understand what it's like to work within a team-based, multidisciplinary setting and provide incentives to higher education institutions to offer training in integrated mental health care, through graduate medical education (GME), graduate nursing education (GNE), and other programs.

While increasing our future workforce is necessary, it alone cannot solve our workforce problem. The time and resources needed will always present limitations to the numbers of new mental health and medical professionals our Nation can train at any one time. Therefore, steps should be taken to expand workforce capabilities in new ways to address current and expected service needs.

Policymakers should consider the following reforms to help local systems begin to update their local workforce capabilities:

- Develop non-medical multi-discipline community workforces to help address service requests that do not require a medical license to satisfy. Offering up payment mechanisms like Medicare to support critical services like peer support specialists would go a long way in strengthening this approach.

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[30] *https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12229.*

[31] *https://thinkbiggerdogood.org/enhancing-the-capacity-of-the-mental-health-and-addiction-workforce-a-framework/.*

- Promote the use of innovative technologies like automated testing and screening platforms to reduce the requirements on medical professionals.
- Develop innovating payment methods and coverage designs like global payments to promote additional testing services from non-medical and technology platforms to better identify and improve access to the right care at the right time.

Community Workforce

We should empower everyone to perform tasks that traditionally clinicians would. There's robust literature out there on it, and it seems to solve several problems at once.[32]

We must also recognize that there are never going to be enough clinicians to meet service demands. Even as we reform Medicare and Medicaid to help primary care better integrate mental health, we will still run into the issue of finding time to undergo trainings and recruit mental health professionals to join their practice in the short term. And in truth, many mental health needs people have are not going to be solved solely at a clinical level, *e.g.*, housing, employment, etc. Of course we will need people to be able to diagnose and prescribe, but we also need many more people to be able to teach important skills for navigating recovery or building a sense of community that supports people in times of crisis. Ideally, these skills would be spread out across many people and can mutually reinforce one another.

In the long term, we are likely to never have enough clinicians to meet the community's demand without additional effort to increase the pipeline. Like what we've seen successfully work in other countries, we need to tap into our unlicensed yet credentialed workforce—such as peer support specialists and community health workers—and also adopt models that empower everyone to take on mental health at a local level. Innovative technologies such as digital therapeutics and telehealth can open up new access opportunities to train communities as well as reach individuals in need.

Congress and this committee could consider grants or financing mechanism to States to help them sort out the regulatory and multipayer financing issues that often stymie creative and innovative ideas for mental health.

3. Modernize Federal Programming and Operations Strategies

We must modernize and connect our Federal programs and operational systems to collaboratively solve for common goals within communities, and to better bring mental health into the national mainstream. Like when corporations merge, we should do a landscape analysis and create a national strategy for synergistic efficiencies among the 55 or more payment systems and thousands of programs that support mental health care in our communities today. Such a step can also help identify redundancies and inefficiencies by allowing for modern programming strategies to break down these silos across all Federal departments and agencies to allow for a more cohesive system for the future. For example, modern Federal funding and programming strategies might allow families and individuals to access a host of different Federal health care, workforce and educational services from multiple different Federal agencies, departments and programs through community and health system access routes.

There are a host of additional steps we can take such as doing a better job of enforcing and expanding existing mental health parity laws that equate mental health and physical or improving care coordination for physical, mental, and behavioral care. In addition, public and private means of coverage.

Communities and local health systems are on the front lines of managing services critical to the mental health and well-being of all Americans. Traditionally, the Federal Government's role has been to provide funding and other resources to these communities to help them manage their service needs. There are dozens of programs, funding streams, and other Federal resources available to communities and local health systems to support the provision of mental health services. However, allowing local communities greater flexibility to plan, program, and allocate these resources would allow programs the opportunity to manage their service needs while investing in local system innovations.

Policymakers should consider reforms to key Federal financing authorities as a means of promoting greater local control over how resources are programmed. At the same time, policymakers can improve how the Federal Government plans for

[32] *https://pubmed.ncbi.nlm.nih.gov/29914185/*.

and allocates funds to communities to help maximize on these critical investments and better justify new expenditures that might be required in the future.

Policymakers should consider:

- **Establishing a national strategy for how the Federal Government can establish "smart" or collaborative financing strategies to improve the efficiency of Federal spending, leverage new uses of existing funds, and create better budgetary certainty for local communities.** The 21st Century Cures Act, which became law, contained provisions intended to establish such a strategy. Policymakers might consider steps already taken by the agency in response to the act to establish such a national strategy more quickly.

  In 2016, there was a Community Solutions Task Force that had a focus on solving major challenges facing communities.[33] Congress could use this as a model for mental health and ensure that in each policy it works on it specifically enables cross-agency and community-level collaboration.

- **Repositioning the Family First Prevention Services Act (FFPSA) and Community Mental Health Services Block Grant (CMHSBG) to act as lead funding authorities for the various acts with overall responsibility for managing and verifying performance aspects related to Federal funds and other resource allocations meant to support the provision of mental health services within local communities.**

- **Requiring the Federal Government to regularly update the Committees of Jurisdiction in the House and Senate on the goals of the reformed financing process including progress against those goals.**

  While the resources provided for by the Federal Government are substantial, overly prescriptive Federal requirements and lack of collaboration amongst the various Federal authorities in charge of overseeing these resource allocations impede the ability of communities to use these resources effectively.

  As example, the Community Mental Health Services Block Grant (CMHSBG) requires communities seeking funding to "ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs." While community mental health centers play an important role, such requirements on local system performance unnecessarily tie the hands of officials struggling to manage growing service needs—especially in areas where solutions would otherwise exist except for Federal regulation.

- **Reviewing the Federal requirements under existing community mental health Federal funding streams and considering easing requirements that unnecessarily impede care.**

- **Including program sustainability measures with new sources of funding or other resources meant to support the operation and modernization activities of local systems.**

  Modern Federal laws like 988 promote modern programming strategies such as program sustainability best practices combined with local autonomy measures to ensure that local officials have sufficient freedom to establish successful and predictable local systems for individuals in need. The ability of local systems to improve their own systems operations through use of information sharing that leads to evidence development and best-practice adoption can help pave the way for continuous system improvement. Such a "system of learning" can provide Federal policymakers and local officials greater ability to collaborate and plan for program modernization today and in the future.

- **Developing information-sharing and best practice development processes to provide local communities and Federal policymakers insights into the need for and design of future reforms.**

While the above areas are the three priorities I have chosen to focus on for today—reimagine care delivery, reconsider the design and capabilities of our workforce, and modernize Federal programming and operations strategies—outlined below are several other notable issues this committee should consider.

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[33] *https://obamawhitehouse.archives.gov/the-press-office/2016/11/16/fact-sheet-establishing-council-community-solutions-align-federal.*

Other Issues and Recommendations to Consider

Mental health parity and health insurance coverage

- The Finance Committee could take aggressive steps to ensure parity enforcement in Medicaid managed care and expansion populations, which is critical to both mental health equity and racial equity. There could now be an opportunity to engage consumers in setting key indicators of access and track progress with intensive oversight from CMS/CCIIO.
- The Finance Committee could ensure parity be applied to Medicare and Medicare Advantage. This will require eliminating discrimination against MH/SUD that is baked into title XVIII of the Social Security Act, and ensuring the full continuum of services are covered, including all intermediately levels of care.[34]
- The Finance Committee could require Medicaid and Medicare Advantage plans to follow Generally Accepted Standards of Care and use level of care criteria from non-profit clinical specialty associations as outlined in the Federal case *Wit v. United Behavioral Health.*

988 and crisis response

- The Finance Committee could make the CAHOOTS enhanced match permanent and extend it to a comprehensive range of crisis services to create a continuum beyond response.
- The Finance Committee could make sure Medicare and commercial insurance plans cover crisis services and look to Medicaid crisis benefits as a model.

QUESTIONS SUBMITTED FOR THE RECORD TO BENJAMIN F. MILLER, PSY.D.

QUESTION SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. In your testimony you noted that it is "inconceivable to rely upon clinician recruitment strategies alone to meet our ever-growing need." Stakeholders across the behavioral health spectrum—including policymakers—are looking at overwhelming workforce challenges.

You mentioned peer support services as one solution. Can you elaborate on how peers help to address unmet need?

Answer. Bringing a workforce that has experience, both firsthand and through additional training, into clinical and community settings can be a powerful tool in enhancing the capacity of our systems and our frontline licensed workforce. And the evidence is clear that peer support services (PSS) work.1 In fact, in 2007 CMS lifted up PSS as an evidence-based practice, and—while Medicare still does not pay for these services—many State Medicaid programs have adopted the model.

There are three characteristics that stand out about PSS.

First, as the name implies, they are peers to those they are serving meaning they have some form of personal or lived experience. In the mental health and addiction field, having a person that knows the challenges of what you are going through can be a powerful tool for healing unto itself.

Second, these peers are equipped with skills that not only allow them to be more than supportive, but also to intervene with evidence-based skills that can be further beneficial to the person they are trying to help. This allows peers to provide higher-touch care than the current workforce would allow, while also ensuring that other clinicians work at the top of their licensure.

Third, PSS can offset the load placed on clinicians and become an extension of clinical services and clinical settings. When we look at wait times for clinicians, it forces us to begin to look to more creative ways to help people in a more expeditious timeframe. PSS do just that—there is an endless supply of individuals with lived experience who can be trained as peers.

For PSS to scale, however, it could benefit from several policy changes. Medicare and most commercial health insurers do not cover PSS, as well as other mental health crisis services, Assertive Community Treatment, Coordinated Specialty Care

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[34] *https://www.realclearpolicy.com/articles/2020/12/30/medicare_must_cover_mental_health_654797.html.*

(for early psychosis), and other team-based interventions. Allowing PSS services to be eligible for Medicare payment would go a long way in helping expand this service line.

In the immediate term, the committee could ensure that mental health and substance use peers could be offered as a supplemental benefit by Medicare Advantage plans, and that they can offer PSS services in the context of integrated mental health care already billable under Medicare, as the recently introduced PEERS Act of 2020 in the House would support. Peers also have a clear role in promoting value in Medicare Accountable Care Organizations (ACOs), and the committee could direct CMS to provide technical assistance to ACOs to better integrate PSS.

And while outside of the scope of PSS specifically, it is important to note that Medicare only covers certain licensed mental health clinicians (*e.g.,* LCSW, psychologists) to bill for services, which leaves a major challenge in building and diversifying the clinical workforce. Medicare has not updated its mental health provider licensure standards since 1989 and is still unaccountable to the Mental Health Parity and Addiction Equity Act. This presents major gaps in coverage for Medicare beneficiaries and can further interrupt continuity of care—leaving families to pay out of pocket or forego essential care entirely. It seems time to modernize Medicare policies for mental health in general and address PSS as we do so.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. The health-care professionals, along with all front-line workers, deserve our gratitude and appreciation.

Their dedication to our communities during this pandemic is something we must recognize and never forget.

A top concern of Wyoming mental health facilities is making sure there are enough staff to care for their patients. It is especially challenging to attract and keep health-care providers in rural communities.

Can you discuss solutions related to workforce development you believe will improve the ability of mental health facilities to attract and maintain staff in rural areas?

Answer. Mental health workforce recruitment and retention is a major need, especially in rural communities. And while I will address this issue, I think it's critical that we think beyond simply finding more clinicians and opening up the pipeline. As I have written about in my testimony, only choosing to focus on these pipeline issues, including attracting the right kinds of clinicians to the settings they are most needed, does not provide immediate relief nor does it enhance a mental health clinic or systems capacity to see more people. If our focus can become on better creating new pathways to allow for individuals to be identified and treated, it's inevitable that new solutions emerge beyond just a clinical workforce.

I believe that Congress and this committee should pursue options like Community Initiated Care (CIC), a concept based on a rich evidence-based often called "task-sharing" or "task-shifting." This is a model of intervention that is not dependent on licensed clinicians and has shown to be highly effective by allowing non-specialized, trained workers, and even "lay" members of the community to learn mental health skills.[1]

Community initiated care is a broadly inclusive concept that democratizes knowledge and empowers individuals to learn how to respond to mental health and addiction issues. Effective components include training and supporting community members to ensure that they acquire the knowledge, skills, and competencies necessary to deliver high quality evidence-informed programs for prevention and early intervention of mental health concerns.

Bringing more mental health skills into the community can help solve several issues at once—it can make the workforce more readily available because we are creating capacity for communities to intervene on issue of mental health and addiction.

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[1] *https://www.commonwealthfund.org/publications/2021/feb/making-it-easy-get-mental-health-care-examples-abroad.*

To this end, Congress and this committee could consider grants or financing mechanism to States to help them sort out the regulatory and multi-payer financing issues that often stymie creative and innovative ideas for mental health like the community initiated care model described above. Offering up payment mechanisms like Medicare to support critical services like peer support specialists or a community workforce could go a long way in strengthening this approach and making it more viable. SAMHSA could push out pilot programs with community health workers, community-based organizations, and other community-based non-professionals to deliver psychological interventions based on the learnings from global mental health. Currently, SAMHSA funds gatekeeper type programs through non-specialists as well as peer-specialists programs, but there has been less support for these community based models. A final option is to consider pilot programs with additional funds through block grants if States commit to exploring the community initiated care approach.

Question. Can you specifically discuss changes to GME policy you believe would improve the pipeline of mental health physicians?

Answer. The first step to growing our pipeline of mental health clinicians is to increase funding for Medicare residency slots. Without this, it will be nearly impossible to increase the number of clinicians like psychiatrists.

Parity implementation and enforcement may also help here, considering that some clinicians eligible to bill for services may be under-reimbursed. A lack of reimbursement makes mental health a less desirable residency slot.

So too would modifying primary care residency training programs. Primary care remains one of the largest platforms for mental health delivery in this country. However, not all residency programs train the future workforce much in mental health—family medicine training programs do train their residents in mental health and in most cases, expose them to onsite mental health clinicians who they can work and train beside. Internal medicine and pediatrics residents get much if any such training.

To change this, we should create mental health training requirements in all primary care residency programs modeled off of family medicines current requirements. In addition, residency programs should also require and support mental health integrated in primary care so that all trainees are acculturated to working in such models and can advocate for them later. If medical education had additional resources and incentives to bolster mental health and substance use training for more categories of clinicians, this would further extend the workforce.

In addition, I shared some ideas in my testimony that I feel could be additive to changes in GME policy. For example:

- Make permanent 1135 waiver allowing Medicaid providers in another State to provide Medicaid services (though, State licensing laws still apply).
- Promote telehealth and other digital service options to expand the service reach of our existing medical professionals.
- Incentivize providers to take additional Continuing Medical Education (CME) classes on current mental health best practices.
- Focus existing federally funded quality improvement organizations on mental health integration across diverse primary care practices and for serving diverse populations, and finance additional learning collaboratives as necessary.

Question. As a doctor, I strongly support increasing access to mental health services, especially in rural communities. Senator Stabenow and I have previously introduced legislation for many years that would allow mental health counselors and marriage and family therapists to receive reimbursement from Medicare.

Can you discuss how the Department of Health and Human Services can improve access for mental health services, especially for those on Medicare?

Answer. One of the best ways to improve access to mental health services is to first consider who is eligible to bill what, where, and for whom.

CMS can ensure that Medicare payments for mental health integration are properly valued and that primary care clinicians have the necessary support and technical assistance they need to implement integrated care. Implementing integrated care models requires time, effort, and practice expenses that may not be fully captured in the current valuation. Further, interested clinicians might not have access to resources they need to set up integrated care in their practice. CMS should work

with clinicians to identify barriers for the adoption of integrated care in Medicare, including misvaluing of codes, to ensure that beneficiaries get access to effective care.

Recently, CMS launched the Community Health Access and Rural Transformation (CHART) model, which could be a promising approach to building the infrastructure for defragmentation and care transformation in rural America. One strategy that HHS could consider is building on the Community Transformation Track of the CHART model but with a specific focus on ensuring comprehensive access to mental health and substance use treatment, unlocking the full range of innovations from virtual care, peer support services, and integrated care models.

The committee could also work with CMMI to ensure that alternative payment models (APMs) currently in progress adequately incentivize implementation of integrated care for Medicare beneficiaries. Model evaluations indicate that past APMs have had little effect on mental health outcomes. However, as mental health has been subject to chronic underinvestment—especially in rural communities—it counts against the benchmark for shared savings when providers implement effective early intervention (such as integrated care models), unless it very rapidly reduces hospitalizations. To address this issue and incentivize investment in early intervention, CMMI could:

- Adjust risk adjustment in ACOs, CPC+, and others to accommodate expected costs from integrated care in mental health, and pair with appropriate quality measure recommendations to ensure accountability; or
- Temporarily waive costs from integrated care models from shared savings calculations.

Question. In particular, can you comment on the merits of allowing licensed professional counselors and marriage and family therapists to receive reimbursements from Medicare?

Answer. Allowing other mental health clinicians outside of psychologists and licensed clinical social workers the chance to bill Medicare could be a slight help in our never-ending numbers game for the clinical workforce—how to get more. There are several benefits to allowing LPC and LMFT to bill Medicare, but the top one is infusing thousands of new clinicians into the workforce.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. The toll that union-sponsored excuses for "virtual learning" has taken on actual kids is extraordinarily sad, especially for our Nation's most vulnerable children. In October 2020, a survey conducted by the Jed Foundation showed that 31 percent of parents said their child's mental or emotional health was worse than before the pandemic. Private insurance data also shows that while all health-care claims for adolescents ages 13–18 were down in 2020 compared to 2019, mental health-related claims for this age group increased sharply. Additionally, the Centers for Disease Control and Prevention (CDC) reports 25 percent of parents whose children attended school virtually were more likely to report an overall worsened mental or emotional health compared to only 16 percent of parents of children attending school in-person.

What programs within the Department of Health and Human Services' (HHS) purview are best poised to support children and schools as they return to complete in-person learning?

Answer. Each agency within HHS offers incredible programs to help support our Nation's children. This includes Project AWARE at SAMHSA, Healthy Schools at CDC, school-based billing under Medicaid, support for school-based health centers at HRSA, and support for families' social and economic needs via the Administration on Children, Youth, and Families (ACYF).

The biggest problem with these programs is scale—these programs benefit the grantees, but don't help most of the children who need them.

To meet this moment, interagency collaboration is needed to coordinate and leverage all available resources to support States and local school systems to provide effective mental health supports for their students. CMS also needs to work with States to help them streamline appropriate billing for mental health services in schools under Medicaid. Several advocacy organizations have also offered up the

idea of creating a White House Office on Children and Youth, and/or a Federal Children's Cabinet to help specifically on many of these issues above.

Question. How can we integrate more telehealth opportunities to expand access to mental health services in schools?

Answer. Congress has already done incredible work promoting access to virtual mental health consults for children in primary care by funding HRSA's Pediatric Mental Health Care Access Program. Congress can integrate more telehealth opportunities in schools by expanding this program further initiating a similar program to support integration with schools as well. As part of this work, CMS can provide technical assistance to States for ensuring that their current approach to Medicaid billing supports telehealth for children's mental health in schools. With these investments in infrastructure and attention to sustainability, millions more children can gain access to virtual mental health services where they are—in schools.

We should also allow States to continue utilizing telehealth flexibilities put in place during the pandemic which facilitate schools both delivering mental health services and billing Medicaid for those services. For example, during the pandemic audio only was an allowable modality of telehealth services, both in terms of being able to deliver services and bill for services delivered using audio only. Other flexibilities include allowing school districts to access out of State providers for telehealth which helps address some of the workforce shortage issues and in general, just allowing school health provider types to bill Medicaid for services delivered.

Congress should also support States in expanding their school Medicaid programs. States that had expanded their school Medicaid programs to allow for billing for non-IEP (individualized education program) services were able to do significantly more Medicaid claiming for telemental health services.

And finally, there should be guidance issued to schools on how best to utilize telehealth to expand access to mental health services in schools. More guidance is needed to help States and school districts navigate Federal policies around telehealth, including reimbursement procedures.

Currently, there is no designated guidance on telehealth for schools, and it would be a perfect opportunity for cross-agency collaboration to develop a piece that supports school districts in expanding access to mental health services in schools via telehealth.[2]

Question. Telehealth has expanded rapidly as a result of the COVID–19 pandemic. Numerous studies have demonstrated the effectiveness of telehealth for behavioral health services.

As telehealth becomes more common among health-care providers, what can Congress do to ensure that patients do not suffer from unnecessary bureaucratic delays?

Answer. It's going to take time for Congress to ensure that every American has access to broadband—this is needed so that everyone has access to telehealth and that existing disparities aren't made worse. However, in the interim, to make sure the greatest number of American can most immediately access telehealth services, Congress should make permanent some of the policies they temporarily put in place during the pandemic. Congress should make audio-only telehealth services permanent, enact payment parity, and allow for telehealth to be available for all forms of outpatient care.

Question. There is a well-researched connection between unemployment and mental health. As recently as April 2021, despite billions of dollars of COVID–19 stimulus, aggregate employment remained 7.9 million jobs below its pre-recession level.

What impact will this failure to get people back to work have on mental health?

Answer. There is a well-researched connection between unemployment and mental health, but it just makes sense: financial insecurity can increase stress, and stress can exacerbate underlying mental health and addiction issues.[3]

Unfortunately, despite billions of dollars of COVID–19 stimulus funds, as recently as April 2021 aggregate employment remained 7.9 million jobs below its pre-

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[2] *https://healthyschoolscampaign.org/dev/wp-content/uploads/2021/03/Providing-Health-Services-During-School-Closures-March-2021.pdf.*

[3] *https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair-COVID-19-FINAL.pdf.*

recession level. And the longer it takes use to close that gap, the great risk we run of seeing an increase in the number of lives lost to suicide and drug overdoses.

Question. Last November, an article published in the *Journal of the American Medical Association* noted that multiple studies indicated that older adults may be less negatively affected by certain mental health outcomes than other age groups.

Are these study outcomes consistent with your own professional experiences working with older adults?

Answer. That study found that older adults appeared to experience less mental health impacts during the early days of the COVID–19 pandemic that other age groups. The article also notes the following:

> The data from various studies contrast the numerous personal stories about how difficult the pandemic has been for the older population. This divergence likely represents the heterogeneity that is a hallmark of aging. Also, resilience captured at the population level may not translate to individuals in specific circumstances. Thus far, there is not a clear understanding of which risk factors and protective factors are the strongest determinants of mental health outcomes, although these may vary from person to person.
>
> Many older adults do not have the resources required to deal with the stress of COVID–19. This may include material (*e.g.,* lack of access to smart technology), social (*e.g.,* few family members or friends), or cognitive or biological (*e.g.,* inability to engage in physical exercise or participate in activities or routines) resources. Clinicians and caregivers must estimate resource availability and consider how the absence of resources can be mitigated for a given individual and family. Of particular importance is the role of technology, which has emerged as an important factor for maintaining social connection as well as accessing mental health services.[4]

In general, older adults are heavily impacted by mental health problems, although in different ways than their younger counterparts. For example, among men, suicide rates are the highest for those over 75 years of age.[5] Other recent studies find relatively consistent prevalence of depression across adulthood.[6] Although risk factors evolve with age, mental health remains a serious issue and older adults often do not have access to appropriate care that meets their particular needs. This is in part why any conversations on Medicare reform must begin to address the deficiencies in the program for mental health and substance use disorders.[7]

Question. Current network adequacy standards often allow networks of specialists who aren't taking new patients or who have long waiting lists. That means that many people needing treatment must go out of network to get care, and only those who can afford the high cost get it. One of the biggest challenges to access to behavioral health-care services is that many behavioral health specialists don't participate in health plan networks.

Why is that, and how can we change that?

Answer. The consequences of inadequate networks can be devastating for American families. Inadequate networks are a major driver of enormous disparities in out-of-network utilization for mental health and substance use disorder (MH/SUD) treatment compared to physical health care. Patients are far too often forced to find out-of-network MH/SUD services because in-network services are not available, and are therefore exposed to much higher out-of-pocket costs, balance billing, and more aggressive insurer utilization controls. Data from Milliman shows out-of-network MH/SUD utilization for both inpatient and outpatient facilities is more than five times higher than out-of-network physical health utilization.[8]

Strong network adequacy standards are essential to ensuring access to MH/SUD care. Unfortunately, for many types of health plans, network adequacy standards are weak, if existent all, and often qualitative in nature. Weak standards effectively

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[4] *https://jamanetwork.com/journals/jama/fullarticle/2773479.*
[5] *https://pubmed.ncbi.nlm.nih.gov/32487287/.*
[6] *https://www.cdc.gov/nchs/products/databriefs/db303.htm.*
[7] *https://www.realclearpolicy.com/articles/2020/12/30/medicare_must_cover_mental_health_654797.html.*
[8] Steve Melek, et al., Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement, Milliman, November 19, 2019, *https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.*

contribute to inadequate networks that result in Americans not receiving the MH/SUD services they need, at enormous cost to individuals, families, and our society. For example, while Federal law requires Medicaid managed care and Affordable Care Act qualified health plans (QHP) to maintain adequate networks, Federal law simply defers to a hodgepodge of State regulatory standards, which often fail to establish concrete access standards that are plainly transparent to consumers, providers, and health plans alike. According to a recent report by the Legal Action Center, only seven States have created standards for State-regulated plans relating to the three most meaningful network adequacy measures: appointment wait times, provider/enrollee ratio, and distance standards.[9]

Importantly, self-funded health plans subject to the Employee Retirement Income Security Act of 1974 (ERISA), which are exclusively regulated by the U.S. Department of Labor, are not subject to *any* legally imposed network adequacy standards at all. Given that the majority of Americans in ERISA plans are covered by self-funded plans, this significant gap in law leaves tens of millions of Americans without a right to adequate networks.

Strong, quantitative network adequacy requirements should be expanded to all types of health plans. These requirements should include provider/enrollee ratios that only measure providers who are active plan providers (measured by billings within the last 6 months to prevent "ghost" networks), as well as appointment wait times (*i.e.,* timely access standards) and distance standards. Timely access and geographic standards directly measure patient access to care and should be required together. After all, care that is theoretically available now but at a great distance or theoretically available nearby but not when needed is tantamount to no care at all. All health plans that cannot ensure suitable, timely and geographically accessible in-network care should be required to cover the cost of out-of-network treatment, without any additional cost-sharing for patients.

Standards should be set, measured and enforced separately for MH and SUD providers, with requirements that plans meet timely access, distance, and patient/enrollee ratios for the full range of provider types and settings that are necessary to treat MH/SUD. While telehealth should be allowed to help plans meet network adequacy requirements in areas with few providers (*e.g.,* rural areas), the availability of telehealth providers should not be allowed to replace patients' ability to access in-person care.

Placing the obligation of maintaining adequate networks on health plans—particularly by requiring health plans to pay for out-of-network care without additional cost-sharing by patients—is the only way to ensure that patients are not continuously victimized by insurers' phantom networks and inaccurate provider directories. Only when insurers must bear the financial risk of out-of-network coverage will they have sufficient incentive to maintain accurate provider directories and recruit sufficient providers into their networks.

Question. Outside of the public health emergency, telehealth services are restricted to certain geographic and clinical settings. Beneficiaries must live in a rural area and have an initial face-to-face visit with the distant-site provider. Once a relationship has been established, periodic in-person visits are also required. With few exceptions, patients must be located in a clinical setting and may not receive care from their homes. In addition, the distant- site provider cannot be located in a rural health clinic or FQHC.

Telehealth has been used broadly during the pandemic to expand health-care access to individuals throughout the country. During the pandemic, Medicare significantly expanded the coverage of telehealth services. A recent Bipartisan Policy Center poll suggests that people receiving mental health and substance use services want a combination of in-person, video, and telephone services even after the pandemic has passed.

What telehealth expansions should remain after the pandemic?

Answer. Telehealth has been used broadly during the pandemic to expand health-care access to individuals throughout the country, as Medicare significantly expanded the coverage of telehealth services.

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[9] Ellen Weber, Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services, Legal Action Center, May 2020, *https://www.lac.org/resource/spotlight-on-network-adequacy-standards-for-substance-use-disorder-and-mental-health-services.*

Outside of the public health emergency, telehealth services are restricted to certain geographic and clinical settings. Beneficiaries must live in a rural area and have an initial face-to-face visit with the distant-site provider. Once a relationship has been established, periodic in-person visits are also required. With few exceptions, patients must be located in a clinical setting and may not receive care from their homes. In addition, the distant-site provider cannot be located in a rural health clinic or FQHC. These are all barriers that will emerge again if the emergency order provisions for telehealth expire—with consequences. For example, placing an in-person requirement back on the patient works against patients as it restricts access to telehealth for those individuals with transportation issues, those in provider shortage areas, or other access barriers. It also prevents the use of telehealth for new patients experiencing a crisis.

The uptick in telehealth utilization for mental health signals that people enjoy when care comes to them—and Americans should continue to have that choice post-pandemic. That's why Well Being Trust supported a Bipartisan Policy Center report earlier this year that highlighted the importance of removing site of service, geographic, and established patient restrictions for telehealth services.[10] In addition, it called for the elimination of the two-way video requirement, which will begin to help address the digital divide and access disparities for those without broadband or video technology.

Congress should make permanent audio-only telehealth services, enact payment parity, and allow for telehealth to be available for all forms of outpatient care. Congress therefore must also, as many have pointed out, make sure broadband is accessible and affordable as to not further disparities, and encourage that we ask clinicians using telehealth services to measure outcomes to show that they work for mental health.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

Question. Your testimony provides a piece to the puzzle of mental health policy that our Nation is currently lacking: strategy. I would like to follow up on this point with a few questions.

Your testimony included thoughts on how the Senate Finance Committee and U.S. Senate should pursue reforms for immediate problems strategically so that these efforts can also allow communities to begin modernizing local systems of mental and behavioral health.

Could you elaborate on those thoughts?

How should Congress pursue legislation to support these twin goals?

Answer. Good mental health is foundational to the health and well-being of every American. Our society, however, treats mental health all too often as a system of medical services for people experiencing a mental health crisis. It spends very little time investing thinking about how we can prevent some of these episodes from occurring in the first place or how to help young people develop strong foundations and self-care tools so that individuals might avoid a mental health crisis in the first place.

Immediate steps need to be taken by Congress to address unmet medical needs such as increasing the availability of the workforce to manage the expected increase in call volume from 988. S.B. 1902 holds great promise in helping address this issue by clearly laying out standards for what should be in a crisis continuum, assuring comprehensive coverage of these services, and finding sustainable funding mechanisms.

However, any legislative vehicle required to pass these reforms could also be used to lay the groundwork for a modern, more wholistic approach to solving our Nation's mental health needs. We need to get ahead of our problems if we are to solve many of them, and reforms at the local level are needed to get us there. We can achieve this by creating opportunities for Americans at all stages of life to participate in mental health and well-being.

First and foremost, we need to enhance the capabilities of local workforces and programs to increase service availability for local communities. Some of that can be addressed through medical professional workforce development but we cannot solve

[10] *https://bipartisanpolicy.org/report/behavioral-health-2021/*.

our need for services through them alone. The development of non-medical community workforces and use of digital therapeutics are two steps that Congress can undertake to broaden the response beyond the need to increase the numbers of local medical workforces. The benefits of the overall availability of services within local communities should have the added benefit of taking some of the burden off of health professionals thereby allowing them greater capacity to address the most severe cases.

Second, I believe the Federal Government needs to reimagine its approach to funding mental health and addiction services in local communities. There are numerous autonomous Federal funding streams and other resources that have been developed over the years but no comprehensive strategy for how they all work together to best support Federal interests. This lack of coordination and differing funding authorities needlessly places undue administrative burden and cost on communities which can lead to inefficient spending and diminished results. outdated approaches to addressing mental health and addiction issues are contributing to ineffective community approaches that don't do enough. Communities in this country need to go through the same type of process to reimagine local operations—a process to help them reform and hold them accountable for improved operations and programming could help improve the effectiveness of the Federal effort even further.

Third, establishing foundations for good mental health should begin early. Our formative years, from birth through the age of 18, are critical to an individual's overall mental health and well-being. Creating early opportunities for education and the development of self-help tools to help a person manage mental health throughout their lives can go a long way to preventing some medical issues before they arise, and help every American build the tools they will need to succeed. There is an immediate need to reinforce this approach right now in our schools, assuring that the staff, the students, and all those connected have access to mental health services and supports.

Lastly, there are concrete steps that Congress can take to improve local health system approaches to mental health care. Some of these ideas are already being advanced by members of the Senate. Others I am happy to provide.

Legislatively speaking, I believe that the Senate Finance Committee has unique statutory authority to lead the charge on larger reform. While a comprehensive solution will need to involve the Public Health Service Act as well, the Family First Prevention Services Act presents a unique model that if adapted could help initiate the type of system and generational reforms that are needed today. In the interest of helping support your efforts, I am in the process of developing a draft legislative outline for your consideration and should be delivering that to you in the next couple of weeks.

Taken together, these steps can begin to create opportunities for Americans at all stages of life to pursue and embrace mental health and well-being.

Question. Your testimony touched on a key concept—updating Federal approaches to funding care for local communities.

How can we more efficiently spend Federal funds already allocated today to local communities?

Also, in what ways can modern technologies improve community and Federal Government return-on-investments?

Answer. The Federal Government spends very inefficiently on mental health and addiction care. There are dozens of Federal programs and authorities created over the years by Congress with no overarching Federal strategy for how they are to work together. This fact contributes to duplicative and other wasteful spending practices.

In addition, some of the Federal rules governing these authorities—such as spending requirements that prevent long-term planning of awarded funds—encourages wasteful and inefficient spending by communities fearful of missing out on Federal dollars. The lack of an overarching strategy for how the Federal Government funds communities, combined with the time and cost of running separate regulatory channels, needlessly adds administrative burden on both communities and Federal officials as well.

As for communities, being more efficient with Federal funds need not only rely upon spending efficiencies alone. For instance, there are numerous programmatic improvements already vetted and proven to save money (under the Family First

Prevention Services Act and other sources) that many local communities have failed to adopt. In addition, self-sustainability provisions and other mechanisms to ensure efficient programming and spending can be added to reform efforts to ensure they maintain fiscal integrity.

Digital technologies offer other options for improving access while improving spending efficiencies. Digital therapeutics (like cognitive behavioral therapy) offer communities alternative sources of medical service without the commiserate cost of training and employing medical professionals. Best practice and evidence development aided by modern digital technologies such as AI can help systems identify where future improvements can be made.

Digital therapeutics along with non-medical workforces also have the added benefit of freeing up medical professionals so that they can focus on the highest-acuity patients. Where local systems are able to recognize and use such alternative service providers, access to care can increase beyond what a traditional workforce can provide—at a lower cost.

Question. You write in your testimony that, "we need to bring mental health care to where people are." This includes schools, workplaces, and primary care. As primary care is the largest delivery of health care this inclusion makes sense, but as you note, there are some barriers.

Can you expand on this thinking?

Answer. Bringing mental health care to where people are is a way of speaking to the need to engage individuals in all phases of their lives in ways most conducive to securing engagement. Fragmentation of mental health and addiction care has made it an ongoing challenge for people to get easy and timely access to services. By bringing care to where people are, we begin to offer more timely opportunities for engagement and lessen the likelihood that a person does not get much-needed care. Delaying care does not lead to improvement—we must be more responsive to our communities needs by assuring care is integrated into the settings they present. We need to pursue novel models that integrate care and support those models with the appropriate payment mechanisms.

Erasing the stigma and improving societies embrace of mental health can best be achieved by engaging people at all stages of life. The stigma of mental health and addiction in our society may be one of the biggest barriers our Nation faces. As a society, we are taught by example to avoid talking about or seeking help for mental illness and give little thought to building familiarity with the pursuit of well-being. Parents typically do not realize the extent to which their own behavior is held up as a model for children. Society does not typically teach children the basics of mental health or the importance of building self-care tools early on as a means of preparing for the years to come. As we grow older, there are many different things that can reinforce these avoidance lessons. The net result is a community approach that encourages people to ignore mental and behavioral issues until they manifest as health-care issues. By then, our lack of familiarity with these areas makes treatment very difficult on people who may have a long course of treatment and recovery ahead of them.

If we are to achieve more positive outcomes in areas of mental health and addiction, we need to break this stigma for current and future generations. For those alive today, that means finding ways to engage people who might otherwise avoid these issues altogether. Each generation alive today can benefit from opportunities to engage in mental and behavioral well-being. If we are to succeed in breaking the stigma for them, we need to create opportunities that relate to where they are in their lives. For children, basic education on the ABCs of mental health can help establish familiarity and strong foundations upon which to deal with issues of mental and behavioral health later in life. For families of young children or those expecting, educational and medical services for mental health can be better integrated in the physical care model in a physician offices or other site of service. For adults and seniors, access to wellness, treatment, and referral services through community workforces or community access points like employers can help begin to break down barriers and make it easier for people interested in taking the next step to more easily find answers.

All policies should be scrutinized for how they limit a person getting access to mental health care—in some cases further fragmenting care—and how they may inadvertently reinforce stigma.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

The Finance Committee meets this morning to discuss mental health care in America. This issue ought to bring Democrats and Republicans together, starting with a single, clear lodestar: every American must have mental health care when they need it.

The shameful reality is, the United States does not come close to meeting that bar today. Multiple Federal laws say that mental health care is supposed to be on a level playing field with physical health care. In practice, however, the system still reflects the dangerous, old stigma against recognizing and treating mental illness, and that's why millions of people are falling through the cracks.

For someone with a mental illness, it can be nearly impossible to find a provider who can meet your needs, or one who accepts insurance—particularly in rural areas or in communities of color. Insurance claims too often get denied or cut off too quickly. Particularly for those experiencing homelessness, the outcome of a mental health crisis is too often incarceration instead of treatment.

Prior to the pandemic, one in five Americans was living with a mental illness. All the evidence suggests the pandemic is adding to the crisis. The proportion of Americans reporting symptoms of anxiety or depression has nearly quadrupled. On Friday, the Centers for Disease Control and Prevention released a new report finding that over the last year, suicide attempts among teenage girls were up by more than 50 percent. Meanwhile, a study the Government Accountability Office conducted at my request found that many provider offices closed or cut staff during the pandemic, resulting in too many patients turned away.

There's a lot for this committee to work on. There are a few key challenges. First, the country needs a larger mental health workforce. There simply are not enough providers, whether it's psychiatrists or therapists or staff in inpatient facilities. For example, due to a major staffing shortage, the psychiatric hospital in Salem is currently being staffed in part by members of the Oregon National Guard. That's in a State capital, where there are people and resources focused on this issue. Other areas have it worse. More than one in three Americans lives in an area with a severe shortage of mental health professionals.

Second, insurance companies must not cut corners when it comes to mental health coverage. This issue comes up all the time during town hall meetings I hold in Oregon—people describing having their claims denied. In other cases, insurance only covers a portion of the treatment people need. Furthermore, it doesn't make any sense to leave somebody experiencing a true mental health crisis waiting for a green light from an insurance company before they can get treatment.

Third, this committee must address the racial inequities in mental health care. Black and Latino Americans are roughly half as likely as white Americans to receive treatment for a mental illness. Suicide rates are much higher among black children. There aren't enough black, Latino, and Native American mental health providers. This is a basic matter of health-care equity, and there's a long way to go.

Finally, the Finance Committee ought to build on areas of recent progress. For example, early in the pandemic this committee led the fight to get Medicare to cover mental health services via telehealth. In December, the Congress made that permanent. This is going to be a game changer, particularly for seniors who live in rural areas. It would work outside of traditional Medicare too.

Senator Stabenow has long been a champion of mental health care. Today the committee will hear about the success of Certified Community Behavioral Health Clinics, a program she fought for and created. These clinics are up and running in 40 States, including Oregon. It's an approach that works, and it's meeting big needs. I believe the Congress ought to look at ways to build on its success.

In March, the Congress also passed a big down payment for a pioneering new approach on mental health services and law enforcement called the CAHOOTS program. It originally comes from Eugene, OR, and it has expanded in bigger cities and rural areas around the State. Under this approach, when there's a 911 call dealing with someone experiencing a mental health crisis, CAHOOTS sends trained health professionals as first responders instead of just police. Health-care providers like it; law enforcement likes it. The American Rescue Plan included a billion-dollar down payment to help States build their own programs like CAHOOTS. Now the Congress

needs to consider what comes next to build these programs successfully and make sure people are getting the help they need, even after the immediate crises end.

It's clear there's a lot of work to be done. Members on both sides have important ideas addressing these issues and more. I want to continue working with members in the weeks ahead, because I believe there's a big need and a big opportunity for legislation on mental health.

COMMUNICATIONS

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June 25, 2021

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Academy of Family Physicians (AAFP) and the 133,500 family physicians and medical students we represent, I applaud the committee for its consideration of the mental health challenges in the U.S. I write in response to the hearing: "Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions" to share the family physician perspective and the AAFP's policy recommendations for ensuring all patients who need mental health care are able to access it.

Mental illness is highly prevalent in the United States and is associated with an increased risk of morbidity and mortality. There are significant gaps in the provision of mental health care services in the U.S., especially related to vulnerable populations. While psychiatric and other mental health professionals can play an important role in the provision of high-quality mental health care services, primary care physicians are the main providers for the majority of patients. Most people with poor mental health will be diagnosed and treated in the primary care setting. Mental illness also complicates other medical conditions, making them more challenging and more expensive to manage. Together, this makes mental health an important issue for primary care physicians.

Screening for mental illness is not new to family medicine but has more recently been linked to quality metrics and payment. Screening for mental illness can be an important strategy for decreasing morbidity, as well as preventing adverse maternal and child health outcomes associated with perinatal depressive symptoms, postpartum depression, or maternal suicide.[1, 2, 3] While important, screening in a busy practice can seem overwhelming, but practices can leverage technology, empower staff, and utilize wellness visits to complete this screening.[4]

Integrating mental health into primary care settings, as well as the blending of primary and preventive medicine into traditional mental health settings, represents a more holistic approach to treatment than the traditional consultative and referral models. Integrating primary care and mental health services increases access for pa-

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[2] Kendig S, Keats JP, Hoffman MC, et al. Consensus bundle on maternal mental health: Perinatal depression and anxiety. *Obstet Gynecol.* 2017;129(3):422–430.

[3] Yonkers KA, Wisner KL, Stewart DE, et al. The management of depression during pregnancy: A report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2009;114(3):703–713.

[4] Savoy M, O'Gurek DT. Screening your adult patients for depression. *Fam Pract Manag.* 2016;23(2):16–20.

tients by making mental health services available in their regular primary care clinics. When integrated into primary care, mental health clinicians can impact the care of more patients than in the specialty mental health referral sector.[5] In the primary care setting, mental health clinicians take on a more consultative and team-based role and focus on helping primary care physicians treat mental health disorders. In this context, mental health clinicians typically reach more patients, and have shorter and more problem-focused encounters than in the context of traditional specialty mental health.

The Collaborative Care Model, supported by various organizations including the AAFP and the American Psychiatric Association, is a model for the successful integration of primary care and behavioral and mental health.[6] At its core, the idea of collaborative care is anchored in team-based care, often in the context of a medical home, and steered by primary care physicians. It involves behavioral health specialists and consulting mental health professionals delivering evidence-based care that is patient-centered.

The collaborative care model at its core is: (1) team driven, (2) population focused, (3) measurement guided, and (4) evidence based. These four elements, when combined, can allow for a fifth guiding principal to emerge—accountability and quality improvement. Collaborative care is team-driven, led by a primary care clinician with support from a "care manager" and consultation from a psychiatrist who provides treatment recommendations for patients who are not achieving clinical goals. Other mental health professionals can contribute to the Collaborative Care Model. Collaborative care is population focused, using a registry to monitor treatment engagement and response to care. Collaborative care is measurement guided with a consistent dedication to patient-reported outcomes and it utilizes evidence-based approaches to achieve those outcomes. Care remains patient centered with proactive outreach to engage, activate, promote self-management and treatment adherence, and coordinate services.[7]

The AAFP urges Congress to support the adoption of the Collaborative Care Model by funding grant programs for primary care practices and encouraging Center for Medicare and Medicaid Innovation models for behavioral health integration.

Telemedicine for mental health is a growing interest in primary care and telehealth initiatives for mental health care are expanding rapidly. While the research is limited on this topic, there are a growing number of studies assessing the benefits, comparative effectiveness with face-to-face visits, and cost comparisons. From January to March 2020, at the beginning of the COVID–19 pandemic, telehealth visits increased by 135% compared to that time period in 2019, and 93% of those visits were for non-COVID concerns.[8] In addition, mental health concerns increased rapidly during the pandemic. Four in ten adults reported symptoms of anxiety, an increase from one in ten the year prior, and more than half of all young adults ages 18–24 reported symptoms of anxiety and depression and were more likely than other age groups to report substance use and suicidal thoughts.[9] Other trends should a disproportionate effect on mental health for communities of color, mothers, and essential workers.[10] The AAFP is supportive of efforts to expand access to mental health services via telehealth and encourage Congress to address the legislative barriers outlined in our previous testimony and Joint Principles for Telehealth Policy. In particular, the AAFP strongly believes that the permanent expansion of telehealth services should be done in a way that advances care continuity and the patient-physician relationship. Telehealth for mental health can help address the

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[6] American Psychiatric Association Academy of Psychosomatic Medicine. Dissemination of integrated care within adult primary care settings. Accessed January 22, 2018.

[7] *Ibid.*

[8] Koonin LM. Trends in the Use of Telehealth During the Emergence of the COVID–19 Pandemic—United States, January–March 2020. *MMWR Morb Mortal Wkly* Rep. 2020;69. doi:10.15585/mmwr.mm6943a3.

[9] Panchal N, Kamal R, 2021. The Implications of COVID–19 for Mental Health and Substance Use. KFF. Published February 10, 2021. Accessed June 17, 2021. *https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/*.

[10] *Ibid.*

shortage of over 6,000 mental health professionals in the U.S., particularly for rural and underserved areas that face a disproportionate impact of the shortage.[11]

Trauma-informed care, an approach to engaging individuals with a history of trauma that recognizes their traumatic experiences, and how it affects their lives, is a promising practice that may facilitate healing and help prevent the consequences of exposure to trauma.[12, 13] An estimated 60% of adults in the U.S. have experienced a traumatic event at least once in their lives.[14] Exposure to trauma, such as intimate partner violence, sexual abuse, rape, neglect, terrorism, war, natural disasters, and street violence predisposes those affected to poor physical and mental health outcomes.[15] The principles of trauma-informed care include: realizing that there is a high prevalence of trauma and it has serious effects; recognizing the signs and symptoms of trauma; responding to the high prevalence by integrating knowledge about trauma into practices, procedures, and policies; and avoiding retraumatizing individuals by using best-practices in screening and history taking.[16]

Disparities are pervasive in all aspects of health, including mental health conditions. While mental health conditions can affect everyone, regardless of culture, race, ethnicity, gender or sexual orientation, some populations experience those conditions at a higher rate.

- American Indian and Alaska Natives (28.3%) experience higher rates of mental illness than white (19.3%), black (18.6%), Hispanic (16.3%), or Asian (13.9%) adults.[17]
- Individuals from the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) community are two or more times as likely as heterosexual individuals to have a mental health condition, and LGBTQ youth are two to three times more likely to attempt suicide than heterosexual youth.[18]
- Nearly one-fifth (18.5%) of the veterans who returned from serving in either Iraq or Afghanistan suffer from either major depression or post-traumatic stress disorder.[19]
- The prevalence of mental illness is similar for individuals living in either rural or metropolitan areas, but the mental health care needs are more often unmet in rural communities due to inadequate services.[20]

Disparities in mental health illness and mental health care are related to coverage and availability of care, quality of care, rates of health insurance, stigma, cultural insensitivity, racism, bias, homophobia, discrimination in treatment settings, and language barriers.[21]

College students face unique mental health concerns, such as non-suicidal self-injury and serious suicidal ideation.[22] There are approximately 20 million students enrolled in U.S. colleges and universities, and the rates of serious mental health

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[11] Mental Health Care Health Professional Shortage Areas (HPSAs). KFF. Published November 5, 2020. Accessed June 17, 2021. *https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/*.

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[14] National Council for Behavioral Health. Trauma-informed approaches learning communities. Accessed January 22, 2018.

[15] Agency for Healthcare Research and Quality. Trauma-informed care *(https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/trauma.html).* Accessed January 22, 2018.

[16] *Ibid.*

[17] National Alliance on Mental Illness. Mental health by the numbers *(https://www.nami.org/mhstats).* Accessed January 22, 2018.

[18] *Ibid.*

[19] Tanielian T, Jaycox LH, Schell T, et al. Invisible wounds. Mental health and cognitive care needs of America's returning veterans. RAND Corporation. 2008. Accessed January 22, 2018.

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[21] National Alliance on Mental Illness. Mental health by the numbers *(https://www.nami.org/mhstats).* Accessed January 22, 2018.

[22] Center for Collegiate Mental Health. 2017 Annual Report *(https://sites.psu.edu/ccmh/files/2018/01/2017_CCMH_Report-1r3iri4.pdf).* Accessed January 22, 2018.

concerns is rising in this population.[23,24] According to the Center for Collegiate Mental Health's 2017 Annual Report, 52.7% of students attended counseling for mental health concerns; 34.2% took a medication for mental health concerns; 9.8% were hospitalized for a mental health concern; 27% purposely injured themselves without suicidal intent; and 34.2% seriously considered attempting suicide, with 10% making a suicide attempt.[25] In fact, some data suggest that suicide may be the most common cause of death in college students.[26]

Attention-deficit/hyperactivity disorder (ADHD) is another prevalent disorder in college students that family physicians may encounter. ADHD's prevalence is estimated to be between 2–8% among college students, and this condition is frequently associated with other psychiatric comorbidities and increases individuals' risk of psychosocial and substance-use problems.[27]

Tobacco use is prominent among individuals living with mental illness. Thirty-six percent of adults with any mental illness use tobacco products, compared with 25.3% for adults without a mental illness.[28] In addition, people who have any mental illness are only half as likely to quit smoking compared to individuals without a mental illness.[29] One study found that nearly half of all deaths were tobacco-related for persons who received substance abuse services, or who received both substance abuse and mental health services.[30] Therefore, addressing tobacco addiction among individuals living with mental illness is an important strategy for decreasing preventable mortality and morbidity among individuals living with a mental illness.

The AAFP has position papers that detail substance use disorders and addiction and tobacco prevention and cessation.

Payment for primary care physicians has historically been inadequate for office visits for mental health diagnoses. This limitation in reimbursement interfered with the family physician's ability to offer comprehensive care and management of mental health conditions, as well as the ability to integrate, from a business perspective, with behavioral health services. However, new coverage policies adopted by the Centers for Medicare and Medicaid Services (CMS) are more promising and may incentivize primary care physicians to provide treatment for mental and behavioral health conditions.[31] These policies, effective January 1, 2017, emphasize collaborative care, where primary care physicians are expected to work in partnership with a behavioral health care manager, and consult with mental health specialists. While targeting populations with Medicare, these policies may also encourage private insurers to offer similar options and may incentivize more family physicians to offer behavioral and mental health care to other populations.

Health care for all people with mental illness should be "affordable, nondiscriminatory, and includes coverage for the most effective and appropriate treatment."[32] Coverage for mental illness should be equal in scope to coverage for other illnesses and all clinically-effective treatments appropriate to the needs of individuals with mental illness should be covered.

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[23] *Ibid.*

[24] National Center for Education Statistics. Fast facts. Back to school statistics *(https://nces.ed.gov/fastfacts/display.asp?id=372).* Accessed January 22, 2018.

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[31] Press MJ, Howe R, Schoenbaum M, et al. Medicare payment for behavioral health integration. *N Engl J Med.* 2017;376(5):405–407.

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Thank you for the opportunity to provide testimony on this important issue. For further questions, please contact Erica Cischke, Senior Manager, Legislative and Regulatory Affairs at ecischke@aafp.org.

Sincerely,

Gary L. LeRoy, M.D., FAAFP
Board Chair

End notes

https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/TS-SenateFinanceCmte-DavisTelehealth-051921.pdf.

https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/LT-Congress-TelehealthHELP-070120.pdf.

https://www.aafp.org/about/policies/all/substance-use-disorders.html.

https://www.aafp.org/about/policies/all/tobacco-preventingtreating.html#:~:text=The%20AAFP%20opposes%20all%20forms,of%20tobacco%20products%20to%20children.

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On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record.

America's hospitals and health systems play a central role in delivering behavioral health care and are uniquely positioned to help patients navigate the behavioral health resources that are available in communities. Psychiatric and community hospitals are a vital source of care for behavioral health patients, providing treatment for a full range of psychiatric and substance use disorders (SUD) by stabilizing patients, establishing and providing quality treatment regimens, and transitioning patients to outpatient and community-based services. The AHA strongly supports efforts to increase access to, and improve the quality of, behavioral health care.

Even before the COVID–19 pandemic, one in five American adults was estimated to have a behavioral health condition, and nearly 60% of adults with behavioral health disorders reported not receiving services for their conditions. But the nation's level of unmet behavioral health needs has been exacerbated by the COVID–19 pandemic. As of June 14, the Centers for Disease Control and Prevention (CDC) reports that more than 33 million Americans have been infected with COVID–19, and, of those, more than 597,000 have died.

The effects of high unemployment, anxiety over the risk of contracting COVID–19, grief over the death of loved ones, isolation from neighbors and friends, and an increase in domestic violence and child abuse are all increasing the incidence and prevalence of mental health conditions and substance use disorder. For example, one in three adults reported symptoms of an anxiety disorder in 2020, compared with one in 12 in 2019.

In addition, the inability to access in-person group therapy and medication-assisted treatment (MAT), in part because of social distancing requirements, has led many with substance use disorders to relapse. According to the CDC, overdose deaths spiked after the start of the pandemic, driven by synthetic opioids such as fentanyl.

Further, the behavioral health effects of COVID–19 are manifesting at a time when the nation's behavioral health care system is ill-prepared to meet the nation's needs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), only 43% of U.S. adults with mental illness received treatment in 2018, and a JAMA study found that 50.6% of U.S. youth aged 6–17 with a mental health disorder received treatment in 2016.

Unfortunately, due to financial pressures, hospitals' capacity to care for behavioral health patients has been significantly diminished, exacerbating a trend that began decades ago. The number of state-funded psychiatric beds per capita decreased by

97% between 1955 and 2016, with the per capita psychiatric inpatient bed count approximately 70% lower than the average among developed nations, as noted by a March 2019 National Association for Behavioral Healthcare report. Lack of access to psychiatric inpatient services and resources will exacerbate existing sever shortages in psychiatric beds nationally. This trend, combined with new closures, will result in more preventable deaths from psychiatric and substance use disorders and more cases of emergency room boarding. As the number of psychiatric beds has declined, the demand for inpatient services has continued to increase, and correspondingly, wait times for those beds has increased dramatically as well.

To address the urgent need for greater access to behavioral health services, the AHA offers the following recommendations to the Committee on Finance.

ADDRESS PHYSICIAN SHORTAGES

At the core of our health care system is a well-trained, diverse workforce. But critical physician shortages deprive many communities of access to needed care. The Association of American Medical Colleges estimates that the United States faces a shortage of between 54,100 and 139,000 physicians by 2033.

In the 1997 Balanced Budget Act, Congress froze the number of Medicare-funded residency slots at 1996 levels, based on projections that the nation would soon have a surplus of physicians. Over the past 24 years, millions more Americans have attained health insurance, the nation's population has grown and aged, and more physicians are retiring—leading to a crisis in physician access. The shortage is even more acute for substance use disorder providers. A recent report from the National Academies of Sciences, Engineering and Medicine highlighted the dearth of clinicians with specialized training in MAT, and SAMHSA has estimated that only 10% of the 22 million Americans with an SUD receive treatment.

Last December, Congress lifted the cap on Medicare-funded residency positions, allowing growth for the first time since 1997. That provision, in the Consolidated Appropriations Act, 2021, created 1,000 new slots that will begin to be distributed in fiscal year (FY) 2023. Increasing the number of Medicare-funded slots would help ease current shortages, and bolster the foundation of our health care system.

The AHA supports the Opioid Workforce Act of 2021, introduced by Senators Margaret Wood Hassan and Susan Collins, which would help abate the national shortage of opioid treatment providers by increasing the number of resident physician slots in hospitals with programs focused on SUD treatment. Existing shortages of SUD treatment providers have led to lengthy waiting periods for treatment and increased mortality from opioid misuse and addiction. The Opioid Workforce Act would help address existing shortages by adding 1,000 Medicare-funded training positions in approved residency programs in addiction medicine, addiction psychiatry or pain medicine. These new slots would constitute a major step toward increasing access to SUD treatment for communities in need. We look forward to working with you to ensure passage of this important legislation.

REPEAL THE IMD EXCLUSION

Since 1965, the Institutions for Mental Diseases (IMD) exclusion has prohibited federal payments to states for services for adult Medicaid beneficiaries between the ages of 21 and 64 who are treated in facilities that have more than 16 beds, and that provide inpatient or residential behavioral health treatment. The discriminatory IMD policy was established at a time when behavioral health conditions were not considered medical conditions on the same level as physical health conditions, state-operated psychiatric facilities were a primary setting for behavioral health care, and patients were admitted for longer-term stays.

We know that successful treatment requires access to the full continuum of care—namely, inpatient care, partial hospitalization, residential treatment and outpatient services. Different types of patients require different clinical services from across the care continuum. Investing only in outpatient care and failing to provide states with relief from the IMD exclusion would continue to deny many of these patients access to the most clinically appropriate care. Additionally, advances in behavioral health care have allowed for shorter inpatient stays and more outpatient treatment options, while funding challenges have led to a decline in the number of inpatient psychiatric beds. Repealing the IMD exclusion would help reverse this decline.

ELIMINATE MEDICARE'S 190-DAY LIMIT ON INPATIENT PSYCHIATRIC TREATMENT

Medicare covers only 190 days of inpatient care in a psychiatric hospital in a beneficiary's lifetime. This discriminatory limit erects a barrier to accessing care for indi-

viduals who have gone beyond their 190-day limit, particularly those with a chronic mental condition.

As the nation looks to recover from COVID–19 pandemic, an even greater mental health crisis awaits. Medicare beneficiaries who did not seek inpatient care during the pandemic because they hesitated to leave their homes or because they have conditions that were exacerbated by the pandemic will need inpatient services. Further, as the nation's elderly population continues to grow and life expectancy continues to rise, the 190-day limit will severely affect access to needed care. To effectively address the needs of America's seniors, Congress should repeal Medicare's 190-day limit on inpatient psychiatric care.

MAKE TELEHEALTH FLEXIBILITIES PERMANENT

Telehealth services, including for mental health and SUD treatment, have improved access to care. The increased use of telehealth since the start of the public health emergency (PHE) is producing high-quality outcomes for patients, enhancing patient experience, and protecting access for individuals susceptible to infection. With the appropriate statutory and regulatory framework, this beneficial shift in care delivery could continue to improve patient experiences and outcomes and deliver health system efficiencies beyond the pandemic. The AHA urges the Committee to consider making these flexibilities permanent.

Additionally, telehealth policies should work together to maintain access for patients by connecting them to vital health care services and their personal providers through videoconferencing, remote monitoring, electronic consults and wireless communications. We support the following: elimination of the 1834(m) geographic and originating site restriction; coverage and reimbursement for audio-only services; an expanded list of providers and facilities eligible to deliver and bill for telehealth services, including rural health clinics and federally qualified health centers; a national approach to licensure so that providers can safely provide virtual care across state lines; and, adequate reimbursement for the substantial costs of establishing and maintaining a telehealth infrastructure, among others.

PROMOTE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH

The use of electronic health records (EHR) can promote the integration of physical and behavioral health care. Yet, significant barriers remain for the adoption of EHRs by behavioral health providers. The 2009 HITECH Act incentivized EHR adoption with payments for providers who participate in the Medicare and Medicaid Promoting Interoperability Programs; however, psychiatric hospitals are ineligible for these programs. In addition to this financial pressure, the nature of behavioral health records—that is, that they are often narrative or follow a different structure than physical health records—as well as conflicting regulatory requirements regarding information sharing has led to far lower adoption of EHRs in psychiatric hospitals compared to general acute care hospitals. We urge the Committee to create opportunities for behavioral health providers to acquire interoperable electronic health records that enable improved information sharing among providers and with public health and other government agencies.

CONCLUSION

The AHA is encouraged that the Committee is examining ways to improve Americans' access to mental health and substance use disorder treatment. We stand ready to work with the Committee as you consider legislation to expand vital behavioral health services to patients and families.

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Statement Submitted by Katherine B. McGuire, Chief Advocacy Officer

The American Psychological Association (APA) thanks the Committee for the opportunity to offer solutions to strengthen the nation's mental health system, which even prior to the COVID–19 pandemic could not meet the needs of people in need of care. APA is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology. APA has more than 122,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

As the U.S. Government Accountability Office (GAO) recently found, "longstanding unmet needs for behavioral health services" continue to persist and were in fact "worsened by new challenges associated with the COVID–19 pandemic" (GAO, March 31, 2021). Over the past year, the pandemic created "a cascade of societal challenges, including illness and death, prolonged social isolation, job loss, and reliance on remote work and online education" while also "cast[ing] a bright light on the destructive effects of health, educational, employment, legal, and criminal justice disparities and inequities" (American Psychological Association, August 2020). The results of APA's "Stress in America" survey series during this time tell a compelling story about the mental health impact of the pandemic on everyday Americans, particularly on communities of color and other underserved communities (American Psychological Association, 2021). This impact manifests in a highly individualized manner, which includes but is not limited to higher rates of emotions associated with prolonged stress, such as anxiety, stress and anger; unexpected fluctuations in weight; disruptions in sleep; and increased consumption of alcohol and dangerous substances.

Innovative solutions are urgently required if we are ever to meet the challenge of addressing the long-term mental health impact of this pandemic while remedying preexisting barriers to accessing these services. However, there is no single solution to addressing this crisis, and the Committee and its members will need to improve policies in multiple areas, including the following:

- **Preserve Recent Expansions in Medicare Coverage of Mental and Behavioral Health Services Furnished by Telehealth.** Congress's and CMS's decision to expand Medicare coverage of mental and behavioral services via telehealth—including those furnished via audio-only communication—prompted a long-overdue expansion of mental health services to many communities that traditionally lacked access to such services. Audio-only services in particular are a critical (and often the only) link to mental and behavioral health services for many individuals and communities that are less likely to have reliable access to technological training or broadband technology, such as older adults, individuals with disabilities, people in rural and frontier areas, lower-income families, and communities of color.

  We remain concerned, however, that this access expansion will abruptly end once the current public health emergency ends, and we hope this Committee will help avoid this "access cliff" and permanently authorize Medicare to cover audio-only telehealth for mental, behavioral, and substance use disorder services. Specifically, we urge the Committee to approve legislation such as the bipartisan bill H.R. 3447, introduced by Reps. Jason Smith and Josh Gottheimer. This bill would permanently establish Medicare coverage of mental, behavioral, and substance use disorder services furnished via audio-only telehealth, provided that the patient has at least one in-person or audio-video telehealth visit within the past 3 years.

  Additionally, while APA supported Congress's decision to eliminate certain site-of-service requirements on Medicare tele-mental health coverage in the year-end budget and COVID package (Pub. L. 116–260), we are concerned that the new six-month in-person service requirement will inequitably limit access to services. Accordingly, APA asks the Committee to take up and pass the bipartisan Telemental Health Care Access Act (S. 2061) sponsored by Senators Cassidy, Smith, Thune, and Cardin, which removes this arbitrary and unnecessary barrier to coverage of tele-mental health services. AP A also hopes that members of this Committee will consider introducing a Senate counterpart to Representative Matsui's Telemental Health Care Access Act (H.R. 4058), which in addition to removing this in-person service requirement, will also eliminate the aforementioned site-of-service requirements for behavioral health services.

  Finally, we hope this Committee will support a bipartisan bill co-sponsored by Senator Stabenow, the Tele-Mental Health Improvement Act (S. 660), which will—both during and shortly after the pandemic—place coverage and reimbursement for mental health and substance use disorder services on the same footing as services provided in-person. We hope members of this Committee will also consider long-term measures to address the inequities in reimbursement between care furnished in person and care furnished via telehealth.

- **Support Innovative Approaches to Combating the Resurgent Opioid and Substance Use Disorder Crisis.** Despite Congress' commendable efforts to combat the opioid epidemic, the COVID–19 pandemic worsened rates of opioid and substance use. According to CDC data, over 88,000 individuals died

due to a drug overdose between August 2019 and August 2020, an astounding 26.8% increase over the previous year (Ahmad, et al. 2021). CDC data also shows that while opioids, and especially fentanyl, continue to account for the bulk of overdose deaths, the use of psychostimulants such as methamphetamine increased by 46% over the previous year (Volkow, 2021). The drug overdose crisis demands a strong public health response which meets individuals with substance use disorders where they are. The CAHOOTS Act (S. 764) introduced by Chairman Wyden embodies this approach, and we urge both its enactment and the adoption of mobile crisis intervention services by Medicaid programs nationwide.

We urge the Committee to advance similarly innovative approaches to this crisis, such as those outlined in: (1) the bipartisan Medicaid Reentry Act (S. 285), co-sponsored by Senator Whitehouse, which allows inmates within 30 days of release to enroll in Medicaid to reduce the risk of relapse upon release; (2) Sen. Hassan's Mainstreaming Addiction Treatment Act (S. 445), which eliminates the unnecessary and counterproductive requirement that prescribing providers obtain a waiver from the Drug Enforcement Agency (DEA) before prescribing buprenorphine for the treatment of substance use disorders; (3) S. 854, legislation introduced by Sen. Grassley to designate methamphetamine as an emerging drug threat; and (4) S. 1457, the STOP Fentanyl Act of 2021—introduced by Senators Warren, Whitehouse, Baldwin, and Booker—that, among other provisions, would remove barriers to the establishment of contingency management programs, an evidence-based form of behavioral treatment developed by psychologists for treatment of methamphetamine, cocaine, and other substance use disorders (De Crescenzo, et al., 2018).

- **Allow Clinical Psychologists to Practice Independently in All Medicare Treatment Settings.** Current law requires physician supervision of psychologists' treatment of Medicare patients in certain settings, such as partial hospitalization programs, surgical centers, and community mental health centers. Medicare is the last health insurer that requires physician supervision of psychologists. Unlike Medicare, *all* other health insurers and state licensure laws allow psychologists to practice independently in *all* treatment settings.

  Most older Americans with mental disorders do not receive mental health treatment from a mental health specialist, and older Americans are much more likely to be prescribed psychoactive drugs—even without an established diagnosis for a mental disorder-than to receive psychotherapy or other behavioral health services, despite the ongoing opioid epidemic and concerns about overmedication in nursing homes and other facilities. Allowing clinical psychologists to practice independently in all treatment settings, as they can do through other health insurance programs, would contribute to reversing this trend. Medicare patients would benefit from improved access to psychologists' services, including psychological and neuropsychological assessments, psychotherapy, and health and behavior assessments and interventions.

- **Incentivize Adoption of a Broad Array of Integrated Care Models.** APA appreciates the Committee's discussions around the integration of primary care and mental health services. Integrated care is an innovative way of improving patient outcomes and satisfaction with care, as well as reducing overall treatment costs, but it requires significant changes to primary care practices' physical offices, information technology systems, management procedures, clinical staffing and policies, health records and data tracking practices, and provider education and training. With these challenges and given differences in patient populations and the goals of the integration effort, there is no "one size fits all" approach to effective integrated primary care. As stated in a recent review, "[t]here are several models and differing levels of integration described in the literature, suggesting that approaches to integration should be responsive to the needs and context of the community" (Vogel et al., 2017, p. 81).

  We urge the Committee to provide support for the implementation of integrated care programs by primary care providers that gives them the flexibility to blend services, models, and interventions in a way that best meets the needs of their patient populations and reflects the healthcare workforce in their community. Support should be made available for all evidence-based integrated care programs meeting the following four criteria:
  - A multi-professional approach to patient care;
  - A structured management plan;

- Scheduled patient follow-ups; and
- Enhanced inter-professional communication.

- **Support Programs that Strengthen Access to School-Based Mental Health Services.** The pandemic continues to have an outsized impact on children and youth, with nearly a third of parents reporting that their child experienced some degree of harm to their emotional or mental health during the pandemic (Gallup, 2020). This population is of concern not only due to their higher overall vulnerability to stress, but also because of the increased risk they will experience adverse childhood experiences (ACEs) such as various forms of abuse, neglect, and household dysfunction. As schools are a key provider of mental and behavioral health services to children, the pandemic often cut off access to mental health services for many children (Nuamah, et al., 2020).

  To aid the nation's school-age children in recovering from the mental, social, and educational impact of the COVID–19, we ask that members of the Committee support the following pieces of legislation:
  - The Increasing Access to Mental Health in Schools Act (S. 1811), introduced by Sen. Tester (D–MT), which would expand mental health services in low-income schools by supporting partnerships between institutions of higher education and local education agencies to increase the number of school-based mental health professionals;
  - The Mental Health Services for Students Act (S. 1841), introduced by Sen. Tina Smith (D–MN), which would build partnerships between local educational agencies, tribal schools, and community-based organizations to provide school-based mental health care for students and provide resources for the entire school community on warning signs of mental health crises; and
  - A Senate counterpart to the Comprehensive Mental Health in Schools Pilot Program Act (H.R. 3549), which would create a new 4-year grant program to help schools that predominantly serve low-income students with building their capacity to address students' mental and behavioral well-being.

- **Address Inequities in Access to Mental and Behavioral Health Services.** The COVID–19 pandemic both highlighted and exacerbated longstanding disparities in access to mental health services, particularly amongst individuals from communities of color. Psychological science continues to inform innovative solutions to combat challenges related to health equity including, for example, guidance on facilitating transparent and thoughtful conversations between community leaders and individuals to enable informed decisions about vaccine behaviors. As a critical first step in remedying these disparities, AP A hopes this Committee will take up and pass H.R. 1475, the Pursuing Equity in Mental Health Act adopted by the House last month. Among other provisions, this bill would authorize funding to support health equity research, build outreach programs to reduce the stigma of seeking mental health treatment, and develop a training program for providers.

APA stands ready to assist the Committee in finding impactful bipartisan solutions to expand the nation's mental and behavioral health system to serve all in need of these services. Please contact Andrew Strickland, J.D. at astrickland@apa.org if our association can serve as a resource.

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June 15, 2021

Dear Chairman Wyden and Ranking Member Crapo:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to provide comments for the record on the hearing: "Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions" that took place Tuesday, June 15, 2021. We appreciate the Committee's leadership on and dedication to addressing behavioral health issues.

ABHW serves as the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health (MH) and substance use disorders (SUDs), and other behaviors that impact health and wellness.

Overarchingly, our organization's goals aim to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, through our policy work, we strive to promote equal access to quality treatment and address the stark inequities created by systemic racism. We are deeply concerned about health disparities in this country in the areas of MH and SUD services and are committed to addressing systemic racism in the healthcare system. We applaud the Committee's commitment to health equity and look forward to working with you to improve behavioral health services in this country.

Behavioral health services have become increasingly important as a result of social isolation, job loss, illness and death, and domestic violence related to COVID–19 and we suspect the utilization of such services will continue long after the public health emergency (PHE) is lifted. Addressing the following issues can play a critical role in expanding access to MH and SUD services and provide long lasting improvements to our nation's behavioral health system.

- Expand the use of telehealth for MH and SUD services.
- Increase access to medication-assisted treatment (MAT).
- Support suicide prevention efforts and increase focus on crisis services.
- Eliminate the Institution for Mental Diseases (IMD) Medicaid exclusion.
- Develop a clear, universal compliance standard related to mental health and addiction parity.
- Ensure health coverage for individuals released from jails and prisons.
- Align 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA).

As you further examine behavioral health issues, we urge you to consider and include the following:

Expand the use of telehealth for MH and SUD services. We appreciate the current guidance and flexibilities in response to the PHE and request that the flexi-

bilities continue for at least one year after the PHE is lifted. These long overdue changes to telehealth policies have allowed payers and providers to ensure people can access necessary MH and SUD services in midst of physical distancing. ABHW members support extending flexibilities past the PHE and simultaneously collecting and analyzing data before making permanent changes. As the need for behavioral health services continues to grow, we urge Congress to support the following policy changes:

- *Eliminate the new in-person visit requirement for mental health services:* We applaud the recent changes made to remove geographic and originating site restrictions on originating sites for mental health services, allowing beneficiaries across the country to receive virtual care from a location of their choosing. However, these changes were accompanied by a new requirement, mandating that an individual must have an in-person visit no less than six months before he or she is eligible to receive mental health services via telehealth. Given that many individuals with mental health issues may not physically be able to leave the home, we urge you to support the Telemental Health Care Access Act, S. 2061/H.R. 4058, which removes the in-person requirement visit prior to receiving Medicare telehealth services for mental health.
- *Expand cross state licensure:* During the pandemic, all 50 states have used emergency authority to waive certain aspects of state licensure laws, thus providing widespread access to care. We encourage efforts for states to foster cross state licensure reciprocity to support increased access to services. We also propose convening a task force of federal and state leaders to examine this issue and outline recommendations on changes that would increase access to behavioral health services.
- *Examine audio-only telehealth services.* ABHW supports patient access to audio-only behavioral health services for the duration of the PHE. However, before audio-only services are made permanent, ABHW strongly suggests that the appropriate regulatory agencies conduct research as to whether or not behavioral health services provided via audio-only are an effective long-term strategy to provide quality, evidence-based, and clinically appropriate care. One way to do this would be to create an audio-only modifier so that it can be used in effectiveness research to differentiate between audio-visual and audio-only services.

  Currently, it is unclear whether audio-only is appropriate for all behavioral health treatments. Specifically, ABHW advocates for audio-only services to be evaluated in partial hospitalization programs, applied behavioral analyses, psych testing, and group therapy before they are reimbursed permanently. Ultimately, audio-only behavioral health treatments should have safeguards built around them and should not be a primary or default avenue for care. Post PHE, audio-only should only be used after it has proven to be effective and is deemed to be in the individual's best interest (for example, the patient has limited broadband access and difficulty accessing video technology).

Increase access to medication assisted treatment (MAT). Research has shown that MAT is the most effective intervention to treat opioid use disorders (OUDs) as it significantly reduces illicit opioid use compared to nondrug approaches and increased access to MAT can reduce overdose fatalities.[1] As such, ABHW supports the following policy changes to increase MAT access.

- *Eliminate the X-waiver.* During the COVID–19 pandemic, overdoses and related deaths continue to rise, making access to MAT crucial. HHS recently published a Notice which allows providers to treat up to 30 patients using MAT without first obtaining the X-waiver. While this is a step in the right direction to treat OUDs, more must be done. As such, we ask that Congress pass the Mainstreaming Addiction Treatment (MAT) Act, S. 445/H.R. 1384. This bipartisan legislation would remove the federal rules established by the DATA 2000 Act that require health care practitioners to obtain a waiver (X-waiver) from the Drug Enforcement Administration (DEA) before prescribing buprenorphine to treat OUDs. The legislation would remove a major hurdle to prescribing MAT, impact existing nationwide shortage of treatment providers, and expand access to OUD treatment.
- *Eliminate the in-person evaluation requirement.* Given that not all individuals with SUDs are able to have an initial in-person visit with a provider due to be-

[1] Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder, Pew Fact Sheet, November 22, 2016.

havioral health provider shortages or physical difficulty traveling, ABHW advocates for actions which would eliminate the in-person evaluation requirement before a provider can prescribe MAT via telehealth. The Ryan Haight Act, originally passed to combat the rise of rogue online pharmacies, requires an in-person evaluation before a provider can prescribe MAT via telehealth. This safeguard likely suppresses the use of MAT because under current law, the evaluation requirement cannot be fulfilled via a telehealth visit.[2] While the Ryan Haight Act allows for providers to use telemedicine when engaged in the "practice of medicine," it is nearly impossible for providers to do so. The definition of "practice of telemedicine" includes seven categories in which a provider could meet the in-person requirement through a virtual care platform, including under a special registration granted by the DEA. However, the DEA never created that registration process. With the Special Registration for Telemedicine Act of 2018, which was part of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, the DEA had until October 24, 2019, to outline rules for providers with a special registration to prescribe controlled substances. That deadline passed without action, severely impeding those with OUDs from receiving the care they need.

As such, we recommend that Congress urge the DEA to move forward with promulgating the telemedicine special registration process rule, as mandated by federal law, to enable providers to prescribe MAT to patients with SUDs by employing telemedicine.

Support suicide prevention efforts and increase focus on crisis services. Last year Congress passed the National Suicide Hotline Designation Act of 2019, making the National Suicide Prevention Lifeline an easy to remember three-digit number, 9-8-8. The need for Americans to have readily available access to mental health crisis services through a ubiquitous number like 9-8-8 is more urgent than ever. We urge Congress to work with the Federal Communications Commission (FCC) to ensure the timely implementation of 9-8-8 by July 2022. Incidences of mental health crises and suicide attempts have been increasing annually, and are exacerbated by the COVID–19 pandemic.

In addition to swiftly creating the crisis line, it is equally important that the crisis line have adequate resources so that it can operate effectively and ensure that all Americans can access it. Since demand will undoubtedly increase for services of the crisis line, there will need to be significant investment after the initial implementation to expand capacity and provide services consistently for mental health crises. Therefore, we ask Congress to pass H.R. 2981, the Suicide Prevention Lifeline Improvement Act of 2021. This legislation would require increased coordination, data sharing, and provide more funding to support community-based crisis service delivery. ABHW supports an evidence-based continuum of crisis care for individuals experiencing a behavioral health crisis, and look forward to working with Congress to promote access to quality crisis services.

Eliminate the Institution for Mental Diseases (IMD) Medicaid exclusion. We urge Congress to remove policy barriers that limit beneficiary access to needed and appropriate MH and SUD care. This includes ending the IMD exclusion, which prohibits Medicaid reimbursement for adults under the age of 65 in residential behavioral health facilities with more than 16 beds. Although the IMD exclusion cannot be fully eliminated without Congressional action, the Administration could increase access and improve appropriate care through expanded use of waivers under section 1115, which would enable states to more broadly cover IMD services. Further, as we have witnessed, national hospital capacity has been pushed to its limits during the COVID–19 pandemic. Waiving the IMD exclusion to Medicaid funding for inpatient behavioral health treatment would free up beds in local hospitals, allowing them to better manage the surge capacity in both inpatient and emergency departments to care for COVID–19 patients. Additionally, new legislation was introduced this year by Representative Napolitano, the Increasing Behavioral Health Treatment Act, H.R. 2611. This legislation would remove the IMD exclusion for states that have submitted a plan to: increase access to outpatient and community-based behavioral health care; increase availability of crisis stabilization services; and improve data sharing and coordination between physical health, mental health and addiction treatment providers and first-responders. We urge Congress to pass this important legislation.

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[2] Kayla R. Bryant, *Health Law Daily Wrap up, Strategic Perspectives: States Fail to Fully Use Telemedicine to Fight the Public Health Crisis,* Wolters Kluwer (September 28, 2018), p. 2.

Develop a clear, universal compliance standard related to mental health and addiction parity. ABHW member companies continue to invest significant time and resources to understand and implement Mental Health Parity and Addiction Equity Act (MHPAEA). Our member companies have teams of dozens of people working diligently to implement and provide MH/SUD parity benefits to their consumers. We have also had numerous meetings with the regulators to help us better comprehend the regulatory guidance and to discuss how plans can operationalize the regulations.

While parity has progressed since its adoption in meaningful ways and access to MH and SUD treatment providers has greatly expanded, systemic issues continue to be a challenge due to other non-parity factors such as the looming shortage of physicians (both psychiatrists as well as other MH and SUD providers). Examples of key changes since the parity law and regulations were enacted include: the fact that routine MH outpatient treatment no longer habitually requires prior authorization or has explicit quantitative treatment limits; evidence-based levels of care for MH conditions are no longer subject to blanket exclusions (*e.g.,* residential treatment for eating disorders); and transparency, documentation, attention to medical necessity criteria all have improved.

However, despite these gains and the parity language in the 21st Century Cures Act, aspects of the law and regulations remain overly complex and technical. As a result, compliance has become a moving target through a patchwork of conflicting and changing guidance. There is new parity language in Section 203 of the recently passed Consolidated Appropriations Act of 2021, and we hope that the regulations related to these parity provisions will provide the clarity payers need to appropriately implement MHPAEA. We strongly support the flexibility built into the law, yet there has been a proliferation of different compliance approaches, tools, and interpretations, which continues to lead to confusion in implementation, is costly for stakeholders, and ultimately hinders patient care. We believe this Administration can re-invigorate efforts to clarify and improve the application of the law for the benefit of all.

Strengthen and expand the behavioral health workforce. We appreciate your support to expand access to care, and address ongoing workforce shortages across the country in order to help ensure people who need MH and/or SUD treatment get the care they need. As one first step, we ask that the Administration and Congress work to increase funding to behavioral health providers so that we have an adequate workforce to meet the increasing need for MH and SUD services. We recommend expanding eligible Medicare providers to include marriage and family therapists (MFTs), mental health counselors (MHCs), and certified peer support specialists.

- *Medicare coverage of mental health counselors and marriage and family therapists.* Recognition of MHCs and MFTs as Medicare providers would increase the pool of eligible mental health professionals by over 200,000 licensed practitioners. Studies have shown that these providers have the highest success and lowest recidivism rates with their patients as well as being the most cost effective.[3] We encourage you to work with Congress to pass the Mental Health Access Improvement Act (S. 828, H.R. 432), which recognizes MHCs and MFTs as covered Medicare providers, helps address the critical gaps in care, and ensures access to needed services.
- *Medicare coverage of peer support services.* Certified peer support specialists can be vital in providing support to people living with mental health conditions and SUDs. These paraprofessionals are individuals with lived experience of recovery from a MH disorder or SUDs. This evidence-based practice helps individuals navigate the often-confusing health care system, get the most out of treatment, identify community resources, and develop resiliency. Due to the COVID–19 pandemic, engagement with treatment and care has been disrupted, but finding and utilizing support in a timely manner can help mitigate negative health outcomes of the disruption. Recently, the Promoting Effective and Empowering Recovery Services in Medicare (PEERS) Act of 2021, H.R. 2767/S. 2144, was introduced. This legislation is an important step in recognizing the unique role of peer support specialists in helping individuals better engage in services, man-

[3] D. Russell Crane and Scott H. Payne, "Individual Versus Family Psychotherapy in Managed Care: Comparing the Costs of Treatment by the Mental Health Professions," Journal of Marital and Family Therapy 37, no. 3 (2011): 273-289.

age physical and mental health conditions, build support systems, and, ultimately, live self-directed lives in their communities.

Ensure health coverage for individuals released from jails and prisons. ABHW strongly supports H.R. 955/S. 285, the Medicaid Reentry Act of 2021, to grant Medicaid eligibility to incarcerated individuals 30 days prior to their release to promote the health care needs of individuals transitioning back into communities. According to the Bureau of Justice Statistics, more than half of those in the criminal justice system suffer from a mental illness. Of those with serious mental illness, approximately 75 percent also have a co-occurring SUD. Allowing incarcerated individuals to receive services covered by Medicaid 30 days prior to their release from jail or prison will expand access to vital mental health and addiction services. Equipping individuals with timely access to addiction, mental health, and other health-related services before release, will facilitate the transition to community-based care upon release that is necessary to help break the cycle of recidivism. This is even more critical in the midst of the COVID–19 pandemic.

Issue regulation for 42 CFR Part 2. We look forward to the promulgation of the next 42 CFR Part 2 (Part 2) rule pursuant to the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020. Part 2, which governs the confidentiality of SUD records, sets requirements limiting the use and disclosure of patients' SUD records from certain substance use programs, including the cumbersome requirement of a signed consent by the patient each time the SUD record is to be shared. The CARES Act brings Part 2 into significant alignment with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Changes in the CARES Act permit a patient to provide one written consent to disclose their Part 2 information for all future treatment, payment, and health care operations (TPO), unless the patient revokes consent. Additionally, under the CARES Act, breaches in a Part 2 program trigger patient notification, Part 2 programs are now subject to HIPAA civil and criminal penalties, and discrimination against Part 2 program patients is prohibited. This legislation culminates years of work from a broad range of organizations, and it represents a number of critical compromises.

Attached you will find recommendations from the Partnership to Amend 42 CFR Part 2 (Partnership), which we have previously shared with the U.S. Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as the Office for National Drug Control Policy (ONDCP). The Partnership, founded by ABHW, brings together a broad spectrum of the healthcare industry to advocate for aligning Part 2 with HIPAA. We urge HHS to ensure that the requirements for Part 2 stated in the CARES Act are reflected in the next Part 2 Rule.

Thank you for the opportunity to provide suggestions to address important behavioral health policies. If you have any questions or would like to discuss ABHW's policy priorities please contact Maeghan Gilmore, Director of Government Affairs, at gilmore@abhw.org or 202-503-6999.

Sincerely,

Pamela Greenberg, MPP
President and CEO

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Statement of Michael G. Bindner

Chairman Wyden and Ranking Member Crapo, thank you for the opportunity to submit these comments for the record.

It seems like we covered this ground last month in the subcommittee, but looking at the budget comments and appropriations history, I see that there is much to pull together. This is a very ambitious title. While I can trace my mental illness to an adrenal tumor and some have a genetic predisposition to disease, while others arrive at dysfunction through abuse, neglect or drug use, I suspect we won't cover everything in the 90 or so minutes that this hearing will last.

Mental health care and addiction services have actually stood up rather well during the pandemic. Zoom, and similar platforms, have stepped in nicely to continue face

to face care where needed. Phone appointments and video calls have also worked in family practice settings where medication management is the only task.

Managing my prescriptions and assisting my housemate in managing his contacts with his are much easier than a trip to our respective mental health providers.

There is one area of major concern that must be addressed, although I am not sure how we can go about it. During this crisis, before there was vaccine hesitancy, there was Zoom hesitancy. Some of our older members simply could not figure out or declined to use video calls to attend meetings.

I experienced this reticence myself, not wanting to download software to my phone that was unknown to me. In the beginning, I was also too ill to do much more than eat, be tired from eating, rest and then go back to bed. It was only the usual miracles experienced by those who are spiritually awake that had me download the software and attend a midnight meeting.

My housemate is not technically savvy. Without my help, and the use of my Chromebook, he would still be visiting his psychiatrist in person, where he would be taken into a room for a teleconference with his doctor.

He is a victim of the digital divide. It inhibits him (as well as the lack of a computer of his own) to seek English as a Second Language courses, which are free at Montgomery College (our local community college). His disability, which is matched by his lack of education and equipment hamper both his treatment and his ability to improve his skills.

This is where improvement is necessary. As I have stated in previous comments for the record, paying a stipend to undertake both computer and basic literacy training is an essential incentive to seek it. Such stipends should not count against his disability payments. If they did, they would be a disincentive toward learning. It is a conservative meme that poverty leads to self-improvement. Research has shown that the opposite is the case. It certainly is for him.

And yes, better broadband in some areas of the country would be helpful, although this would not solve the problem of digital illiteracy, especially among vulnerable populations. Most people have access to the Internet through their cable companies, although those that do not should be given free access paid for by higher cable fees.

During the pandemic many mentally ill SSDI beneficiaries were not going out much and did not have many places to go. Libraries and movie theaters have been closed. Some were working in tense situations and need a vacation. Those of us receiving SSDI benefits are spending more on food of late. Let me illustrate.

Even before the pandemic, my SSDI was inadequate for food, medicine, clothing and cable. If I owned a vehicle, there is no way I could maintain it or even buy gas. I have an above average benefit, high enough to be ineligible for SNAP or Medicaid. Many are not so lucky, even on a good day.

In the last few months, days have not been so good. Were it not for stimulus payments, I would be running out of food as I write this and would not have just bought new clothes, from socks and underwear to a jacket I can wear when the Committee finally asks me to testify in person. As it is, I will need to use the last $600 from my December payment (which should have come through Social Security) to attend my upcoming high school reunion. While I have wifi, I cannot afford cable and a car is still out of reach.

Let me underline a point. In most months, new underwear is not an option, I rely on free bus rides due to the pandemic and subsidies from Ride On and there is never enough money in that last week before the check comes. When it does arrive, the cupboard is bare.

Double underline: food prices are skyrocketing. Part of the problem may be too much money chasing too few goods, but retirees and the disabled find (our)selves between a rock and a hard place. We need a COLA and we need it now. Most of us cannot even afford cola. **Because this is a short term emergency due to the Pandemic, it should be funded out of the general fund until the normal process kicks in for next year.**

The important point is that, if wage growth is considered inflation, the retired and disabled can be given not only a Cost of Living Adjustment, but also have their income history rebased for inflation. Even with Chained CPI, such an increase will take the financial pressure off of many such households, including mine.

Home and Community-Based Health Care are addressed in the President's Budget. Home and community-based care should be funded by goods and services taxes as part of a newly created Medicare Part E. Senior Medicaid should be entirely federalized, with other clients insured through the President's proposal for a public option.

President Reagan's New Federalism proposal would have removed Medicaid from state budgets in exchange for ending or block granting other federal programs. This was a good idea then and a better idea now. Medicaid Part E should be created to both relieve states and the District of Columbia (or Washington, Douglass Commonwealth) from providing Medicaid for seniors and the Disabled and seeing to the enforcement of practice standards for nursing homes who receive these funds.

For workforce development and general recovery, Psychiatric Rehabilitation Programs, such as the Center for Behavioral Health in Rockville and Cornerstone Montgomery in Gaithersburg are essential. To make them more attractive, and to increase our ability to manage—especially in the period before disability programs kick in, participation should be paid at the minimum wage.

People will participate in this care more frequently if their opportunity costs are met. Those with less than a full education should receive it through public and private providers and also be paid to do so.

Health care currently provided through Medicaid should be dual eligible for everyone, regardless of income and before it kicks in entirely be a public option. Instead of using a larger system, clients should have the option of receiving coverage through the PRP provider's employee plan.

Low wages are endemic among the mentally ill. We need a raise, along with the rest of the working poor (and not so poor—who make more when the minimum goes up). The Minority proposed a $10 wage as a counter-offer to $15. A $12 wage for a 40 hour week puts us at parity to 1965, when the wage peaked and the war over wages started with the Kennedy-Johnson tax cuts. An $11 wage with a 32 hour week is also acceptable. With increased productivity, the work week should be shorter. The minimum wage should be indexed to inflation, including during any transitional period—which should have the goal of $18 per hour ($15 is a 20th Century goal).

Not raising minimum wages has been justified by the reactionary sector that claims that in the end, the market will sort everything out. The perception that doing the right thing makes a business non-competitive is the reason we enact minimum wage laws and should require mandatory leave. Because the labor product is almost always well above wages paid, few jobs are lost when this occurs. Higher wages simply reduce what is called the labor surplus, and not only by Marx. Any CFO who cannot calculate the current productive surplus will soon be seeking a job with adequate wages and sick leave.

The requirement that this be provided ends the calculation of whether doing so makes a firm non-competitive because all competitors must provide the same benefit. This applies to businesses of all sizes. If a firm is so precarious that it cannot survive this change, it is probably not viable without it.

Mentally ill people deserve to have families, just as others do. Increasing the child tax credit is as essential to us as to anyone. The child tax credit level passed in the American Recovery Act should be made permanent and doubled, with distribution through private sector payrolls, unemployment insurance benefits, emergency benefits for families and paid participation in educational programs.

There are two avenues to distribute money to families. The first is to add CTC benefits to unemployment, retirement, educational (TANF and college) and disability benefits. The CTC should be high enough to replace survivor's benefits for children.

The second is to distribute them with pay through employers. This can be done with long term tax reform, but in the interim can be accomplished by having employers start increasing wages immediately to distribute the credit to workers and their families, allowing them to subtract these payments from their quarterly corporate or income tax bills.

In recent decades, the problem of veteran disability determinations has remained troubling, with the Pandemic complicating processing. When a job gets too big to manage with staff, two options remain—contract out as much work as possible, including consolidating case files and making easy determinations—and sharing responsibility for processing with the Department of Defense. The handoff from DoD to DVA should be seamless.

The mental health and housing needs of veterans, both recent and lingering, is endemic. This is another area where coordination with DoD would prove helpful. This help must go beyond management and computer systems and include the human element of soldiers, veterans using services and those who need services can interact on a less formal, but not unprogrammed basis.

The DVA and DoD must both actively facilitate this and join state and local governments in reaching out to those who suffer, from active duty soldiers to veterans both receiving and in need of services. For those mentally ill or addicted veterans who do not trust the system, less restrictive systems should be developed—including providing camping supplies and a place to camp and a more permissive attitude to active drinking and drug use until help is sought. Such systems do not encourage use. No addict needs encouragement. They build the trust that makes recovery possible.

The largest provider of mental health services (including to veterans) is the correctional system. Job one is to shift from correctional modalities to new methods featuring mental health, education (including ESL programs) and addiction medicine. Warehousing young males of any race, but particularly African-Americans multiplies societal pathologies. While some forms of illness, such as sexual violence and physical violence or murder may require higher security, others can be treated as patients rather than criminals.

The Department of Justice can take the lead in both practice and in developing best practices for state correctional systems. Part of this would be specialized facilities based on the type of crime committed.

For example, sex offenders would be in facilities of their own. Those who remain dangerous post-sentence would still be detained until they are no longer dangerous. Such decisions must be based on science, not the desire for further punitive measures.

This change would migrate to local law enforcement, *i.e.,* policing.

A pilot program could be developed to respond to certain incidents (especially those involving mental illness or alcohol) with immediate dispatch of emergency medical teams. This would require more ambulances, more mental health facilities and a pause in applying restraints until medical personnel arrive.

Funding more hospitals and ambulances would be part of this, possibly with some form of federal grant program. Private corrections facilities can also be transformed into contracted medical facilities with security contracting provided as a subcontract to mental health systems, both secular and religious. Catholic Health Association members come to mind. Both public and private educational systems would be an integral part of such facilities and be treated as an essential function, rather than the first item cut when states wish to minimize their spending by essentially torturing (and dehumanizing) inmates.

New standards of individual and societal protection must be developed. Improved standards of care and security will require much more funding than state and local governments are willing to commit to. This simply drives the problem to the correctional system, which is the largest provider of mental healthcare in this nation. The term for this practice is pennywise and pound-foolish.

It is too easy to get out of treatment and too hard to get it. Hospitalization for medication management is sometimes needed but rarely given. Often, people are released before a stable routine is established, including management of side effects. It is hard to create a good care plan in a five day hold. For both mental illness and alcoholism, it must be harder to simply sign out without a real prospect for long-term recovery. Again, the term is penny wise and pound foolish.

A final reform, which will save money and resources, is to create a plea in criminal cases of guilty by reason of insanity. Those who enter this plea would be confined in the facilities detailed above for at least the minimum sentence for their offences, with no release after that if the subject remains a danger to society.

If relapse occurs or treatment protocols are evaded after release, rehospitalization must be automatic and last until a treatment program is more deeply ingrained. There should, of course, be protections on both sides in the decision to release subjects—both for the protection of the rights of subjects who made be held for punitive, rather than hygienic reasons and, as importantly, the interests of the victims of crime, including but not limited to the possibility of physical danger. Sometimes, exile should be a part of release.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

EATING DISORDERS COALITION FOR RESEARCH, POLICY, AND ACTION
PO Box 96503–98807
Washington, DC 20090

STATEMENT OF ALLISON IVIE, MPP, MA, GOVERNMENT RELATIONS REPRESENTATIVE

Chairman Wyden, Ranking Member Crapo, and members of the U.S. Senate Committee on Finance, thank you for holding this important hearing entitled, "Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions" to ensure the nation has the services and supports in place to care for individuals across the nation with mental illness and addiction, including those with eating disorders.

The Eating Disorders Coalition for Research, Policy, and Action (EDC) is a nonprofit organization comprised of patient and caregiver advocates, treatment providers, advocacy organizations, and academics, aimed to advance the recognition of eating disorders as a public health priority throughout the U.S. By promoting federal support for improved access to care, the EDC seeks to increase the resources available for education, prevention, and improved training, as well as for scientific research on the etiology, prevention, and treatment of eating disorders.

As the number of new COVID–19 cases continues to decline, eating disorders diagnoses continue to climb. Research indicates a 30 percent increase in eating disorder diagnoses since March 2020 compared with data in previous years.[1] EDC members, the **National Eating Disorders Association has seen a 53 percent increase in their call volume to their helpline since March 2020 and the Alliance for Eating Disorders Awareness has already served 7,000 individuals representing all 50 states and 32 countries and provided approximately 50,000 referrals for treatment since January 2021.** This is just a sampling of the magnitude of services our coalition members are doing to support individuals and families in need. Despite this incredible work, we know there is still work to be done to improve the care for individuals with eating disorders.

Eating disorders are serious mental illnesses that affect 28.8 million Americans over the course of their lifetime.[2] They have the second highest mortality rate of any psychiatric illness, with one death occurring every 52 minutes as a direct result of an eating disorder.[3] **Without access to comprehensive treatment, eating disorders create great economic distress, costing the U.S. economy $64.7 billion annually with the federal government shouldering $17.7 billion of that cost.**[4] Ensuring comprehensive coverage for eating disorders treatment has the potential to mitigate disease progression or relapse into higher levels of treatment. **Without access and/or coverage to treatment, higher levels of eating disorders treatment cost the U.S. $29.3 million in emergency room visits and $209.7 million in inpatient hospitalizations annually.**[5]

Eating disorder prevalence rates among the senior and disabled populations are similar to the general population at approximately 3 percent to 6 percent.[6, 7] However, older Americans with eating disorders are particularly seri-

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[1] Tanner, Lindsay. (May 23, 2021). Pandemic has fueled eating disorders surge in teens, adults. Associated Press. Retrieved from: *https://apnews.com/article/coronavirus-pandemic-virus-lifestyle-eating-disorders-health-27c9d5680980b1452f7e512db4d9f825.*

[2] Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: *https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/.*

[3] *Ibid.*

[4] *Ibid.*

[5] *Ibid.*

[6] Peat, Christine; Peyerl, Naomi; and Muehlenkamp, Jennifer. (2010). Body Image and Eating Disorders in Older Adults: A Review. *The Journal of General Psychology,* 135:4, 343–358.

[7] Mangweth-Matzek B, Hoek HW. Epidemiology and treatment of eating disorders in men and women of middle and older age. Curr Opin Psychiatry. 2017;30(6):446–451. doi: 10.1097/YCO.0000000000000356.

ous as chronic disorders or diseases may already compromise their health.[8] Inadequate nutrition as a result of their eating disorder can result in memory deficits; cognitive decline; decubitus ulcers; impaired healing of sores, wounds, or infections; and dizziness, disorientation, and falls, which can initiate a cascade of pathophysiological events leading to a 30 percent to 40 percent mortality rate.[9] **Tragically, 78 percent of deaths from anorexia nervosa occur in the elderly.**[10]

Prevention and early intervention are the best tools to prevent disease progression for those with mental illness or substance use disorders. Given the complexity of eating disorders, a multidisciplinary treatment team that includes a medical provider, psychiatrist, psychologist, and registered dietitian is considered to be the four key provider components for comprehensive eating disorders treatment. The exponential rise in eating disorders as a consequence of the pandemic further underscores the importance of early intervention.

Unfortunately, Medicare does not provide outpatient coverage for medical nutrition therapy (MNT) for individuals with eating disorders. This coverage only applies to beneficiaries that are diagnosed with diabetes or end stage renal disease. This lack of coverage leaves individuals susceptible to disease progression and in need of a higher, costlier level of treatment. According to the American Dietetic Association, nutritional therapy conducted by a registered professional is an "essential component" for the treatment of patients with anorexia nervosa, bulimia nervosa, and other eating disorders.[11] Research shows mental health interventions for eating disorders may not be successful if the underlying nutritional issues haven't been addressed first, since nutritional deficiency causes cognitive issues (*e.g.,* depression) that can impede recovery.[12] Nutrition counseling guides patients in identifying problematic behaviors and setting realistic and achievable nutrition related goals to support clients in making behavior changes. Nutrition education includes conversations about discrepancies between knowledge, beliefs and behaviors, ultimately empowering the patient to normalize eating and make healthier decisions.[13]

Fortunately, Congress has legislation to address this gap in coverage with a bipartisan bill entitled, the Nutrition Counseling Aiding Recovery for Eating Disorders Act or the **Nutrition CARE Act (H.R. 1551/S. 584)** led by Senators Maggie Hassan (D–NH) and Lisa Murkowski (R–AK) and Representatives Judy Chu (D–CA–27), Jackie Walorski (R–IN–02) and Lisa Blunt Rochester (D–DE–AL). **The legislation would provide Medicare Part B coverage for medical nutrition therapy for beneficiaries diagnosed with an eating disorder at the same coverage levels beneficiaries with diabetes and end stage renal disease receive.**

This legislation is a small, critical step in ensuring the federal government is meeting the mental health needs of Americans across the lifespan. We urge the U.S. Senate Committee on Finance, Health Subcommittee to move this bill forward for consideration to the full committee as we work together to support the 2 to 2.5 million Medicare beneficiaries with eating disorders that could benefit from the Nutrition CARE Act.

Thank you for your consideration.

Sincerely,

Eating Disorders Coalition for Research, Policy, and Action Members in Formation:

Academy for Eating Disorders	Reston, VA
Academy of Nutrition and Dietetics	Chicago, IL
Alliance for Eating Disorders Awareness	West Palm Beach, FL

[8] Peat, Christine; Peyerl, Naomi; and Muehlenkamp, Jennifer. (2010). Body Image and Eating Disorders in Older Adults: A Review. *The Journal of General Psychology,* 135:4, 343–358.

[9] Dudrick, Stanley. (2013). Older Clients and Eating Disorders. *Today's Dietitian,* 15:11, 44.

[10] Dudrick, S. (2014). Older clients and eating disorders. *Today's Dietitian,* 15(11), 44.

[11] Ozier, AD; and Henry, BW. "Position of the American Dietetic Association: Nutrition intervention in the treatment of eating disorders." *NCBI/NLM/NIH. https://www.ncbi.nlm.nih.gov/pubmed/21802573.*

[12] Rosen, David. (2010). Clinical Report—Identification and Management of Eating Disorders in Children and Adolescents. American Academy of Pediatrics, 126:6.

[13] Ruiz-Prieto, Inmaculada; Bolanos-Rios, Patricia; and Jauregui-Lobera, Ignacio. (2013). Diet Choice in weight-restored patients with eating disorders; progressive autonomy by nutritional education. *Nurtricion Hospitlaria,* 28:5, 1725–1731.

Eating Disorders Coalition for Research, Policy, and Action Members in Formation:—Continued

Alsana: Eating Disorders Treatment and Recovery Centers	Ballwin, MO
Bannister Consultancy	Durham, NC
BE REAL USA	Chicago, IL
Cambridge Eating Disorder Center	Cambridge, MA
Center for Change	Orem, UT
Center for Discovery	Los Alamitos, CA
Eating Disorder Coalition of Iowa	Clive, IA
Eating Disorder Hope	Redmond, OR
Eating Recovery Center	Denver, CO
Farrington Specialty Centers	Fort Wayne, IN
Gail R. Schoenbach FREED Foundation	Warren, NJ
International Association of Eating Disorders Professionals	Pekin, IL
International Federation of Eating Disorders Dietitians	Dallas, TX
Laureate Eating Disorders Program	Tulsa, OK
Monte Nido and Affiliates	Miami, FL
Montecatini	Carlsbad, CA
Moonshadow's Spirit	Webster, NY
Multi-Service Eating Disorders Association	Newton, MA
National Eating Disorders Association	New York, NY
Park Nicollet Melrose Center	St. Louis Park, MN
Project HEAL	Brooklyn, NY
REDC Consortium	St. Paul, MN
Rogers Behavioral Health	Oconomowoc, WI
Rosewood Centers for Eating Disorders	Wickenburg, AZ
Stay Strong Virginia	Chesterfield, VA
Strategic Training Initiative for the Prevention of Eating Disorders	Boston, MA
SunCloud Health	Northbrook, IL
The Donahue Foundation	Richmond, VA
The Emily Program	St. Paul, MN
The National Association of Anorexia Nervosa and Associated Eating Disorders	Chicago, IL
The Renfrew Center	Pittsburgh, PA
Veritas Collaborative	Durham, NC
Walden Behavioral Care	Waltham, MA
WithAll	St. Louis Park, MN
Wrobel and Smith, PLLP	St. Paul, MN

HEALTHCARE LEADERSHIP COUNCIL
750 9th St., NW, Suite #500
Washington, DC 20510

June 21, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chair Wyden and Ranking Member Crapo:

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing on, "Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions."

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies—advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

The COVID–19 health pandemic has created significant barriers to accessing mental health services. A January study found that over 40% of adults have reported struggling with anxiety or depression since the beginning of the pandemic.[1] The impact of COVID on mental health is expected to continue to be a challenge in the coming years. We applaud Congress for providing over $4 billion in the Consolidated Appropriations Act and $3.8 billion in the American Rescue Plan Act for mental health services. These investments will provide much-needed assistance to struggling communities.

We encourage the Committee to examine ways to improve access to mental health services, particularly via telehealth options. A recent survey found that approximately 50% of patients using telehealth services were seeking behavioral health treatment.[2] Providing mental health treatment via telehealth provides a unique opportunity to reach underserved patients. Estimates have found that up to 60% of patients do not arrive for their behavioral health appointments.[3] By using telehealth solutions to deliver such care, providers have been able to deliver much needed assistance to patients in their homes. Patient satisfaction in receiving behavioral health treatment via telehealth[4] has shown that providers can innovate in care delivery without sacrificing quality.

The COVID–19 health pandemic has also exacerbated the substance use disorder (SUD) crisis in the United States. From May 2019–June 2020, the number of deaths related to drug overdoses rose 20% and a record number of Americans died from overdoses.[5] Preliminary data expects 2020 to be the worst year on record for drug overdoses.[6] In order to respond to this crisis, Congress and federal agencies took swift action to ensure patients struggling with SUDs received proper care. We applaud the Drug Enforcement Agency's (DEA) decision to temporarily waive in-person requirements to prescribe controlled substances. This has allowed patients to continue to receive important medications, particularly buprenorphine. HLC also thanks the Centers for Medicare and Medicaid Services (CMS) for finalizing regulations mandated under the SUPPORT Act that require providers to use electronic prescribing for controlled substances (EPCS). Requiring EPCS puts a more advanced monitoring system in place to ensure that controlled substances are only prescribed when necessary and allows for relevant authorities to monitor potential trends. We encourage Congress to work with federal agencies to further implement flexibilities

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[1] Nirmita Panchal et al., The Implications of COVID–19 for Mental Health and Substance Abuse, Kaiser Family Foundation (February 10, 2021), *https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/*.

[2] Shira Fischer et al., The Transition to Telehealth During the First Months of the COVID–19 Pandemic, RAND Corporation (January 8, 2021), *https://link.springer.com/content/pdf/10.1007/s11606-020-06358-0.pdf*.

[3] Eric Berger, No-Cancel Culture: How Telehealth Is Making It Easier to Keep that Therapy Session, *Kaiser Health News* (May 24, 2021), *https://khn.org/news/article/no-cancel-culture-how-telehealth-is-making-it-easier-to-keep-that-therapy-session/*.

[4] Joe Gramigna, Patient satisfaction high for psychiatric telehealth platforms in partial hospital program, Healio (March 25, 2021), *https://www.healio.com/news/psychiatry/20210325/patient-satisfaction-high-for-psychiatric-telehealth-platforms-in-partial-hospital-program*.

[5] Usha Lee McFarling, As the pandemic ushered in isolation and financial hardships, overdose deaths reached new heights, STAT News (February 16, 2021), *https://www.statnews.com/2021/02/16/as-pandemic-ushered-in-isolation-financial-hardship-overdose-deaths-reached-new-heights/*.

[6] Chris Sweeney, A crisis on top of a crisis: COVID–19 and the opioid epidemic, Harvard T.H. Chan School of Public Health (February 16, 2021), *https://www.hsph.harvard.edu/news/features/a-crisis-on-top-of-a-crisis-covid-19-and-the-opioid-epidemic/*.

that would allow patients to receive medications through the duration of the public health emergency (PHE) while maintaining robust safety and monitoring programs.

HLC appreciates your work on improving mental health outcomes for patients and looks forward to working with you on future solutions. Please feel free to contact Tina Grande at 202–449–3433 or tgrande@hlc.org with any questions.

Sincerely,

Mary R. Grealy
President

HR POLICY ASSOCIATION, AMERICAN HEALTH POLICY INSTITUTE, AND NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS

June 15, 2021

The HR Policy Association, the American Health Policy Institute, and the National Alliance of Healthcare Purchaser Coalitions appreciate the Committee holding this important hearing on behavioral and mental health care issues.

The HR Policy Association is the leading organization representing chief human resource officers of over 390 of the largest employers in the United States. Collectively, their companies provide health care coverage to over 20 million employees and dependents in the United States. The American Health Policy Institute, a part of HR Policy Association, examines the challenges employers face in providing health care to their employees and recommends policy solutions to promote affordable, high-quality, employer-based health care. The Institute serves to provide thought leadership grounded in the practical experience of America's largest employers.

The National Alliance of Healthcare Purchaser Coalitions (National Alliance) is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and health care value across the country. Its members represent private and public sector, nonprofit, and Taft-Hartley organizations, and more than 45 million Americans, spending $300 billion annually on healthcare.

The National Alliance, HR Policy Association and the American Health Policy Institute are also part of The Path Forward initiative to execute a disciplined, private sector approach to systematically and measurably improve five established best practices of mental health and substance use care. Below are our policy recommendations to improve access to behavioral and mental health care services.

Sincerely,

D. Mark Wilson
President and CEO, American Health Policy Institute
Vice President, Health and Employment Policy
HR Policy Association
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Michael Thompson
President and CEO
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Collaborative Care Model (CoCM)

While employer health plans and Medicare reimburse providers in collaborative care practices, behavioral health is not broadly integrated with primary care. Because behavioral health conditions often initially present themselves in primary care settings, this lack of integration leaves patients with undiagnosed or poorly managed behavioral health conditions. Increasing the number of collaborative care practices would improve access to behavioral health services, increase the effectiveness of treatment, and reduce disparities in identification of behavioral health issues. Over 70 randomized controlled trials have demonstrated collaborative care models are more effective and cost efficient than usual care.[1]

Policy Recommendations

1. Allocate funds to support a change effort to provide technical assistance, training and startup funds to allow for large scale adoption for collaborative care across the country. Collaborative care can be delivered virtually or by in person

[1] *https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.*

care managers meaning this model can deliver to large medical groups or small and rural primary care practices.

2. CMS should establish a national Technical Assistance (TA) center and regional extension centers to assist primary care practices in implementing the CoCM.
3. Incentivize behavioral health care providers to adopt electronic health record technology that is interoperable with general health care providers into their practices.
4. Expand research on promising integrated care models.

TeleBehavioral Healthcare (TBH)

Background—During the COVID–19 pandemic, Medicare rules related to TBH have been liberalized resulting in an exponential growth in the use of TBH, including enabling cross-state care which has been critical to underserved areas and rural communities. However, the requirements for employer health plans around how TBH is provided and reimbursed remain far too restrictive and result in access and quality disparities. TBH has the potential to overcome patient stigma and improve access and efficiency of care for BH services. We know that since the COVID–19 public health emergency, there has been a significant increase in patients keeping their appointments. In general, when patients keep their first appointment, they are more likely to keep subsequent appointments; and when patients are satisfied with treatment, they are more likely to continue with their course of therapy. Research also suggests that TBH results in better medication compliance, fewer visits to the emergency department, fewer patient admissions to inpatient units, and fewer subsequent readmissions. However, many older adults and people with disabilities, lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have them. Likewise, many in racial/ethnic and low-income communities lack access to broadband or video-enabled devices, which only expands the health inequities in the U.S.

Policy Recommendations

1. Eliminate cross-state border restrictions on TBH on a permanent basis for Medicare, employer and commercial plans. Licensing requirements should be based on the location of the provider not the patient.
2. Enable patient access to TBH without having the first provider appointment be in person.
3. Make permanent the allowance of first-dollar coverage of telehealth in high deductible health plans. Specifically, Congress should pass the Telehealth Expansion Act of 2021 (S. 1704).
4. Allow employers to offer standalone "excepted benefit" telehealth benefits.
5. Adopt technology-neutral requirements, permitting use of different types of technology platforms for telehealth services.
6. Establish a uniform set of rules for multi-state telehealth benefit plans to eliminate state restrictions that block patients from telehealth benefits.

The HR Policy Association, the American Health Policy Institute, and the National Alliance welcome any opportunity to provide input and speak in further detail about improving access to behavioral and mental health care services. We look forward to working with you on this important topic.

THE PARTNERSHIP TO AMEND 42 CFR PART 2

April 13, 2021

Robinsue Frohboese
Acting Director and Principal Deputy
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Dr. Neeraj Gandotra
Chief Medical Officer
Substance Abuse and Mental Health Services Administration

5600 Fishers Lane
Rockville, MD 20852

Re: 42 CFR Part 2—Recommendations for Next Rule

Dear Ms. Frohboese and Dr. Gandotra,

The Partnership to Amend 42 CFR Part 2 (Partnership), writes to provide recommendations for the U.S. Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to consider when drafting the new rule for the 42 CFR Part 2 (Part 2) provisions in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). We have appreciated working with HHS and SAMHSA on Part 2 in the past and welcome the opportunity to partner with both SAMHSA and OCR on this important issue moving forward.

The Partnership is a coalition of nearly 50 organizations committed to aligning Part 2 with the disclosure requirements of the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment, and health care operations (TPO).

This is a time of unprecedented urgency. First, the Centers for Disease Control and Prevention's preliminary estimate is that more than 81,000 Americans died of drug overdose in 2020. Second, federal health officials believe the drug crisis is only being amplified by months of social isolation, high unemployment, and diversion of public health resources, all a result of the COVID–19 pandemic.[1] Given this alarming correlation, an important part of responding to the COVID–19 pandemic will be to simplify coordination of care for substance use disorders (SUDs), which ultimately will prevent gaps and expand access to care. Furthermore, we anticipate SUDs may continue to rise even after the COVID–19 pandemic is over, reflecting the extreme toll it has taken on Americans. As such, we believe quickly issuing the proposed rulemaking, as required by section 3221 of the CARES Act, will both help curb the SUD epidemic and also strongly supports the incoming Biden-Harris Administration's Build Back Better strategy.

Previous requirements in the Part 2 regulation led to segmented data, interrupted flow of that data, and ultimately hindered informed diagnosis, treatment, and implementation of an individual's care plan and access to care. The CARES Act takes great strides to remedy these issues by promoting partial alignment between Part 2 and HIPAA, though the two privacy frameworks remain distinct, particularly for consent purposes. Nevertheless, the law clearly strives to bring Part 2 in line with HIPAA, a fact being embraced by industry thought leaders. For example, the Medicaid and CHIP Payment and Access Commission (MACPAC) noted during its December 2020 meeting that the CARES Act "[p]ermanently aligns 42 CFR Part 2 and HIPAA."[2]

Additionally, and most importantly, the Partnership staunchly supports patient privacy. We are acutely aware that even if the sharing of information is made easier, it has limited utility without continued strong protections for patient privacy. Without trust, patients may not seek the care they need to treat SUDs. We are also aware that individuals may be concerned that SUD records will be used against them by law enforcement.

These are significant concerns. However, the CARES Act protects patient rights in two important ways. First, it allows an individual to revoke his or her consent to sharing SUDs records, giving patients control over their information.[3] Second, SUD records are expressly prohibited by law from being used in civil, criminal, administrative, or legislative proceedings against a patient by any government authority (unless authorized by court order or patient consent). Furthermore, SUD records specifically cannot: (a) be entered into evidence in criminal prosecutions or civil actions; (b) form part of the record for a decision or otherwise be taken into account in government agency proceedings; (c) be used by a governmental agency for law

[1] Dan Goldberg and Brianna Ehley, Biden's other health crisis: A resurgent drug epidemic, *Politico,* November 28, 2020.

[2] Aaron Pervin and Erin McMullen, Promoting Behavioral and Physical Clinical Integration Through EHRs, 2020. *https://www.macpac.gov/wp-content/uploads/2020/12/Integrating-Clinical-Care-through-Greater-Use-of-Electronic-Health-Records-by-Behavioral-Health-Providers.pdf,* last visited April 1, 2020.

[3] Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Pub. L. No. 116–136, section 3221(b)(1)(C).

enforcement purposes or investigations; or (d) be used in a warrant application.[4] As such, we believe the changes made to Part 2 by the CARES Act will allow for smoother care coordination while simultaneously strengthening patient privacy.

As you begin drafting the next Part 2 rule, we submit the following for your consideration:

Original Consent Process. While the Confidentiality of Substance Use Disorder Patient Records Final Rule (final rule) issued in July 2020 takes an important step forward to address the issue of patient consent, we believe more needs to be done in this regard. The final rule allows an entity, instead of an individual, to be specified as the recipient of Part 2 records, which broadens the scope of the consent and incrementally relieves the burden on patients and providers. However, this is not enough because a new patient consent is needed each time there is a new entity where the Part 2 record needs to be disclosed.Fortunately, the CARES Act further simplifies the process by requiring only one consent, after which the Part 2 record can be used or disclosed by a covered entity or business associate for the purposes of TPO in accordance with the HIPAA regulations.

Additionally, please note that although the initial consent requirement was amended under section 3221 of the CARES Act to allow a general designation (instead of a specific practice), there still remains a roadblock in practice: the list of disclosures requirement in Part 2. Specifically, section 2.31 of Part 2 mandates that "upon request, patients who have consented to disclose their patient identifying information using a general designation *must be provided a list of entities to which their information has been disclosed pursuant to the general designation*" [emphasis added]. Due to the list of disclosures requirement, practitioners are often uncomfortable attempting to use the general designation in the consent.

Recommendation: Ensure that the consent requirements in the next rule are simple and straightforward so additional administrative processes are not imposed on patients, providers, or payers (including health plans and their subcontractors). The consent process should be easily folded into existing HIPAA compliance processes, preferably with the patient's acknowledgement of HIPAA practices and the patient's Part 2 consent incorporated into the same document at intake where feasible. Furthermore, include language to address the conflict with Part 2's list of disclosures requirement.

Transmission and Retransmission of Data. The CARES Act plainly states that once written consent is obtained, a Part 2 record may be transmitted and retransmitted for TPO in accordance with HIPAA regulations. No further consent should be required for TPO unless the patient revokes consent.

Recommendation: Include specific language directing covered entities and business associates to disclose and redisclose data in accordance with HIPAA regulations.

The final rule also requires physically separating records with Part 2 data. However, such physical separation is difficult once the data is transmitted, as very few integrated systems or Health Information Exchanges (HIEs) can manage the consent process for a completely separate database for Part 2 records. The separation of data not only creates an administrative burden, but also makes the data difficult to obtain by subsequent treating providers, ultimately hindering patient care. For example, we have heard anecdotes of physicians physically carrying two separate laptops for the purposes of compliance with the data segregation requirements.

Recommendation: Specify that once Part 2 data is transmitted or retransmitted with patient consent, there is no requirement to segregate a patient's Part 2 data from the rest of a HIPAA database, with the regulatory requirement for data segmentation terminating upon transmission or retransmission.

Revocation of Consent Provisions. The patient's ability to revoke consent is an important privacy protection supported by the Partnership. However, serious administrative issues arise when there is an expectation that a revocation be retroactively effective. Specifically, practices are now required, under the Promoting Interoperability program, to incorporate information from outside sources for medications, allergies, and other problems. If revocation is mandated to be retroactive, there is technically no way to go back and isolate this data from a patient's overall clinical record.

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[4] *Id.* at section 3221(e).

Furthermore, it is critical that the responsibility for managing the revocation remain with a designated entity. We believe that the management of the consent revocation should be the responsibility of the Part 2 treatment entity that contributed that data and that program would be responsible for seeing that the Part 2 data is not being transmitted either to another covered entity or business associate.

Recommendation: Specifically state that the revocation of consent for Part 2 data transmission is effective only from the point of revocation going forward and that responsibility for the revocation should be limited to those who are so notified by the patient and their respective actions.

Scope of Part 2 Consent Process. SAMHSA's current guidance seems to indicate that a Part 2 consent should not impede the transmission of behavioral health data that does not originate with a Part 2 program. However, this is very different in practice as there is much confusion on how to handle behavioral health data. Providers hesitate to share behavioral health data because they are concerned that they may be violating Part 2 requirements related to consent.

Recommendation: OCR and SAMHSA should explore, in partnership with stakeholders, how to exclude behavioral health data from the Part 2 data and incorporate the findings into the rule and any subsequent frequently asked questions or guidance. Similarly, OCR and SAMHSA should explore, in conjunction with the States and stakeholders, policy mechanisms for promoting the use of behavioral health data for care coordination purposes when state privacy laws may impose restrictions beyond both Part 2 and HIPAA.

Research. The final rule permits disclosures for the purposes of research under Part 2 by a HIPAA covered entity or business associate to non-HIPAA covered individuals and organizations. However, the CARES Act does not specifically address disclosures for the purpose of research.

Recommendation: Include a provision in the next rule, consistent with the last rule, to ensure that disclosures for the purposes of research from a HIPAA covered entity to a non-HIPAA covered entity are permissible.

Patient Rights. The final rule does not address patient rights. However, in Section 422(j) of the CARES Act, it is stated that nothing in that section can be construed to limit patient rights related to privacy protections for protected health information as defined under Section 164.522 of the HIPAA Privacy Rule.

Recommendation: Include specific language to ensure that patient privacy rights are protected in accordance with the CARES Act and HIPAA.

Claims Data Access. Currently, HHS provides patients' claims data through various initiatives, including to organizations participating in alternative payment models. Accountable care organizations, for example, are provided claims data at least monthly, and sometimes weekly. But these data lack SUD-related information because of limits of Part 2.

Recommendation: We urge HHS to start providing SUD-related claims data to providers practicing in alternative payment models to help support their work in population health management.

Thank you for your time and consideration on this crucial issue. Please feel free to contact Deepti Loharikar, Director of Regulatory Affairs, Association for Behavioral Health and Wellness, at loharikar@abhw.org or (202) 505–1834 with any questions.

Sincerely,

Maeghan Gilmore, MPH
Chairperson, Partnership to Amend 42 CFR Part 2

Members of the Partnership

Academy of Managed Care Pharmacy • Alliance of Community Health Plans • American Association on Health and Disability • American Health Information Management Association • American Hospital Association • American Psychiatric Association • American Society of Addiction Medicine • American Society of Anesthesiologists • America's Essential Hospitals • America's Health Insurance Plans • AMGA • Association for Ambulatory Behavioral Healthcare • Association for Behavioral Health and Wellness • Association for Community Affiliated Plans • Association of Clinicians for the Underserved • Blue Cross Blue Shield Association • The Catholic Health Association of the United States • Centerstone • College of

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OFFICE OF THE UNITED STATES SURGEON GENERAL

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

Thank you for your leadership and dedication to this critical issue. As you mention in your letter, the COVID–19 pandemic has not simply created a new mental health crisis, but rather exacerbated a longstanding crisis that continues to affect people across this country. I was deeply concerned about the mental health of our country before the pandemic, and my concerns have grown over the past year.

Before COVID–19, mental health conditions were widespread in the United States, and there was significant unmet need for mental health diagnosis and treatment among young people and adults. Drivers of this crisis before the pandemic included stigma, shortages in the mental health workforce, health disparities, limited investments in prevention, and treatment services that were too limited and insufficiently integrated with primary care. And the cost of this crisis is accumulated in both human suffering and financial losses, as people with mental illness incur higher health care spending for non- mental health associated conditions and billions of dollars in lost earnings per year.

The pandemic has added urgency to these challenges. Millions of people have experienced the trauma of family, friends, and neighbors dying or being hospitalized with COVID–19. Working people have lost jobs or had their hours cut. Parents, disproportionately mothers, have endured significant stress in caring for their children and adapting to virtual schooling. An estimated 40,000 children in America lost a parent to COVID–19, and millions of children have been isolated from their friends and supportive school environments. Patients dealing with anxiety, depression, addiction, and other illnesses have had their access to treatment disrupted. And health care workers have gone through unimaginable pain watching, in some cases, dozens of their patients die of this terrible disease. The statistics on substance misuse, which so often occurs alongside mental illness, are also heartbreaking:

More than 87,000 of our neighbors, friends, and family members died of a drug overdose over the past year—the highest number of yearly drug overdose deaths in recent memory.

Mental health has been an important issue for the Office of the Surgeon General dating back to 1999, when my predecessor, Dr. David Satcher, released the landmark Surgeon General's Report on Mental Health. As a nation, we've come a long way since then in raising awareness about mental health, helping reduce stigma and shame, and expanding access to mental health treatment.

But the pandemic has reminded us just how much more remains to be done.

We must expand access to mental health services, by supporting mental health telehealth programs, training more mental health professionals, enforcing the 2008 Mental Health Parity and Addiction Equity Act, and integrating mental health services with primary care. We must do more to protect our children, who at times struggle for years with undiagnosed mental illness, by increasing access to mental health diagnostic and treatment services and by investing in evidence-based social emotional learning programs. We must extend further help to those at risk for suicide, including transitioning to full national availability of 988 as the new national suicide prevention and mental health crisis number. And we must target our efforts to communities that have struggled with high rates of depression, anxiety, and suicide—including health care workers whose alarmingly high rate of mental illness and burnout poses a threat to our ability to provide care to people throughout our nation. In all this work, we must prioritize equity, as we know that rural communities and communities of color face higher rates of mental health stigma and less access to treatment.

Perhaps most challenging of all, we must change the way we think about mental health. For too long, mental illness was a source of shame, and that shame prevented people from seeking help and compounded their suffering. Through our words, our actions, and our example, we can help people recognize that you are not broken or deficient if you are struggling with your mental health. Each of us can play a role in providing support to those who are suffering and in affirming their humanity. When we treat mental health with the same importance and urgency as physical health, when we apply ourselves as much to prevention programs as treatment efforts, when we set bold goals and hold ourselves to account, then we will see the change our nation needs.

We have many reasons to be hopeful. We have evidence-based programs, such as the Certified Community Behavioral Health Clinics, that are well-positioned to provide critical behavioral health services and expand access to care across the nation. We have school-based programs which have demonstrated their ability to reduce rates of mental illness and substance use disorders in a cost- effective manner. And we have millions of people across America whose lives have been touched by mental illness and who now want to be part of the solution. We can use this opportunity during the COVID–19 pandemic, when more people are talking about mental health and increased funding is being directed to address mental health issues, to act and take bold steps to improve the mental health of our country.

Responding to the mental health needs across America should be a central focus both during and after this pandemic, and I appreciate the attention you and others in Congress have brought to this issue. I know the road ahead is steep. We have much work to do. And we are still making our way through a difficult pandemic. But the progress we have made gives me faith in what is yet to come.

As the Committee moves forward under your leadership, HHS is committed to working with the Senate Finance Committee—and all of Congress—to address America's mental health crisis. Thank you for the opportunity to weigh in on such an important issue. I look forward to learning from you and partnering with you in the months ahead to tackle the nation's mental health crisis.

Sincerely,

Vivek Murthy, M.D., M.B.A.
U.S. Surgeon General
Vice Admiral, U.S. Public Health Service