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BEHAVIORAL HEALTH CARE WHEN AMERICANS NEED IT: ENSURING PARITY AND CARE INTEGRATION

HEARING

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BEHAVIORAL HEALTH CARE WHEN AMERICANS NEED IT: ENSURING PARITY AND CARE INTEGRATION

WEDNESDAY, MARCH 30, 2022

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

The hearing was convened, pursuant to notice, at 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, Cortez Masto, Warren, Crapo, Grassley, Cornyn, Cassidy, Lankford, and Daines.

Also present: Democratic staff: Shawn Bishop, Chief Health Advisor; Eva DuGoff, Senior Health Advisor; and Michael Evans, Deputy Staff Director and Chief Counsel. Republican staff: Gable Brady, Senior Health Policy Advisor; Kellie McConnell, Health Policy Director; and Gregg Richard, Staff Director.

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

The CHAIRMAN. The committee will come to order. Today the committee meets for our third hearing on mental health care this year, and we are going to begin with mental health parity.

For 13 years now, the parity law has required equal treatment by insurance companies of mental health care and physical care. That law was a result of extraordinary efforts by two late Senators, Senators Wellstone and Domenici. Both came from families touched by mental health challenges, and I can tell you there are a lot of Senators who have experienced the same thing.

The parity law was supposed to be a game-changer, yet instead, mental health patients have spent the last 13 years all too often bogged down in insurance company foot-dragging, red tape, and piles of excuses.

This committee—and I appreciate Senator Crapo and Senator Cornyn, Senator Stabenow, Senator Cantwell—our colleagues are committed to fixing this on a bipartisan basis. I also say—it is not on the docket today, but I strongly believe that more needs to be done to hold the executives of these mental health companies accountable. I am going to give four examples of what is wrong.

First, too many Americans are getting shoved by these insurance companies into ghost networks. When you are stuck in a ghost network, you cannot get a provider to take your insurance. The insur-

ance company directory of providers is often wrong, or 10 years out of date, or insurance companies pay so little for mental health services that patients get stuck with the whole bill. When families pay good money for insurance and wind up with a ghost network, you sure do not feel like you are getting parity. You feel like you are getting ripped off.

The next example is, mental health patients are getting whacked by coverage limits that cut off their stays in a hospital. Health treatments ought to be driven by a professional diagnosis, not an arbitrary cap set to protect insurance company profits.

Third, insurance companies are relying on loopholes to deny coverage, requiring prior authorizations before they pay for care. Setting unreasonably high standards for the medical subsidy of mental health care is just wrong, particularly for somebody experiencing a mental health crisis. These bureaucratic roadblocks to insurance coverage can be fatal. If you break your arm, you do not have to make a dozen phone calls and put together a mountain of paperwork to prove to your insurance company that you have to see a doctor. A mental health crisis should not be different.

Fourth, we have heard repeatedly—and I have talked to my colleagues about this—of stonewalling on paying claims. I was struck during the pandemic that even leading health institutions, like our own Oregon Health and Science University, could not get mental health claims paid by the insurance companies. At first, the insurance companies just waltzed them around, but then I wrote a letter calling for a GAO inquiry into the stonewalling. And what do you know? The floodgates opened up and a gusher of money was sent to Oregon Health and Science Center for these claims. It should not take a U.S. Senator weighing in to get paid for mental health care in America.

These four barriers make a mockery out of the parity that Senators Wellstone and Domenici envisioned. And as we know, those two did not agree on everything, but they sure thought that we ought to do right by mental health patients. And that is what the parity law is about.

Tools like ParityTrack, which is now run by an organization headed by former Surgeon General David Thatcher and former Congressman Patrick Kennedy, are out there working to hold States and Federal regulators accountable for enforcing parity law. It is going to take a lot of work in Congress, and at the grassroots level, to address these issues. But I want to say, as we touched on here today, we have working groups. Senator Crapo has been meeting me more than halfway to try to deal with this, and this committee is going to work until we get these problems fixed.

Now I will wrap up with the second challenge and then go to my friend, Senator Crapo. What we want to do is bring mental health and physical health closer together. Mental health should not be fenced off from the rest of the health-care system. That lack of integration, which I guess is the technical term practitioners use, also can be fatal.

People typically start with a primary care doctor, but less than half the patients who receive a referral to a mental health-care provider are able to get the care they need. The approach is often too slow to help somebody really get through a crisis. As many as one

in three people who have died by suicide saw their primary care doctor within a month of their passing. Let's be clear. We are not talking about any kind of blame game on primary care docs who are trying to do their best in a difficult time, seeing dozens of patients every day. The truth is, patients need more options. What is needed, and what we have been talking about on our committee—and again, I appreciate Senator Crapo having these conversations with me. What we need is a fresh strategy so we can get primary care and mental health care for as many people as possible at almost the same time. That is really the lodestar within the interminable delays that slow down badly needed care.

Taking care integration beyond the doctor's office is another priority. I am very proud that in my home State we have come up with something called "CAHOOTS." We got it into law, got it placed in Medicaid, where for the first time mental health folks and law enforcement are teaming up on some of these very difficult situations on the streets. The mental health people like it. The law enforcement people like it. I think it is the wave of the future.

There is a lot of work to do. The committee is focused on guaranteeing that Americans can get the mental health care they need when they need it.

I thank all of our witnesses. I think it is going to be a particularly important hearing. I also want to thank Senator Cornyn. I understand you have worked with one of your Texas folks to have them come on up, and if you would like to introduce them at some point, we can do that.

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, Mr. Chairman. And I appreciate our partnership on this. We have a strong record of bipartisan solutions on big deals, and this is another one of those, and I appreciate that. Thank you. And thank you to our witnesses, some of whom have come across the country to testify before the committee today.

We have heard from providers across the continuum of care, government officials, and policy experts who have shared a range of thoughtful perspectives and recommendations. This is the fourth mental health hearing that this committee has held this Congress. Despite diverse viewpoints on some policy questions, all have agreed on the profound importance of ensuring all Americans have access to high-quality mental health-care services.

Our country has experienced a challenging couple of years. Even as hospitalizations and deaths caused by COVID–19 continue to decline and stabilize in the United States—hopefully permanently—the pandemic will have lasting impacts on the Nation's mental health. Lockdowns, school closures, and other government restrictions led to social isolation, new and worsened cases of depression, and widespread anxiety. For many, the pandemic also resulted in tragic personal losses, worsening these and other mental health conditions.

I have also heard from health-care providers across Idaho, where the stress and uncertainty of the pandemic have further exacerbated professional burnout. Onerous regulatory burdens have caused many physicians and allied health professionals to retire early, or to reduce their hours. The resulting workforce shortage makes it more challenging for patients to access the mental health services they need.

Studies have found that the prevalence of mental health illness is similar between rural and urban areas, but individuals living in rural and frontier areas often face significant barriers in accessing needed mental health services closer to home. On average, rural residents have to travel further to receive services, and providers are less likely to practice in these communities.

While the pandemic has increased the pervasiveness of mental health concerns, it also has led to innovative solutions that address these challenges much better than in the past, such as the expansion of telehealth services. Telehealth expands access in underserved rural areas, improves care coordination and integration, and provides more privacy to patients to combat stigma.

While there is no easy solution, I am committed to working alongside my colleagues to tackle these challenges in a bipartisan and fiscally responsible way. We cannot simply throw more money at the problem and expect to solve everything. Instead, we must focus on developing data-driven, innovative, and creative solutions to address these challenges.

I look forward to hearing from today's panel on their ideas to ensure that Americans in need can access timely, high-quality mental health-care services. Thank you all for being here, again.

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

The CHAIRMAN. Thank you, Senator Crapo. And we will go on to the member introductions in just a minute. I want to touch on what Senator Crapo talked about. He and I have teamed up often over the years—whether it is forestry, transportation, health-care issues—and I think it would be fair to say the two of us think this is one of the most important challenges that we have dealt with, because this was a challenge before the pandemic, and it will continue to be after the pandemic. So you have a group of Senators, Democrats and Republicans, who are all in on this.

One other quick point. And that is, Senator Crapo made mention of the telemedicine piece. And one of the best parts of the budget that passed—and it was led by this committee—was to make sure that we could get audio-only telemedicine. And my colleagues remember, we all sat here, and the practitioners said, "Hey, we love broadband. Get it. Get going. Make it happen. But until you do it, get audio-only, and audio-only, particularly for seniors, folks in rural areas." So, Senator Crapo and I really dug in for audio-only coming out of our hearings, and I want to thank him for that.

Okay, on to the introductions. John Dicken of the Government Accountability Office has done a lot of work for us over the years. I believe I am one of the largest partakers of GAO work, if you were to add all of the characters up in the Congress. He does a good job on the health-care markets, public health issues, private markets, and we appreciate that he has been at GAO since 1991,

with a master's degree in public administration from Columbia University.

Now I would like to let Senator Cornyn introduce Dr. Andy Keller, and then we will have Senator Cantwell introduce Dr. Anna Ratzliff.

OPENING STATEMENT OF HON. JOHN CORNYN, A U.S. SENATOR FROM TEXAS

Senator CORNYN. Thank you, Mr. Chairman. It is my pleasure to introduce our next witness, or one of our witnesses, Dr. Andy Keller. Dr. Keller is president and CEO of the Meadows Mental Health Policy Initiative, a Texas-based nonprofit dedicated to improving mental health delivery, care delivery, in Texas and across the Nation. He is a licensed psychologist with more than 20 years of experience in behavioral health policy financing and best practices. His work is centered on helping communities implement evidence-based and innovative care, and developing regulatory and financial frameworks to support them. Dr. Keller and the Meadows Institute have been leaders in the establishment of innovative programs that I hope will be emulated across the country.

In June of last year, the Meadows Institute Lone Star Depression Challenge was named the recipient of a $10-million Lone Star Prize. This challenge, in partnership with the Center for Depression Research and Clinical Care at UT Southwestern, will catalyze an unprecedented Statewide and national effort to put depression care in Texas on par with care for heart disease and cancer.

The Meadows Institute also helped lead the development of Right Care in Dallas, which uses a multidisciplinary response team to reshape behavioral health crisis response in the city, and divert people who are suffering mental health crises who happen to commit crimes or encounter the police so that they can get the care and treatment that they need to recover and get better.

I was glad to be joined by Meadows Institute last month to discuss the incredible work Dallas is accomplishing because of its collaboration with Right Care. Dr. Keller is a wealth of knowledge and a steadfast advocate for innovative mental health policies.

I am sure we have a lot to learn from his testimony. So, Dr. Keller, welcome here. Thank you for your service to Texas and the Nation, and it is a pleasure to have you here today.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cornyn.

Senator Cantwell?

OPENING STATEMENT OF HON. MARIA CANTWELL, A U.S. SENATOR FROM WASHINGTON

Senator CANTWELL. Thank you, Chairman Wyden, and thank you to you and Ranking Member Crapo for holding this important hearing. And I really do appreciate the collaboration between the two of you.

I want to take a moment to introduce Dr. Anna Ratzliff, who is from the State of Washington, who has been a pioneer in improving the mental health-care system. Dr. Ratzliff is a psychiatrist and professor at the University of Washington, Department of Psychiatric and Behavioral Sciences. She served as a psychiatric con-

sultant delivering behavioral health care in primary care settings in Washington State. And she is a national expert on the Collaborative Care Model that helps medical teams improve and coordinate and integrate care. I cannot tell you how important this work is.

She has also served in several national and international leadership positions that helped clinics implement the Collaborative Care Model. She has additional expertise in suicide prevention and training the mental health workforce, including serving as the director of UDub's psychiatric resident training program and director of the University of Washington integrated care training program. She is a member of the American Psychiatric Association and has partnered closely with APA to disseminate and promote improved access to care through integrated care and to advocate for policies that would support deployment of the Collaborative Care Model more broadly.

Dr. Ratzliff, thank you so much for being here today. Thank you for taking time to talk about this innovative model. I think you will find the members here, at least present, including Senator Stabenow, to be very up on these issues, and just very anxious to understand how we as a Nation really, if you ask me—you know, I served 6 years in our State legislature on the Health Care Committee, and everything was, did it improve the quality of care, did it help us lower costs, and did it deliver more transparency in the system? And we usually voted for the things that did all three.

This is exactly what collaborative care does. And that is why it is so important. So, thank you, Mr. Chairman. Thank you for holding this hearing.

The CHAIRMAN. Thank you, Senator Cantwell. And, Dr. Ratzliff, we are going to have the Northwest collaboration action between Washington and Oregon, because we so appreciate your leadership. And just so the record notes, as Senator Cantwell touched on, the American Psychiatric Association, of course, has been at the forefront of developing these integrated care models. They recommended to us Dr. Ratzliff, so we are glad that that is happening.

And Mr. Reggie Williams is here. He leads the Commonwealth Fund's program on international health policy and practice innovations. They focus on behavioral health. As you know, Senator Stabenow has been our leader on all things relating to behavioral health, so we are glad you are here to focus on that. Prior to his work with the Commonwealth Fund, Mr. Williams worked for 15 years as the managing director at Avalere, focused on evidence-based medicine policy, digital health policy, and he chaired the board of directors of Mental Health America, an important nonprofit. He got his bachelor's degree in biomedical ethics from Brown University.

Okay, let's get on with our witnesses. And let's start with you, Mr. Dicken.

STATEMENT OF JOHN E. DICKEN, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Mr. DICKEN. Thank you, Chairman Wyden, Ranking Member Crapo, and members of the committee. I am pleased to be here today to discuss the new GAO report released today titled "Mental

Health Care: Access Challenges for Covered Consumers and Relevant Federal Actions." This is the most recent in a series of GAO reports examining ways that the pandemic has affected behavioral health care and examining State and Federal oversight of behavioral health-care parity.

In 2020, 53 million Americans in the United States—which is one in five adults—had any mental illness. This includes an estimated 14 million people who had serious mental illness. The COVID–19 pandemic and related economic crisis have intensified concerns that even more people are affected by mental health conditions, and that people with underlying mental health conditions could be experiencing increased severity of those conditions. Further, the pandemic has highlighted longstanding concerns about the accessibility of health-care services, even for those with health-care coverage.

The bottom line of today's report is that health-care coverage does not guarantee access to mental health-care services. Based on interviews with 29 stakeholder organizations, and a review of research, GAO found that consumers experienced challenges finding mental health-care providers in their health plan's network.

For example, providers who were listed as "in network" may not be accepting new patients, may have long wait times, or do not provide the specific service the patient is seeking. In some cases, they actually may not be in the plan's network at all. Challenges like these can cause consumers to face high health-care costs, delays in receiving care, or difficulties in finding a provider close to home.

GAO found that factors contributing to these challenges included low reimbursement rates for mental health services, and inaccurate or out-of-date information on provider networks. GAO also found that consumers experienced challenges with restrictive health plan approval processes and plan coverage limitations, both of which can limit their ability to access services. Many of the stakeholder organizations interviewed, and research reviewed, noted that the process for gaining approval for mental health services can be more restrictive than it is for other medical services.

For example, representatives from one health system reported that some health plans are less likely to grant prior authorizations for mental health hospital stays compared with medical and surgical hospital stays. Some stakeholders also noted various coverage limitations and restrictions that limit consumers' access to certain mental health-care treatments, or limit the types of providers eligible for payment. These include certain statutory restrictions on the types of mental health-care providers eligible for reimbursement under Medicare.

Let me conclude by briefly noting some of the Federal efforts that may address some aspects of the challenges that consumers experience attempting to access mental health care. The Departments of Labor and Health and Human Services are taking steps to improve access to mental health providers, including steps to enforce requirements for certain health plans to update and maintain provider directories. The Substance Abuse and Mental Health Services Administration, with HHS, is managing several programs aimed at addressing structural issues that contribute to a lack of capacity in mental health-care systems. This includes grant programs to in-

crease access to community-based mental health care. And the Health Resources and Services Administration, within HHS, is managing several programs that provide funding intended to increase the mental health workforce.

Finally, there are Federal efforts focused on issues with health plan administrative approval processes. The Departments of Labor and HHS are taking steps to enhance their oversight of the use of non-quantitative treatment limits by behavioral plans, such as requirements for prior authorization. This is part of their broader responsibility to oversee compliance with mental health parity laws. These laws generally require that coverage of mental health treatment be no more restrictive than coverage for medical or surgical treatment.

This concludes my prepared statement, and I would be pleased to respond to any questions the committee may have.

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

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

Dr. Keller?

STATEMENT OF ANDY KELLER, Ph.D., PRESIDENT AND CEO, AND LINDA PERRYMAN EVANS PRESIDENTIAL CHAIR, MEADOWS MENTAL HEALTH POLICY INSTITUTE, DALLAS, TX

Dr. KELLER. Chair Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for your leadership on these issues, including the excellent work of the committee gathering feedback from across the country and putting actionable policy ideas that you summarized in the report that was just released by the committee.

My name is Andy Keller. I lead the Meadows Mental Health Policy Institute. We are dedicated to helping Texas and the country move forward the availability and the quality of evidence-driven mental health and substance use care. I want to thank you also for setting aside this hearing to focus specifically on the harms caused by the dramatic lack of parity today in mental health and substance use disorder benefits across the country, and for bringing us together to look at solutions.

As I describe in more detail in my written testimony, we all need to come together. It is going to take providers, health purchasers, insurers, regulators, and people and families affected by mental illness and addiction to address these issues. But we also need action by the Federal Government. It is essential for creating the infrastructure nationally that we need to move out of this decades-long quagmire.

And, Chair Wyden, you described well that our behavioral health today is worse than it has ever been, and the pandemic made it worse. Suicide is currently the fourth-leading cause of loss of life years. Overdose deaths claim even more people and increased by almost a third during the pandemic. During last year, the Surgeon General offered an unprecedented first-ever public health advisory focused on the mental health of the Nation's youth, and these consequences fall hardest on Black, Indigenous, Hispanic, and other people of color who too often receive inequitable and less culturally responsive care.

There are really two reasons why we are in this mess. First, we have dramatically cut spending on behavioral health over the last 40 years. The cuts started in the 1990s, and today we spend 20 percent less compared to the rest of health care on mental health than we did before these cuts and these aggressive mechanisms that Mr. Dicken described quite well were put into place.

The other reason is that we have failed, until recently, to begin to actually enforce those parity laws that five successive presidential administrations put into place, dating back to the Clinton administration. And continued enforcement is essential. Just to give you a couple of the outcomes of the impact of the nonquantitative treatment limitations—which is a mouthful, but it is an important thing for us to focus on—Mr. Dicken described how commercially insured people are five to six times more likely to use out-of-network care because of the limitations that were just described. And when we look at reimbursements, it is not hard to see why. Reimbursements for mental health are consistently 20 percent lower than benchmark reimbursements for other specialties and for primary care.

And these barriers have to be addressed by all of us coming together. It is not going to be enough just to have regulatory enforcement. We are also going to need to increase the infrastructure for primary care-based interventions like collaborative care.

I want to just focus on three solutions. There is more detail on these in my written testimony. The first is that enforcement does need to continue. Laws are not enough. We can have a speed limit, but unless it is being enforced, people are not going to obey it. And that has only been going on really in earnest since late last year.

It is also going to require more effort there and additional funds to expand the breadth of those efforts. We would also like the Department of Labor to be vested with the authority to assess civil monetary penalties for parity violations, and we would also like to see ERISA amended to provide the DOL with authority to directly pursue parity violations by entities that provide administrative services to ERISA-group health plans. That sort of expanded enforcement needs to continue, and it needs to be broadened.

The second thing is, the parity protections should be extended to Medicare beneficiaries. The data suggests that the failures of commercial plans apply as much or more so to Medicare beneficiaries, especially the lack of available providers. And there are also numerous gaps in the Medicare mental health and addiction benefits that are not faced by people with commercial coverage, or with Medicaid in most States.

And the most important thing that Congress can do would be to launch an emergency initiative to bolster the capacity of primary care to effectively serve more Americans and relieve the pressure on specialty networks. Integration works, and it is really our only path forward. While insurers do need to do more, they cannot on their own—no matter how much we regulate and enforce—fix a misdesigned health system. Today we fail to detect and treat needs until 8 to 10 years after they emerge. The Collaborative Care Model which was described can leverage the availability of psychiatrists 3.5 times over. The Primary Care Behavioral Health model can leverage other licensed practitioners 2.5 times over. Both are

currently covered by Medicare or almost all commercial payers and most Medicaid plans. But no single payer can do this. It is going to take an infrastructure investment. The RAND Corporation has laid it out in a study last year that showed how to do this. There is existing legislation filed in the House by Representatives Fletcher and Herrera Beutler that could form the basis for this. It is legislation that every medical association supports. It would need to be broadened to include primary care behavioral health, and expanded many times over—probably in the hundreds of millions of dollars—to have the breadth needed.

We are doing this in Texas now: $20 million put up to get a third of the State through those reforms. This will be the standard of care in 20 years. But if we wait that long, we are going to lose 2 million more Americans to suicide and overdose.

Thank you for the opportunity to be here today.

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

The CHAIRMAN. Dr. Keller, you may not have seen it, but when you mentioned expanding coverage for Medicare folks, everybody was nodding their Adam's apple off. So thank you for that and for your leadership.

Dr. Ratzliff?

STATEMENT OF ANNA RATZLIFF, M.D., Ph.D., CO-DIRECTOR, ADVANCING INTEGRATED MENTAL HEALTH SOLUTIONS (AIMS) CENTER; AND PROFESSOR, UNIVERSITY OF WASHINGTON, SEATTLE, WA

Dr. RATZLIFF. Thank you, Chairman Wyden, Ranking Member Crapo, and thank you to the committee for conducting this hearing today. My name is Dr. Anna Ratzliff. I am a psychiatrist and professor at the Department of Psychiatry and Behavioral Sciences at the University of Washington. I have personal experience with the providers delivering integrated care, and I am the co-director of the AIMS Center, which has implemented a model of integrated care, which has been talked about today, the Collaborative Care Model.

As a member of the American Psychiatric Association, I have partnered closely with the APA to promote this model through policy and advocacy. Effective integrated care is an important solution to our current health-care crisis, as everyone is talking about.

The Collaborative Care Model is a specific model of integrated care developed at the University of Washington to treat common mental health conditions such as depression and anxiety in primary care settings. This model is evidence-based, with over 90 validated studies showing its effectiveness, and has been recognized by the Centers for Medicare and Medicaid Services with specific billing codes that were introduced in 2017.

I believe the power of integrated behavioral health care, and specifically the Collaborative Care Model, is best illustrated through patient voice. Daniel was one of my patients who has given me permission to share his story. Daniel is a young adult who had been struggling with untreated mental health conditions since he was an adolescent, and these eventually led to a suicide attempt. He finally sought treatment through his primary care provider, and on his first visit she recognized that he was struggling with mental

health symptoms and connected him that day to a behavioral health-care manager whose office was just down the hall.

Daniel was able to walk with his PCP to meet this behavioral health provider, and later scheduled an intake appointment within the same week. As a psychiatric consultant, I was able to review his case within a few days, and during my regular meetings with my behavioral health-care manager. My consultation was done using telepsychiatry, since my office was not located in that primary care setting. And this approach allowed me to review multiple patients in the clinic in the time that it would normally take me to only see one patient.

Although I did not see Daniel in person, we were able to determine his diagnosis, and I provided recommendations around medications to be prescribed by his primary care provider, and for behavioral interventions to be delivered by his behavioral health-care manager right there in primary care, where he was comfortable being able to get care. Within weeks, he was feeling better. And he enrolled in a local community college. He eventually was able to successfully complete his training and become a medical assistant.

This example is important because Daniel said that he never would have sought mental health care if it had not been so seamlessly available in his primary care setting. And his mother feels that this access saved his life.

As you can see from this patient's experience, integrated care has several important features. Patients can receive care without the need for referrals, which frequently can take months and often results in patients not being able to receive any care. More widespread use of the Collaborative Care Model can help alleviate some of the portion of the mental health workforce shortage that was mentioned in the preceding testimony.

As a team-based approach, this model leverages expertise like mine as a psychiatric consultant to support 60 to 80 patients in as little as 1 to 2 hours a week. Innovative care allows for the early diagnosis and intervention of mental health conditions and has proven to reduce suicidal ideation and prevents emergency room visits and hospitalizations.

Additionally, this model has demonstrated effectiveness in addressing the behavioral health needs of special populations. This model has been able to be delivered in rural settings, often using telehealth to bring psychiatric expertise to these communities.

The Collaborative Care Model is also an important strategy to improve behavioral health equity. Studies that compare depression outcomes in BIPOC and White patients who receive treatment with the Collaborative Care Model show either equivalent or significantly better outcomes for the BIPOC patients.

Finally, expanding the use of the Collaborative Care Model can also help reduce health-care costs. Studies have demonstrated that for every $1 spent on the Collaborative Care Model, about $6½ in total health-care costs are saved in the subsequent years.

Although the implementation of the Collaborative Care Model makes sense, the requisite startup costs have proven to be a barrier to its adoption by primary care practices. I encourage the committee to consider the following policy recommendations endorsed

by the APA to further the adoption of the Collaborative Care Model.

Fund primary care offices to assist with the implementation of the Collaborative Care Model. Eliminate the cost-sharing requirement under Medicare to remove an additional barrier for patients and Medicare beneficiaries. Increase the current reimbursement for CPT codes for the Collaborative Care Model to more appropriately reflect the value and benefits of services and care being provided.

In closing, I want to reiterate how encouraged I am by the bipartisan, bicameral support we have seen from Congress, and in particular this committee, regarding addressing our most pressing mental health and substance use disorder needs.

Thank you.

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

The CHAIRMAN. Thank you very much. We are going to look forward to working with you.

Mr. Williams?

STATEMENT OF REGINALD D. WILLIAMS II, VICE PRESIDENT, INTERNATIONAL HEALTH POLICY AND PRACTICE INNOVATIONS, COMMONWEALTH FUND, WASHINGTON, DC

Mr. WILLIAMS. Good morning. Thank you, members of the Senate Finance Committee, for inviting me to speak. Chairman Wyden, Ranking Member Crapo, you have both been leaders on this pressing issue. Your bipartisan commitment will advance solutions for people in need.

I am Reggie Williams, and I lead the international program at the Commonwealth Fund. I also co-lead our work on behavioral health. For over 10 years, I have volunteered my time in the mental health community, currently serving on the boards of the Youth Mental Health Project and The Fountain House. In the past, I have chaired the board of Mental Health America. My focus has been on improving systems that people and their families must navigate to achieve the lives they want to live.

I testify today not only as someone who has spent 20 years in health policy, but also as a Black man who strives to manage his own mental health. We all know there is a behavioral health crisis in the United States. The crisis is nationwide, without regard for political affiliation, class, or education. It is particularly acute for economically disadvantaged and historically excluded communities.

At the core of the crisis is unmet need. There have been incredible strides with the Affordable Care Act, but yesterday's Senate Finance Committee bipartisan report, the GAO report, definitively details the unmet needs and barriers, especially for Black and Latino people, youth, and Medicare and Medicaid beneficiaries.

The problem is big and complex. However, I believe we have the tools to make meaningful change in people's lives. There are three things that we can do.

First, integrate mental health and substance use care with primary care. Two, expand and diversify the behavioral health workforce. And three, leverage the potential of health technology.

Integration: Expanding the capacity of primary care providers through integration increases access. Studies show that patients view primary care providers as trusted sources of information. That

can combat stigma. Integration offers a solution that includes everything from consultation, co-location, and patient-centered decision-making goals. It also helps when we think of this integration across a broad continuum. Innovative payment approaches can continue to support integration through new fee-for-service billing codes, care management payments, bundled payments, and primary care capitation. As policymakers contemplate ways to support CMS in the States, there are many promising models to consider. As I stated in my written testimony, the Southwest Montana Community Health Center, a Federally Qualified Health Center in Butte, MT, links people to counseling and community programs, and has demonstrated substantial reductions in substance use. Another is addressing social isolation through psychosocial rehab by connecting people with serious mental illness to primary care, psychiatric care, and home and community-based services. This approach has reduced hospitalizations and decreased costs for Medicaid.

Expand and diversify the workforce: The evidence supports including a wider array of providers and behavioral health-care teams. Trained and accredited peer support specialists leverage their lived experience to engage people and reduce substance use and the use of hospitals and emergency rooms. Community health workers have demonstrated that every dollar invested in a community health worker returned nearly $2.50. Further, engaging peers and community health workers who are representative of the communities in which they live can be an important way to address stigma.

Another example has been seen in the introduction of new types of providers like the general practice mental health worker. They have been successful in the Netherlands, where they have been integrated into primary care and have prevented exacerbations of mental health.

Despite improved outcomes and cost savings, most Americans do not have access to the providers I mentioned. To remedy that, there is an opportunity to implement financial incentives, support efforts to recruit and retain, implement learning collaboratives and quality improvement initiatives, and ensure insurance coverage for a broader workforce, including peers in the Medicare program.

Leveraging health technology: During the pandemic, the use of telephone and online platforms skyrocketed. In additional, digital health tools have received unprecedented investment and can help solve the provider shortage. On the other hand, we do not want to champion the use of tools that are ineffective or inaccessible for beneficiaries, especially for people facing the greatest barriers, such as rural Americans or people with disabilities. It is critical that the expansion of health technologies be undertaken with universal and equitable access in mind. As Congress and the Biden administration weigh options for extending telehealth flexibilities, it will be essential to ameliorate rather than exacerbate these disparities. It is also noteworthy that the temporary continuous coverage requirement that kept Medicaid coverage intact during the public health emergency helped to ensure access to these services.

In conclusion, as I stated, the problem is big and complex, but we have the tools to improve lives, especially for youth, people with

serious mental illness, those in rural communities, and historically excluded Black, Latino, and Indigenous communities. In the coming months, we can work together to implement bipartisan policies to expand access to equitable and affordable care. Our communities will be stronger for it, and I believe we can be better.

Thank you.

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

The CHAIRMAN. Mr. Williams, thank you. And thank you all for very valuable testimony.

Let me start with you, Mr. Dicken. And I very much appreciate your helping our investigators work through this bizarre array of ghost network practices that are just flagrant rip-offs, in my view. And I wanted to ask you about one instance. You basically, working with the various studies, found that in 83 percent of the instances within your report, families would try to get an appointment for a child with an adolescent psychiatrist, and they could not get one.

So my first question to you is, is that sort of thing common?

Mr. DICKEN. Yes; thank you, Chairman Wyden. And you are right that we did find in multiple studies and heard from many stakeholders concerns about those provider directories not being accurate, calling them, in some cases, ghost networks. And so we heard across, whether it was Medicaid plans, private insurance plans, Medicare plans, in multiple cities, problems that many providers listed in a directory would not be available for new patients, or not available at all.

The CHAIRMAN. Very good. We will also say for shorthand, it is common, because it is clear that is what you said.

All right; Dr. Ratzliff, ghost networks. Have you seen these kinds of practices, Dr. Ratzliff?

Dr. RATZLIFF. Yes, I unfortunately have had patients who needed to seek care and would go to their provider directory, call sometimes 30 or 40 providers, and be told that there was no access, no availability, be put on wait lists, or just never hear a response. And this often resulted in people not being able to access the care that they needed.

The CHAIRMAN. So you would call, in these kinds of instances, something like this nothing resembling parity?

Dr. RATZLIFF. Nothing resembling parity. You could go out and get a primary care provider in those practices, in those insurance panels, but not access to mental health care.

The CHAIRMAN. All right.

Dr. Keller, why is this happening? What is the problem? Because I personally think this is making a mockery, a mockery out of the parity law, based on what we just heard from Mr. Dicken and Dr. Ratzliff. Why is it happening?

Dr. KELLER. It is happening for two reasons. One, we are not paying on par. The studies clearly show that the insurers are paying 20 percent less in reimbursement compared to other specialty care and primary care. So they are not paying enough. And that is why people who want to pay cash, who will pay more, are somehow magically able to get people.

The second thing is the administrative hassle. The thing that the non-quantitative treatment limitations do is, they make it a hassle. And that is the other reason why people only take cash: they do not want to have to fill out all that paperwork. They do not want to have to have people call multiple times to get authorizations. They do not want to be harassed. So the administrative burden and the lack—I mean, it is not rocket science. It is two things that are driving this down.

The CHAIRMAN. But isn't part of it that nobody is holding these giant insurance companies accountable? Because I think you heard me describe the situation at Oregon Health and Science University. Now, I go up there regularly, as we all do, to talk to our universities, and talk to the practitioners, and they basically said they could not get the claims paid. I said, "Oh, I bet some of it has to do with the challenge during the pandemic; folks were worried about COVID, and you could not get workers, and folks would leave for other fields."

And we all kind of thought about it, and I said I was going to open this GAO inquiry, which Mr. Dicken knows is what has led to this effort this morning. And after there was a small newspaper story—this was not like a headline everywhere—a small newspaper story saying we were going to have an investigation here into whether the parity law was really being complied with, and OHSU got a gusher of payments within a matter of weeks. And you do not know really whether to laugh or cry, because we are glad that folks got reimbursed, but we cannot say that every single Senator in this body is going to suddenly take the place of enforcers.

We have to get these insurers and these agencies and people who are supposed to carry out this law to get off the dime and get serious about this. Because as far as I can tell, the big insurance companies are just muscling everybody around with their excuses and this parade of reasons why they should not have to comply with the law that is 13 years old.

In fact, I heard one statement from one of them saying, but we are still working through what the law is about. What a bunch of baloney! After 13 years—and Senator Wellstone and Senator Domenici had a good law. My brother was a schizophrenic, and we saw it for years and years. The Wyden family would go to bed at night worrying about whether my brother was going to hurt himself or somebody else. And when we passed the law of Senator Wellstone and Senator Domenici, I said this was going to be a new day for everybody else, every other family that was dealing with these issues, but we are in the same position today because of these insurance companies muscling everybody around and figuring out excuses for not complying with parity.

So, we are going to get to the bottom of it. You all have been great.

My friend, Senator Crapo.

Senator CRAPO. Thank you, Mr. Chairman. And to you and to our witnesses, I have to step out for a quick meeting, so I only have a chance for one quick question here, and I think I will choose you, Dr. Keller. I could ask this to any of you, but we have heard a lot of discussion today about the Collaborative Care Model. Could you

just describe in a little more detail, get down in the weeds a little bit? What is the Collaborative Care Model and how does it work?

Dr. KELLER. I am happy to. So the Collaborative Care Model basically puts a behavioral health-care manager in the primary care practice. So it is to help the primary care doctor be able to carry out the additional procedures that are necessary to assess, diagnose, and treat mental health and addiction disorders within primary care. So it is just like the doctor now has a nurse, and he can go and take your blood pressure, and he can take your temperature, and that helps the doctor out so she can do her part.

The behavioral health-care manager basically extends the ability of the primary care provider to do those in-office, and it works just as well with virtual presence through telehealth as it does through in-person.

And then there is also a psychiatric consultant to help with medication questions. And that psychiatric consultant reviews what is going on, is there to help support the primary care doctor, so the primary care doctor can treat—upwards of 70 percent of mental health conditions can be treated successfully in primary care with the same or better outcomes than specialty care with those two supports.

And then the other thing is, they have special data systems to track people. Because what happens is, if you have depression, sometimes you do not take your meds. Sometimes you do not come back to your appointment, and somebody needs to make sure you do not fall through the cracks. And so the registry and the tracking system, the care manager uses to make sure the person does not fall through the cracks.

Senator CRAPO. So this obviously involves additional providers and additional staff in a traditional doctor's office, if you will. Correct?

Dr. KELLER. I would say, Senator, that it is a redeployment of staff into them. We do not need more people to do this; we need them redeployed in the primary care settings.

Senator CRAPO. All right. And so does this mean, though, that there is a need for us to change either the mandates or the incentives, or what have you, in the insurance markets? Or does it mean—and I think Dr. Ratzliff talked about this—that we need to change the reimbursement policies in Medicare and in other government-run health-care systems? Is that piece of it, the finance side of it, something that we need to be able to tool up?

Dr. KELLER. There could be some tweaks to that, but basically once it is up and running, payment mechanisms in commercial care and Medicare and most Medicaid plans currently cover it somewhat adequately. But what they do not cover are the startup costs, and they do not cover the technical assistance needed to convert a practice quickly. So it is really getting over that hump of startup where we require additional investments.

Senator CRAPO. Well, thank you. I am going to have to run. I will be right back soon, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Crapo. We are going to be working on all of this together.

Senator Stabenow is next.

Senator STABENOW. Well, thank you so much, Chairman Wyden and Ranking Member Crapo. It is just a very exciting time for those of us who have worked a long time on mental health issues to see the focus on this committee—thank you so much—and to, frankly, see the focus in President Biden's budget, which is the strongest focus on investments in mental health and addiction I think ever. So that is exciting as well. And I did want to say, as the person who was honored to offer the amendment to the Affordable Care Act to implement the Wellstone-Domenici mental health parity language, it is shocking to me to see that we still do not have this after all of this time.

But I want to thank all the witnesses. You have done a great job explaining why integrated behavioral health care is so very important. And I think for us, we have to make it clear that integrated health care is much more than a buzzword or the name of a new payment model. It really is a system-wide transformation that we need to make happen. It requires funding community behavioral health care the same way we fund physical health care in the community. For far too long, behavioral health care has been funded through grants and inadequate reimbursements where providers were paid for an individual service but not for the broader range of services that address the patient's full range of needs, like community health centers are reimbursed for.

So the good news is, this is changing. And I want to again commend President Biden for including in his budget, for the first time, an extension across the country to all States for our bipartisan, evidence-based Certified Community Behavioral Health Clinics. And these clinics see everyone who walks in the door. They are open 24/7, 365 days a year, which is so important—mobile crisis stabilization, check-in visits with peer support, specialists treating mental health and substance abuse, working with hospitals, primary care, veterans groups, everybody in the community. So what we need to do is make sure we are fully moving forward on this model.

So, Dr. Keller, I know Texas has nearly 40 Certified Community Behavioral Health Clinics. Can you talk about the role of these clinics in improving access to behavioral health care in Texas? How is the model working in your State? And then, what would it mean to Texas to be able to fully participate in the fully funded program that Senator Blunt and I have been leading, but so many members of our committee, including your own Senator from Texas, are cosponsoring?

Dr. KELLER. Well, thank you, Senator Stabenow. And thank you for your leadership on this, and for Congress's leadership, because it is a critical model. In fact, it is so effective and so important that we have moved it forward with 38 of our 39 community centers in Texas, despite not being one of the eight States that had the sort of easier path to do that. And we put it together with sort of—and it is super effective. And I mean, just think about it. A lot of times our community behavioral health centers are really the only provider in a region in our rural areas. So not only are they a bulwark for the service to people with severe mental illness, with addiction, but to folks with less severe concerns in the community. And it is very important that that be undergirded.

I mean, the real challenge we have is funding. And we have been able to do that through a hodgepodge of our 1115 waiver, with some interesting negotiations with CMS—and the grant programs that were extended under the pandemic were very helpful. But that sort of funding is insecure. It is a constant battle to figure out how we continue to do this, and the type of direct Federal funding that HQFCs currently have is what we need.

And it really is, I believe, Senator, a parity issue; that we need to put these behavioral health treatments on par. I think we saw during the pandemic how hard it was to get funding out. You and Senator Cornyn had to team up to get those funds out there and to provide relief funds to behavioral health providers, because there are not those direct paths. And that patchwork of funding is a barrier at multiple levels, but the model itself is extremely effective, including by bringing addiction treatment into the integration, which is essential.

Senator STABENOW. Well, thank you. And it really is. If we are to have full parity, we have to have parity in reimbursement. We have to have parity in funding. And that is what this does. It says the wonderfully successful Federally Qualified Health Centers model that everyone supports, strong bipartisan support, is now going to be applied on the mental health and addiction side.

And in so many places, I know in Michigan for sure, they are located at the same place. They are fully integrated, which I think really is the goal for us: to be able to serve our people in the community.

Let me speak just a little bit more. We have heard from all of you about the fact that many private health plans are still not providing mental health parity, not moving forward on this. I strongly support the administration's efforts to crack down on this. We need to do more. We need to enforce the laws on the books so that Americans can get the care they need.

But I think we also have to do more. You have talked about Medicare, which is very important. I know it is also included in the President's budget, to include making sure that Medicare beneficiaries have access. They have to have the best type of providers as well, which goes to the question of workforce. And that is an area that Senator Daines and I are working on in this committee.

So we have a bipartisan bill—I have a bipartisan bill with Senator Barrasso to add licensed professional counselors and therapists to the Medicare program and increase access to licensed clinical social workers, for example. Also, I am very supportive of Senator Cortez Masto's and Senator Cornyn's work to expand access to peer support specialists.

So, Mr. Williams, could you talk about the importance of counselors, peer support specialists, clinical social workers in the mental health workforce area, and why a strong workforce can help us achieve real parity?

The CHAIRMAN. This will be the last question on this round. It is a very important one. We just have 20 members all waiting to ask questions. Mr. Williams, respond, if you would, to Senator Stabenow.

Mr. WILLIAMS. Thank you, Senator, for that question. Peer support specialists and community health workers are vital resources

to expand the workforce. As we have discussed, the need is quite wide. And these individuals and professionals who are peers, are community health workers, can expand the availability of resources and supports. We see that in places where you cannot have someone necessarily co-located or integrated in a full model that can be intensive. But just having one or two additional people that a physician can turn to, to refer an individual to to get services, can be very important.

Our data show that those individuals who are delivering those services actually meet people's needs in a wide variety of ways by being individuals who can be concordant with their needs. They understand the experience that they have had, and they can then refer them to services to get them out of the situation that they are in. And so, when we think about the expansion of the workforce, adding things like care management payments, bundled payments, primary care capitation, are all ways in which these expanded workforce individuals can be paid and reimbursed in our current system.

The CHAIRMAN. Very important, and I strongly support Senator Stabenow's work on this critical issue.

Our next members—and we will see who is online and who is here—would be Senator Grassley, Senator Cantwell, and Senator Cornyn.

Senator Grassley, are you online?

[No response.]

The CHAIRMAN. Senator Cantwell?

[No response.]

The CHAIRMAN. Senator Cornyn is here. We welcome him. Please.

Senator CORNYN. Thank you, Mr. Chairman.

Dr. Keller, I am looking at some of the statistics with regard to self-injury and suicide among children, particularly given the terrible circumstances of the pandemic, the isolation, the anxiety over being able to put food on the table, jobs, and the like. It had a particularly heavy toll on our children. In the first half of 2021, children's hospitals reported cases of self-injury and suicide in children ages 5 to 17 at a 45-percent higher rate than during the same time in 2019. I know that in Texas, 12 publicly funded medical schools have come together for the Texas Child Mental Health Care Consortium to provide telehealth services to children at school.

Can you talk a little bit about the importance of leveraging technology like telehealth in order to deliver those services, and the challenges we have across the economy in terms of trained workforce to be able to provide the access that we would all like to see expanded and provided?

Dr. KELLER. Certainly. Thank you, Senator, for that question. And that Texas experience, I think, has been instructive by the way we brought all 12 medical schools together. And really that is where most of our child psychiatrists and our child fellows are. So we only have a couple of hundred child psychiatrists in Texas, and being able to bring more of them together through that network was essential. And we did it through telehealth.

And right now, that telehealth network is available for real-time urgent care requests in hundreds of districts across Texas, reaching

over 2 million of the 5 million school-aged children we have in Texas. And we were able to stand that up during the pandemic through legislative funding, and we were able to have that be Statewide.

And it is critical that we not just have UT Southwest or Baylor College of Medicine and Dell involved, but also UT Tyler, and Texas Tech El Paso, and Texas Tech Lubbock being able to reach out, because they know their communities, and telehealth allows them to get to those schools and do those real-time urgent care visits. And we were also able to use ARPA funds allocated by the last legislature, the Texas legislature, to expand that. So now it is not just urgent care, but we are actually able to do more routine care. And it has been essential.

It is essential too, because it provides supports in primary care. And I would say that those emergency room statistics you talked about, when we talked with—working very closely with Children's Health in Dallas, the priority they have put in terms of what is the best way to reduce pressure on the emergency room is primary care interventions. It is basically leveraging those primary care networks, helping them do more so that children do not end up having to get in the situation where they end up in our emergency rooms.

Senator CORNYN. And of course, I mentioned the work that the Meadows Institute is doing on the Lone Star Depression Challenge. Depression, as you point out, can affect people periodically at different times. Unfortunately, we have seen, particularly among our veterans population, the self-medication that makes things actually worse rather than better.

We know that about 60 percent of the people who die as a result of a gunshot are suicides. And it strikes me that untreated depression is a real public health emergency and challenge. Could you talk a little bit about the Lone Star Depression Challenge and what lessons that you have learned so far that would be helpful to inform Federal policy?

Dr. KELLER. Yes, Senator. Thanks for asking about that. Well, basically what Dr. Ratzliff described, the Collaborative Care Model, we borrowed that from our friends in Washington State, and a leading philanthropist in Texas whom you know well, Deedie Rose, the Meadows Family, and most recently Lyda Hill, have basically put in $20 million to allow us to work in partnership with Texas medical schools to bring health systems across the State into overcoming those startup costs.

Basically, they are funding the startup costs that Dr. Ratzliff described. And by the end of 4 more years—we are about a year into it, and within 4 years, we are going to have a third of the State able to access Collaborative Care. And right now, Baylor Scott and White Health System is furthest along in that. And in the first several clinics they have, they serve actually several hundred thousand people a year. We have seen depression outcomes go from 15 percent remission to over 60 percent within the first year, because it works.

And so, it is the startup costs, and that is really what Texas philanthropists have come together to do through the Lone Star Depression Challenge. And we are very appreciative.

Senator CORNYN. You and Dr. Ratzliff talked about the Collaborative Care Model, but we have found multidisciplinary teams very helpful in other areas like law enforcement, and I mentioned the Right Care Program, and Dallas has a great model. A concern of mine has been, for a long time—and I think we all share this concern—is people who are suffering a mental health crisis are a danger to themselves and the law enforcement officials who encounter them. Because when 911 is called, they obviously—the police are not always trained to deescalate the confrontation and to make sure that the person who is in crisis is actually diverted to appropriate mental health care.

Could you just briefly—because I know time is limited—comment on how you think that model is working? And is this something that we could continue to share with other parts of the country?

Dr. KELLER. Yes, Senator. I think it is similar actually to the CAHOOTS model that Chair Wyden talked about. By pairing paramedics and mental health professionals together, we can reach more people.

The way we do it in Dallas with the MDRT models is, we have them directly partner with law enforcement as well, so they can respond to any 911 call. And we now have taken that citywide, and we are seeing not only are arrests very low, but less than 2 percent of folks actually end up in jail. Most of those folks actually had outstanding warrants. So people were looking for them. So very few people end up in jail. But also, very few people end up in the hospital, because the teams use community paramedicine to be able to provide follow-up care and make sure people get to their appointments and get the care they need.

So it is basically taking the community paramedicine model to mental health folks with mental health needs.

Senator CORNYN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cornyn. And thank you again for your help in this whole effort.

What is important about CAHOOTS—and I will just be very brief—is this is a chance to bring mental health folks and law enforcement folks together. You know, what we did as we started it in Oregon is we said, "Look, the big challenge here is to make sure that the professionals in these fields are able to do what they were trained to do." That is what I heard consistently from mental health folks and law enforcement people.

Obviously, if there is violence taking place, you need to make sure the community gets an added measure of safety, and that is a law enforcement role. And that is what we know, which you all have told us. So many of the instances on the streets are mental health issues. And what is striking—and I want to commend my colleagues. Senator Booker has been very interested in this idea from the very beginning, and Senator Scott has been very interested in this idea.

So I think we have a chance to bring together something of a coalition around these issues, and that is what we are going to try to do on mental health more broadly in this committee. But I appreciate you bringing up CAHOOTS, and for Senator Cornyn having you up here.

Senator Grassley, I think you are next in line based on arrival.

Senator GRASSLEY. I have a long lead-in for a question for Dr. Ratzliff and Dr. Keller. Three years ago, Senator Bennet and I of this committee passed the ACE Kids Act to establish a pediatric home health for kids with complex medical conditions so that dozens and dozens of specialists and doctors can coordinate their care, and that coordination is very, very important. This October, the Centers for Medicare and Medicaid Services will fully implement this act. Medicaid programs will have the tools to better coordinate, rather than these families facing barriers to care and the red tape that goes with it.

We know that these kids with complex medical needs are also more at risk for mental illness. One study suggests that 38 percent have mental health diagnoses, and many face challenges in accessing mental health care. Their parents are five times more likely to have poor mental health issues as well.

So it is important that CMS implement the ACE Kids Act timely, but Congress also has to follow this along with another Grassley-Bennet bill, Accelerating Kids Access to Care. It will streamline the screening and enrollment process for out-of-State kids or their providers, and I hope that this bipartisan bill would be in the committee's mental health package. The bill will improve the mental health of the kids with complex medical needs.

So to you folks: what can the ACE Kids effort learn from the collaborative care and coordinated care models, especially when trying to improve mental health care for kids with complex medical needs? I will start with Dr. Ratzliff.

Dr. RATZLIFF. Thank you, Senator, for that question.

So Collaborative Care has shown to be an effective model for addressing adolescent depression, pediatric ADHD, and some of the other common mental health disorders. So implementing the Collaborative Care Model in practices that serve our kids and children is a very important strategy to increase access to that effective treatment. I think also, there is the opportunity, especially for children with complex needs, to be able to address all of their needs in one place, hopefully reducing the burden of their families in really trying to coordinate that care.

Many of my patients comment on the fact that they did not have to manage that communication between the different providers when that service was all offered together in one setting. So I think that is a really important opportunity, to reduce that burden of the family really having to coordinate the care.

And also, I think it makes it easier for the providers. We know that provider burnout is a really big challenge right now. And so, anything that we can do to make that easier for the whole care team, I think, is very important.

Senator GRASSLEY. Dr. Keller?

Dr. KELLER. Well, I would just—Dr. Ratzliff explained that well. The only thing I guess I would add is that you have—right now it takes 8 to 10 years before we reach a child with mental health needs with effective treatment. And so, being able to broaden this to every pediatric practice—both specialty ones that deal with children who have special needs, but also every child being able to have access to the screening—is essential.

And it is also important around stigma, which is an issue across the board, but also for historically underserved and excluded communities, people in poverty. If you have to have somebody go back to a second appointment, we are going to have—studies show 50 percent of people fall through the cracks just by saying, "Okay, we need you to go see the specialist."

So by having all of that there, detecting early, those are really the things that make it work. And that is part of, I believe, the description of the bill you all are looking at, and it also is available more broadly in the Collaborative Care Model.

Senator GRASSLEY. A short follow-up to Dr. Ratzliff. Is telehealth for mental health any advantage, or just more access but not necessarily filling in?

Dr. RATZLIFF. I think telehealth is a very important part of really creating those spectrums of health-care access. I think it helps with a couple of things. I think the most important thing that it helps with is the redistribution of the specialty expertise.

So a lot of our—as I think Dr. Keller said—a lot of the people who are child analysts and psychiatrists work for large medical centers, or live in larger cities. So, especially for our rural populations, our communities where they might not have a child and adolescent psychiatrist for example to consult, you can get that expertise through telepsychiatry. And that makes a huge difference for patients getting the kind of expertise that especially patients with complex needs often need, those experts being able to weigh in and provide recommendations. And sometimes a single visit can be enough to really get the recommendations to a primary care provider, or other medical provider, who can then implement that plan.

And so, it is also a way to, I think, leverage a scarce resource, right? So sometimes a single visit might be enough, and you do not have to actually have ongoing care as long as you are having that care coordinated by the local treating provider whom that family already feels comfortable with, trusts. And again, that is a big important thing for people receiving care, because they often can receive that then from a trusted provider.

Senator GRASSLEY. Can I have one more?

The CHAIRMAN. Of course. Sure.

Senator GRASSLEY. This will be my last one. I might have some for answer in writing. And I do not know to what extent you are up on things in rural areas, because I missed your opening statement, Dr. Ratzliff, but suicide rates among youth have risen over the last decade, and are generally higher in rural America. In December, the Surgeon General issued an Advisory on Youth Mental Health to draw attention to this urgent issue. While the advisory indicates rural youth are more at risk, the advisory does not speak to the specific resources for rural young people.

So to you, Dr. Ratzliff: given the lack of rural resources provided by the Surgeon General's advisory to improve youth mental health, what mental health resources are available for rural youth? And if you are acquainted with organizations like FFA or 4H, are there possibilities for working through those organizations?

Dr. RATZLIFF. Thank you for this question. I think there are a couple of models that people are using to try to increase access for

mental health for youth, and I will give an example from Washington State. We have something called the Pediatric Consultation Line that allows any primary care provider really in Washington State, any pediatrician, to actually get behavioral health consultation on patients, get support provider to provider, so that those providers that are located in rural settings can actually get that kind of support.

I think the idea of community organizations—and I was actually in 4H, so I think it is a great one to think about—actually there are opportunities there to really think about how we maybe make those organizations more aware of how to recognize youth at risk. And then often those communities know their community and can connect people to care.

So I think there are opportunities to think about how we really engage our community organizations and partner with either their local primary care providers, or other services, to make sure that anybody who is identified can get the help they need.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Grassley.

And, Dr. Ratzliff, apropos of your further comments on telehealth, just so you know a little bit of the history of this committee, not only did Senator Crapo and I team up on the audio-only portion of the latest iteration of how to expand telehealth, but essentially the way this came to be was, before he retired, this committee, under the leadership of then-Chairman Hatch, produced the CHRONIC Care law, which was the first law to acknowledge that Medicare is no longer just an acute-care program. It is primarily chronic disease: cancer and diabetes and heart disease and strokes.

Anyway, Senator Crapo remembers the centerpiece, and this was something Chairman Hatch deserves great credit for, because he worked with Senator Crapo and I. It was completely bipartisan—Senator Bennet and Senator Warner—the major telehealth provisions in that package. And we were just on our way to kind of getting them implemented when Seema Verma, then Donald Trump's head of CMS, called us up and said, "Hey, can we use your stuff for essentially the model for the initial round of telehealth provisions in CARES and the like?" And we were able, Senator Crapo and I and others, to shoehorn that part of the CHRONIC Care law, the telehealth provisions, and it really became the Medicare jumpstart for finally getting serious about telehealth.

So when you talk to us about these issues, you have our attention. And continue to keep your foot on the pedal because, at a minimum, when we are concerned about inflation, it costs people a ton of money to fill their gas tank and go out and get to a provider. So there are ways to save money here. This is an inflation-combating tool.

All right, let's see where we are. Let me call out to others in order of arrival. Senator Cassidy?

Senator CASSIDY. Senator Cassidy is here.

The CHAIRMAN. Senator Cassidy, are you there?

Senator CASSIDY. I am here. Do you have me?

The CHAIRMAN. Wonderful. Let us hear from you.

Senator CASSIDY. Sounds great.

Dr. Keller, you mentioned the importance of access to evidence-based services for those with severe mental illness. As we both know, the Coordinated Specialty Care is an evidence-based suite of services for those with first-episode psychosis. And it is part of a mental health reform bill that Chris Murphy and I put together in 2016 to expand access, and yet I find out that this access is actually quite limited, even though NIH verifies that it is just what we should be doing.

So I have learned, in general, Medicaid will cover parts of the continuum, but not a coordinated specialty care comprehensive approach; that every State receives SAMHSA community health block grant dollars, which are a required set-aside for first-episode psychosis that could be braided into the Medicaid dollar to provide the comprehensive access.

So I guess my question to you, as being on the front line, is why has it been so difficult to implement the Coordinated Specialty Care for States and providers? I guess I will start with that.

Dr. KELLER. Well, thank you, Senator Cassidy, for bringing attention to that. I want to commend SAMHSA for the set-aside for first-episode psychosis care. In Texas, we have used that to dramatically expand our capacity. The problem is that it is primarily available to people who are either uninsured, who are served through the block grant, or some people with Medicaid. And Medicaid makes it difficult to pay for it because of the fragmented funding approach that you talked about.

So, I think the reforms you talk about and the need for Medicaid to have value-based purchasing arrangements, and bundled payments to be able to pay for that, would make it easier to expand that access. But I think it also needs to be expanded to commercial insurance. And this is why parity enforcement is essential, because the onset of schizophrenia, the onset of severe bipolar disorder, is not limited to people without insurance or who are in poverty. People with commercial insurance deserve the same access. And I will tell you, today we have a two-tiered system in the State of Texas for people with Coordinated Specialty Care. We have excellent access for people who do not have insurance, and we have almost no access for people who do have insurance, unless they want to pay out of pocket.

Senator CASSIDY. Well, let me ask you. One, that is very troubling, but for those who do not have insurance, what I have heard and what I think I heard you say, is that Medicaid and SAMHSA do not really work well together. By the way, you can thank Congress for making SAMHSA do that set-aside.

But with that said, they do not work well together. And yet, then you said that they actually have excellent access. So would you square that for me?

Dr. KELLER. Yes, absolutely. So the work has been done on the ground in Texas by Texas providers to basically take the set-aside, which—thank you to Congress for doing that, because that did make it easier for our providers to stand that up. And then they have to do the mind-numbing work at the clinic to do that, and not every clinic is able to do that.

So, the access for uninsured people through the block grant is excellent. The access through Medicaid is spotty. And really, I do be-

lieve you are correct, Senator, that better coordination—and I believe the current SAMSHA Assistant Secretary is working on that. I think for CMS, it needs to be a priority. CMS has so many things going on. If they could prioritize this for expedited sort of work, and work on these bundled payment arrangements, that would be wonderful.

Senator CASSIDY. Okay.

Mr. Williams—thank you very much for that—you spoke about the mental health of people who are dually eligible for Medicare and Medicaid, and that nearly one-third of duals have a serious mental illness such as schizophrenia, bipolar, or severe major depressive disorder, at a rate three times higher than that of the non-dual patient.

But you know, dual-eligibles have worse outcomes than those who are not dually eligible. And my office has been looking at this, and we have found if you take a State which does not have a dual-eligible population compared to one that does, and it is the same type of patient in both States, the academic literature suggests that where they do not have two forms of coverage, they actually do better. If you will, giving them the second form of coverage, dividing the care between the incentives for the care, actually ends up making things worse.

So, any thoughts about that, because the duals do terribly? And is part of the problem the fact that they are duals as opposed to having only one payer?

Mr. WILLIAMS. Senator, thank you for that question. The needs of the duals population are complex. Administrative barriers disproportionately deter poor and marginalized communities and individuals from receiving health-care services. Low-income people who have to work long hours, or have limited health literacy, or——

Senator CASSIDY. Well, Mr. Williams, I am almost out of time. So let me cut to the chase. Is it possible that actually making them a dual, giving them both Medicaid and Medicare coverage, although you do it because you want to help, may be part of the problem?

Mr. WILLIAMS. Our health-care system is complex. We need individuals like patient navigators to really help dual-eligible Medicare beneficiaries access services. And back to my three points that I mentioned in my remarks.

Mental health services can be integrated at the site of primary care. So engaging in that primary care office and getting people access to the services and navigating those administrative requirements is important. Second, having qualified providers like peers, community health workers, and others that can be resources for individuals to help them navigate the complexity. And then finally, the sharing of technology and information. Having data at your fingertips as a provider and as a patient are ways that you can navigate those complexities associated with being a dual-eligible.

And we see promising things with special needs plans which have been customized to meet the behavioral health needs of many individuals.

Senator CASSIDY. I thank you, and I yield, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cassidy. And, Senator Cassidy, before you go, let me just note we very much appreciate your

leadership on this. Your expertise on all these health issues is much appreciated.

Okay, let's see. The next Senators in line of appearance would be Senator Cardin, Senator Lankford, Senator Brown, and Senator Daines.

Senator Cardin, are you out there in cyberspace?

[No response.]

The CHAIRMAN. Senator Lankford?

[No response.]

The CHAIRMAN. Senator Brown?

[No response.]

The CHAIRMAN. Senator Daines? And I understand Senator Bennet is available online right now.

Senator BENNET. Thank you, Mr. Chairman. Can you hear me?

The CHAIRMAN. Yes.

Senator BENNET. Great. And I just want to thank you and Ranking Member Crapo for continuing this incredibly important work on mental and behavioral health. I want to thank—I listened to some of the discussion earlier, and I just want to thank Senator Grassley and Senator Cornyn for their partnership on these issues. And I really hope, colleagues, that we are able to come together on a bipartisan bill here in the Finance Committee on this really important set of issues. I think we will. I think we can. And I also want to take the opportunity to thank my colleague from North Carolina, Richard Burr. I am grateful that we are partnering again to address the important issue of parity.

But before I get to parity, I want to make an observation about the integration. Colorado has been working to integrate mental health and primary care for years. In 2014, Colorado received $65 million in State Innovation Model funds to create a coordinated, accountable system of care that improves integration of physical and behavioral health services in over 300 primary care practices.

While the initiative was a great success, most practices were not able to keep their integration work going once the Federal funding ran out. And I appreciate the witnesses' comments and their testimony about a number of successful models.

I am also interested in models that might not be mentioned today. Other community-centered evidence-based models like those across my State should receive our support as well.

So, Mr. Williams, could you comment on the importance of centering and establishing these integration effort practices with the specific communities they serve in mind? And should we make sure that increased reimbursement for integration is targeted for more than a handful of models?

Mr. WILLIAMS. Thank you for that question, Senator. And yes, I believe that there are many opportunities and ways to ensure the integrated model. As was articulated in the bipartisan report that was released yesterday, there is a broad continuum of ways you can achieve integration. And doing so ultimately helps get people access to services.

Telehealth is obviously a way in which you can assure that, where you have a low mental health resource, substance abuse resource area, you can get access to providers and other individuals who can help those people. And that can be done through very sim-

ple means like phone and texts. But the solutions that I also mentioned are around workforce, around expanding the use of technology. They are all ways in which you can provide a wide variety of services to individuals.

I think, when you look at the models that have been pioneered by groups like the Cherokee Health System in Tennessee, that have federally qualified health-care clinics but also have a behavioral health component that is strong within their programs, they blend those two resources together to provide the services and supports for individuals. And they do that in a customized way based upon these individuals' needs. And so, we have the payment policies in place through bundled payments, through capitations, that could support this type of care delivery. Making these investments will help increase access regardless of location.

Senator BENNET. Thank you for that comprehensive answer. I appreciate it.

Mr. Dicken, since the final regulations implementing the Federal parity law went into effect in 2014, Colorado has worked hard to ensure compliance across our Statewide Medicaid managed care system. Last year, Colorado's health financing department released a report on how Medicaid parity is faring. And I am proud that our Medicaid system is compliant across the majority of requirements. But they and our department of insurance have both highlighted the difficulty in establishing parity for non-quantitative treatment limitations, or NQTLs. This includes non-numeric benefit limitations like medical necessity criteria, network admission standards, preauthorizations, and step therapy.

In my view, NQTLs largely affect a patient's ability to obtain the care they need when they need it. And I believe that improved technical assistance and clear guidance from Federal agencies like CMS would give States and other insurers the tools they need to improve compliance.

With just the few seconds I have left, Mr. Dicken, in your work at the GAO have you found areas where better technical assistance and guidance would help improve compliance, especially when it comes to NQTLs in plan benefits?

Mr. DICKEN. Thank you, Senator Bennet. You are correct that we have heard of a number of challenges that stakeholders have in terms of those non-quantitative treatment limits. The Department of Labor and CMS have, over time, provided more guidance, more frequently asked questions, responses on how to address those. But it continues to be a challenge that many stakeholders identify, and that the Department of Labor and CMS have identified in their investigations. But there continue to be non-quantitative treatment limitations that are different for mental health than for other medical and surgical services.

Senator BENNET. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet. I appreciate your good work on all of this.

Our next four will be Senator Carper, Senator Casey, Senator Warner, and Senator Cortez Masto. And to give our guests a little bit of a situational awareness, kind of a brief, it is going to get a little hectic around here, because we are going to have votes, and

both Senator Crapo and I are working on the important Russian trade bill, or cutting off normal relations with the Russians. So we will be going back and forth. But we are just going to keep this going, and the two of us can do that.

Okay, Senator Carper is next.

Senator CARPER. Mr. Chairman, can you hear me?

The CHAIRMAN. Tom, we cannot hear you.

Senator CARPER. I will try again. Testing, testing. Can you hear me now?

The CHAIRMAN. Yes.

Senator CARPER. All right; great. All right, I want to say "thank you" to our witnesses today for your testimony. Before I begin, I want to say again, thank you, Mr. Chairman, for the opportunity to work with Senator Cassidy on this bipartisan working group that focuses on addressing the pediatric mental health crisis. I think we have made real progress so far, and I look forward to continuing our work on this important issue with my co-chair, our good friend Senator Cassidy.

I think it is clear that COVID–19 significantly exacerbated mental health stress on children, and on a lot of adults, highlighting our Nation's acute shortage of mental health services. My State of Delaware had over 9,000 Delawarians who suffered from some sort of depression. However, according to the State, our State students who have access to mental health resources within schools are 10 times more likely to seek care.

Last year, the Finance Committee heard testimony, you may remember, from the U.S. Surgeon General, who stressed that one of the most central tenets in creating accessible and equitable systems of care is to meet people where they are. For most people, that is right there in schools. Just last week, our Secretary of Health and Human Services, Xavier Becerra, and Secretary of Education, Miguel Cardona, announced a joint department effort to expand the school-based health services.

It is clear that there is a growing momentum to recognize the role that schools already play in ensuring that children have the health services and support necessary to build resilience and thrive. Investing in schools and community-based programs has been shown to improve mental health and emotional well-being of children at low cost, a high benefit, and a good outcome.

Mr. Williams, a question, please—and any of the other panelists who may want to respond too, but we will start off with Mr. Williams. How can we further improve coordination between primary care and mental health providers to better support our children? Working through school-based services, do you see a role for the Federal Government beyond providing guidance and tactical assistance to State programs? Mr. Williams, please.

Mr. WILLIAMS. Thank you for that question, Senator.

Senator CARPER. You're welcome.

Mr. WILLIAMS. Connecting primary care and behavioral health is very important to build a strong connection between the providers and community organizations, and this is vital for our Nation's youth. The current behavioral health crisis is particularly notable for its impact on our Nation's youth. Less than half of adolescents with depression over the past year reported being able to receive

care, and this was even more acute in Black and Indigenous People of Color.

Hospitals are reporting emergency room visits among adolescents rising at a high rate. Numerous models that I shared in my written testimony show the power of bringing community-based providers and organizations close to the health-care system to improve access to service and build that connection.

Through integration, expanding the workforce, and using technology, we can improve collaborations with community service providers. They can be just down the hall, like the models we mentioned today, but they can also be a phone call or a video-chat away. However, there needs to be appropriate financial resources in place to ensure that community-based organizations are not awash with references from the health-care system.

Integrated approaches need to be a two-way street in which the community service organizations and others have resources at their disposal to provide this care and need. And so, through things like global payments, capitation, and other approaches, you can ensure that there are enough dollars that can flow to the individuals who would provide the bridge to services that are so important.

Thank you.

Senator CARPER. One other quick question, Mr. Williams. In your perspective, how can telehealth be used to better integrate behavioral health care within the primary care setting, particularly for the pediatric population? Go ahead.

Mr. WILLIAMS. Pediatricians are often the first line of defense in many ways. They are trusted individuals whom people go to when they have care concerns about their children. And so there is an opportunity there to empower that primary care provider, that pediatrician, to get access to services and do it in a trusted manner.

Some of the models that we have reviewed and looked at have provided primary care providers and pediatricians tools and resources so that when they see the first inkling of a potential issue or problem that a child is facing, they can then appropriately identify the right service for them.

And so you try to use these evidence-based models in an effort to connect people to the services that will best meet their needs. And you do not necessarily have to have a person in the office, but you can also pick up the phone, or use health technology to be able to connect people. So there are many different ways in which you can achieve that goal.

Senator CARPER. Mr. Chairman, if I could in closing, just note that last fall Senator Cornyn and I introduced legislation called Telehealth Improvement for Kids Essential Services, TIKES, and it can provide guidance and strategies to States on how to effectively integrate telehealth into their Medicare and CHIP programs. We think we are on to something, and hopefully we will have the opportunity to discuss it further at a later hearing. Thank you so much. And thanks——

The CHAIRMAN. Thanks for the good work you are doing, Senator Carper, with Senator Casey. So I am going to run and vote, and—excuse me, Senator Carper and Senator Cassidy are working together. And Senator Casey will be next online. Thank you.

Senator CASEY. Mr. Chairman, thanks very much for this opportunity to have this hearing. And I want to start with Mr. Williams.

We know that so many people in our country need the services we are talking about here today, but often they do not access them because the systems that they have to navigate are so complex. These are seniors, people with disabilities, who depend upon both Medicare and Medicaid. We know that over 12 million Americans are eligible for both programs, both Medicare and Medicaid, so-called dual-eligibles. A half-million of those 12 million are in the State of Pennsylvania.

Mr. Williams, as you note on page 5 of your written testimony, and I am quoting here: "Nearly one-third of individuals dually eligible for Medicare and Medicaid have been diagnosed with a serious mental illness." And then you go on to say that the rate is three times higher than for those who are not dually eligible. At the same time, they have to navigate two completely separate health-care programs. They might have one insurance card for their primary care doctor, another insurance card for behavioral health, and then a third one for prescription drugs, and the list goes on from there.

Earlier this year, Senator Tim Scott and I introduced the PACE Expanded Act, Senate bill 3626, which is legislation to expand the availability of these programs that integrate primary care, behavioral health, and other services. So my question for you, Mr. Williams, is, how would meaningful integration involving Medicare and Medicaid help ensure that people who rely upon both programs can access the behavioral health services that they need?

Mr. WILLIAMS. Thank you for that question, Senator Casey. The administrative barriers that disproportionately deter individuals are high for dual-eligible beneficiaries. Having to navigate two systems can be difficult. It is a trait that we find is common across our health-care system in the United States.

Complexity is something we like here in the United States, and it is something that we need to focus on navigating. In fact, the United States is the only country that has a workforce called "patient navigators." Those individuals are charged with helping people manage the benefits which they have, and doing it in an effective manner so that they can get the services they need.

To help dually eligible Medicare and Medicaid beneficiaries, mental health services can be integrated at the site of primary care and can help eliminate gaps in services to providers and the community. There, there is an opportunity for the coordination, colocation, or setting of shared goals that can be used to ultimately develop a care plan for an individual.

You also have a host of other qualified providers that can be brought into the care system through these coordination activities. Peers, community health workers, other professionals can be a part of the care team and provide the continuity and coordination to help people over time. And then finally, I say health information technology provides a wide variety of ways to ensure that the data and information that are available are in the hands of both the providers and the patients, making their traversing of the health-care system that they are a part of easier.

Finally, there are a wide variety of plans, special needs plans in particular, that have customized their benefits for behavioral health. And they have shown promise in being able to meet the needs of beneficiaries, both of Medicare and Medicaid, in a good and positive way.

So there is lots of complexity, but we have the people, organizations, data, and systems to navigate this complexity. Thank you.

Senator CASEY. Mr. Williams, thanks very much.

My last question is for Dr. Ratzliff. I wanted to ask you about an issue that is particularly important to folks in rural areas and communities of color. Community organizations—whether they are faith communities or different workplaces or early childhood programs, schools—are often the first to know the signs that a child or a teen is experiencing a mental health challenge.

My question is, how can integrated behavioral health and primary care practices partner with these community-based organizations to connect people with mental health support?

Dr. RATZLIFF. Thank you so much for that question. I will answer with an example that I have seen in a project we supported in California, where actually, for example, a senior center became closely partnered with a primary care organization. And what they actually did is that they could have a bidirectional support for the patients whom they served.

So that senior center might be the first place that, for example, depression or anxiety was recognized. They could make sure to try to connect those patients to that primary care organization so that they could get access to integrated behavioral health that was located there. And additionally, part of integrated behavioral health is also addressing psychosocial needs. And sometimes those patients needed to be more engaged, to be activated, to get connected to community, to find purpose in their life. And that was where often that organization, that community-based service, could be coordinated and be part of the treatment plan, really, for that patient.

So that is an example of how that might work together.

Senator CASEY. Thanks very much.

Thanks, Mr. Chairman.

Senator CRAPO [presiding]. Thank you.

Senator Lankford?

Senator LANKFORD. Thank you very much. You all, thank you for the testimony today; it is very helpful.

I want to drill down on an area we have not talked about much, and that is the CCBHC program on this. In Oklahoma, we received a grant through the pilot program on there. Our Oklahoma State Department of Mental Health and Substance Abuse then separated out 1,400 tablets to law enforcement, different areas across the State, to be able to get immediate response back. What we have seen through that has been pretty remarkable, quite frankly. We have saved about $15.5 million in jail time, and about 82 percent of the people who would have been headed to jail were actually headed to treatment facilities instead.

What I am interested in—that is what we are seeing in Oklahoma. What are you seeing in other parts of the country, for those of you who are tracking that? And is this a model that we can con-

tinue to help? When I talk to law enforcement in Oklahoma, they will tell me their jails have the greatest number of people with mental health needs than any other facility in the entire State. And their law enforcement is trying to figure out how to be able to help those folks with mental health issues initially, and to get treatment to them the fastest possible way. But obviously they are generalists and trying to deal with all things law enforcement and trying to get to a specialist as quickly as they can.

What have you seen as a response to this in other areas of the country? And what can we do to multiply this?

Dr. Keller?

Dr. KELLER. Well, your neighbors to the south in Texas have seen similar results, Senator. And I think the essential thing, regardless of what State you are working in is, you need to do two things.

You need to be able to get that mental health provider embedded with law enforcement, preferably able to respond without having law enforcement as an option, so that the behavioral health provider—and we found also that paramedicine has helped too, if you can bring community paramedics in there as well. But the essential thing is being able to get that out—and you are right. Telehealth works fantastically for that because it provides that expertise out there. But the second thing you need is, you need a place for people to go. You have to have treatment in the community. And so CCBHCs are essential for that.

So, in a lot of rural areas, collaborative care can be for primary care practices there. And what we have found is most important is same-day access to a prescriber. And if you can do that, and you put those two things together, you are going to see fantastic outcomes.

Senator LANKFORD. Okay, that is very helpful.

I want to drill down a little bit. I am a co-sponsor of the NOPAIN Act, which is trying to deal with the issue of opioid addiction, and to try to find other treatment options to be able to help those folks dealing with pain. And there are a lot of folks with chronic pain, but we need to find other options for them as early as possible in the process on that.

What are we dealing with right now in trying to be able to help individuals with chronic pain, dealing with other alternatives that are non-addictive? What have we seen a rise of, or any other treatments that you have seen?

Dr. RATZLIFF. I can start. Thank you for that question.

I think one of the things that we are seeing is that there are alternatives. Some of the medications for OUD treatment can be effective for addressing pain as well. I think that takes a lot of coordination to actually support patients in making the transition into new treatments.

And so again, I think the focus on being able to do that in primary care with those patients who are often showing up is really critical. Some of the models of integration that we are talking about today are one approach that could be helpful to actually provide that support, where patients are often seeking that help from their primary care doctor.

Senator LANKFORD. I have a follow-up with you as well on the issues of rural health care. Dr. Keller just mentioned that as well, and the telehealth issues in rural health care. I know this is also an area that you have worked on.

What can you bring to us as we are dealing with rural mental health care?

Dr. RATZLIFF. Thank you for that question.

I talked a little bit in my initial testimony about how the Collaborative Care Model and other models of integration have shown to be effective in rural settings as well. We get as good and sometimes even better outcomes in some of our rural practices where we have implemented mostly Collaborative Care, since that is the model I work on.

I can talk about my personal experience with that. At the University of Washington, we actually partnered with a rural access hospital that was in a county that did not have a single prescriber. So occasionally, someone would come in for a day and that was it. That was what was available in that community.

When we implemented Collaborative Care there, that rural access practice had a primary care practice. We were able to—they hired a behavioral health-care manager. Some of us at the University of Washington actually provided consultation or support to that primary care practice. And what we saw was incredible work done by those primary care providers. But they felt really supported, having access to people like us who had expertise that they did not have, and being able to really serve their community. And I think that that was a really powerful example of how you really need to get creative in partnerships and leveraging the workforce in new ways.

Senator LANKFORD. Okay. Thank you.

Thank you all for the work that you are doing on this and bringing to this. This has been an important issue for our committee. Obviously, coming out of COVID there has been greater attention to juvenile mental health, but quite frankly, it has been mental health across the entire country as we continue to be able to process through this. So I really appreciate your testimony today.

Senator CRAPO. Thank you.

Next is Senator Daines, and he will be followed by Senators Warner and Cortez Masto.

Senator Daines?

Senator DAINES. Mr. Chairman, thank you. I understand this is the fifth hearing the Finance Committee has held this Congress to discuss mental health. I think about so many Montanans and Americans across our country battling mental health, as well as the addiction issues. I do appreciate the committee's efforts here to bring better outcomes for patients. I think everything we are doing here is a means to better outcomes, which is going to be the end.

The past few months I have been working with Senator Stabenow. We have been working to develop policy solutions that are going to help strengthen and improve the mental health workforce.

The numbers are pretty staggering. If you look at the shortages in mental health professionals, the estimate that we have seen is 148 million Americans live in mental health professional shortage areas. That is 45 percent of our population. And I can tell you in

a rural State like Montana, these shortages can even be more severe. As they say, it is a long way between telephone poles in a place like Montana. I am looking forward to discussing how we break down some of these barriers and be better at leveraging our workforce to expand critical access to care for patients in Montana and around the country.

A few questions. Back in Montana we have had a successful peer support network that allows people who have gone through recovery to help others who are battling with mental health or addiction challenges. Nothing is better than having a success story and a role model to help someone else in need. We have seen that peer recovery support leads to reduced hospital admission rates, increased quality of life, and decreased cost to the mental health system. That is why I have cosponsored the PEERS Act, which would expand access to peer support services for mental health and substance use disorders.

Dr. Keller, why do you think peer support is successful? And what would it mean to patients if Medicare was allowed to cover such services?

Dr. KELLER. Well, Senator, thank you for that question, and I think you explained it actually quite well. People being able to relate to the experience of having gone through something, and also having overcome something and—even if your symptoms are not fully addressed, or you are still struggling with things—to be able to move your life forward.

And that is really the unique value that peers are able to bring. And they should be available in every type of health coverage that we have, including Medicare, and apparently, they're not. So I think extending that to people with Medicare would basically be an important step of parity in terms of being able to have the same sort of access that often we have in Medicaid programs.

I would also argue that commercial plans should be looking at that more too, because encouraging commercial plans to do that—and showing the evidence—is an excellent way to expand the workforce. And there is unique effectiveness in peers because of their lived experience.

Senator DAINES. Yes, well, I appreciate that insight, and I think on the peer side too, it is not only the benefit to the person who is being helped, but the person who is doing the helping also further strengthens their resolve and commitments. I always say, if you want to really learn something, go teach something, right? And then you really have a much stronger passion for the subject.

Earlier this month I worked with my colleagues on this committee to secure the extension of the CARES Act policy which allowed employers to offer first-dollar telehealth. In rural States, again like Montana, it is critical to ensure that workers and their families have access to affordable care, including mental health services. I was also encouraged to see that additional telehealth flexibilities were extended by Congress so that patients were able to continue accessing important telehealth services no matter where they live.

Dr. Ratzliff, how valuable have these telehealth flexibilities been in terms of increasing access to psychiatric care? And moving for-

ward, should telehealth be part of the solution to help address the workforce shortages?

Dr. RATZLIFF. Thank you for that question. I think they have been incredibly important. I have multiple examples from my practices of patients who either accessed care for the first time using telehealth, or really were able to stay connected to really lifesaving medications—for example, some of the practices that I am working with that are providing medications for opioid use disorder. Being able to actually continue to access those services probably saved patients' lives.

I think that it is very important that we continue to be flexible, to allow patients to access the care they want at the time they need it, and ideally in the mode that they need it. You know, many people, for example, find it very helpful to continue working, being able to actually use telehealth as a way to continue to access care and not have to take a half day off work to be able to go to a single appointment.

So I think that is very important. I do think that there is an important policy piece that we should think about. In some of the policy work, especially around Medicare, there is a requirement that you have to actually be seen once in person every 6 months. And it is the only stipulation like that around telehealth care. And I do not know why it is just there for mental health. And so I would urge that we think about changing that, because I think it is, again, a parity issue. I do not know why for mental health there would be that stipulation. That decision should really be between the clinician and the patient to make, if that needed to be.

Senator DAINES. Thanks for flagging that issue. I am out of time, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Daines.

We are now on to Senator Warner.

Senator WARNER. Thank you, Mr. Chairman. And let me echo what so many of my colleagues have said about both the value of telehealth and the workforce shortage issues we have. And I agree with Senator Daines's earlier comment. This notional idea that there ought to be different standards on mental health providers in terms of the in-person visits versus other providers does not make much sense to me.

I want to direct my first question to Mr. Williams. Your written testimony was really helpful in terms of coordination between primary care and mental health. And as we just discussed, and other witnesses testified, the fact that Medicare is actually doing a reimbursement on these consults for telehealth mental health practices makes a lot of sense. But I am told from practitioners in Virginia that failure to have that Medicaid match is really preventing some of these mental health services from being delivered on a telehealth basis.

So, Mr. Williams, would providing a Federal match to State Medicaid programs for telehealth consults really help this collaboration between primary care and mental health care?

Mr. WILLIAMS. Thank you for that question, Senator. And yes, providing additional services, supports, and dollars to help ensure that people have access to telehealth is important. And I think telehealth, as we have all discussed here today, is a really positive way

that has much potential to kind of ensure that there is access to the provider and services.

But I think we also must realize that telehealth has not been evenly accessed. Black and rural Medicare beneficiaries have lower telehealth use compared to others. Telehealth use varies dramatically by State, with higher use in the Northeast and the West, and lower use in the Midwest and the South. So we have a little bit of work to do to understand those differences. Yes, the expansion is positive and good and provides an avenue for more access. But there is also the opportunity to ensure that everyone gets equal access.

And I just would like to note that the temporary continuous coverage requirement that kept Medicaid coverage intact during the public health emergency helped to ensure access to a wide variety of services, and that should include telehealth. Thank you.

Senator WARNER. Thank you. And I do think this notion of continuing some level of Federal match on Medicaid for telehealth is important.

I want to go to Dr. Keller. I was pleased to see in the 2022 parity report to Congress that new authorities were given to the Department of Labor, Treasury, HHS, that have led to increased and improved enforcement. But as I was looking through that, I saw one health insurer and two of their large plans actually covered nutritional counseling around diabetes—I have a type 1 diabetic daughter, so that is very important—but it did not cover the kind of consultations needed around anorexia, bulimia, and other eating disorders. Unfortunately, I have a lot of personal family history with a daughter who has those type of eating disorders, actually the same daughter with type 1 diabetes with maybe TMI. But the number of colleagues and others who are experiencing this has become almost endemic in itself.

So, Dr. Keller, what other ways can we look at trying to make sure that we—I know that there was enforcement action in part of this area—but what other things can we do, at the initial stage of plan design, to make sure that this critical area around eating disorder plans is not discriminated against in terms of coverage?

Dr. KELLER. Well, Senator, I really appreciate you bringing attention and sharing your experience on that with your family. I would actually like to provide some additional detail, because there are some specific things around eating disorder diagnosis that we would like to share. But I would say in general, one of the biggest problems that enforcement is trying to address right now is the fact that we are treating the below-the-neck physical health conditions differently than the above-the-neck. And unfortunately, our body is connected. And I think nothing, no mental health disorder, expresses that more than eating disorders. And I think the example you bring up shows exactly the thing. And the reason is, you have different people in these insurance companies managing those benefits.

So, on the below-the-neck needs—you know, nutrition—they are designing it in a way to try to advance outcomes in a more integrated way. On the above-the-neck psychiatry piece, they are trying to limit those costs and to try to weed out spending more. And they are being very successful. They are spending 20 percent less

than they used to before these things went into place, and unfortunately the burden is being felt by families. And so, being able to continue enforcement is essential for that and to have the exact same parity, and also have them working across the divisions within the insurance companies to try to end those sorts of things.

And I think also, being able to do primary care interventions, whether it is Collaborative Care, primary care, behavioral health, other integrated models, is essential because we are also not detecting those needs until 8 to 10 years after they begin. And so we put the burden on the family to have to discover those needs and figure out what to do, often in a crisis.

And so, if we are looking earlier when we are dealing with health, nutrition, weight gain, other types of things in those well-child checks for the child, and we are addressing their mental health at the same time, we are going to find those needs sooner and begin to treat them better, just like we do now for cancer, like we do now for heart disease. We have to get the detection earlier, and the care in primary care.

Senator WARNER. Well, Dr. Keller, I appreciate that. And I hope I can get more information from you.

And, Mr. Chairman, I would love to continue working with you and the committee on this very important issue.

The CHAIRMAN. Thank you, Senator Warner. We know this is important to you, and we look forward to working closely with you.

Senator Whitehouse? Oh, excuse me; Senator Cortez Masto—I apologize to my colleague—is next. Senator, are you out there?

Senator CORTEZ MASTO. I am here, thank you.

The CHAIRMAN. Wonderful. It is your time.

Senator CORTEZ MASTO. Thank you so much for holding this hearing. It is such an important topic that we need to address. I am so pleased that the Senate Finance Committee is working on addressing mental health. I am pleased to be able to join my colleague, Senator Cornyn, in cochairing the Subcommittee on Increasing Integration, Coordination, and Access to Mental Health.

Let me start with Mr. Williams. We have established that Medicare coverage issues persist among seniors, just as they do among families. And if you believe the old adage that "as goes Medicare, so goes the market," then the mental health coverage gap in Medicare has consequences for private coverage too.

So, Mr. Williams, let me ask you this. If there was better Medicare coverage of mental health, could we reasonably expect better commercial coverage as well?

Mr. WILLIAMS. Thank you for that question, Senator. Yes, I believe very much that Medicare sets a benchmark. I started my career focused on Medicare policy. In doing so, and working at the National Academy of Social Insurance, I learned that through Medicare policy, the rest of health-care policy goes.

We have seen that consistently with the Medicare Modernization Act, with several Balanced Budget Acts, through the Affordable Care Act, that when we use the leverage of the Medicare program, it effects change throughout all of the health-care system. And we have that opportunity to do and make that same change with behavioral health, which includes both mental health and substance use services.

And a vital way in which that can be done is through the expansion of peer support. Certified and trained accredited peer support specialists have been able to help individuals achieve recovery goals and do it in a cost-effective way. And so, if Medicare were to expand coverage of that type of provider, that benefit would, one, be available to Medicare beneficiaries, but it would also set the precedent that would be an area of focus and opportunity for the commercial sector.

And so, yes, an action in Medicare is great for Medicare beneficiaries. It meets their needs. But it also is the beginning of a chain of change that ultimately will impact the entire health-care system.

Senator CORTEZ MASTO. Mr. Williams, thank you. And that is why this conversation is so important. And I was pleased to be able to introduce legislation around peer-to-peer counseling programs and was so pleased that Senator Daines joined me, and we were able to get it passed because we have seen the benefits of really putting in place action around addressing mental health and doing something about it, and why the conversations we are having are so important.

But let me ask Dr. Keller this, because a couple of witnesses have talked about mental health crisis services in the context of parity in Medicare. If you get into a car accident, a paramedic trained in emergency medicine takes you in an ambulance to an emergency room where you are cared for by a physician. You might be admitted for a few days and sent on your way with follow-up instructions. But if you are experiencing a mental health crisis, the ambulance cannot take you to a crisis center. Medicare will not pay for the health providers that are best equipped to treat you in that moment—people like peers or licensed counselors—and they will not pay for your nights in a stabilization facility. They will not pay community health workers who help to set you up with a counselor for ongoing care.

So, Dr. Keller, if we are to achieve parity in Medicare, do we need to expand coverage of the crisis services as well?

Dr. KELLER. Well, Senator, thank you for that question. And thank you for your leadership on this in partnership with Senator Cornyn on Senate bill 1902, which would extend that to Medicare. And it is essential for exactly the reasons you said.

And that really begins at the moment when the person shows up, because not only will Medicare not cover the crisis care, it will not pay for the CAHOOTS person that might be coming to help you with your mental health care, or the right care person.

We need to have the Medicare coverage kick in just like Medicaid does now, just like some commercial insurance does now, at the point of crisis all the way through to the transport and to get the person to the stabilization unit, and to cover the full array of crisis services which do include peers as well as essential providers within that network. And I think it is important on the Medicare side. It is also important on the commercial side.

So I think parity across Medicaid, Medicare, and commercial payers in this area—and your bill, I believe, does that, and we strongly support that.

Senator CORTEZ MASTO. And thank you. And I have to thank Senator Cornyn and his staff. They have been great partners on this legislation. Clearly, we need the parity, and we need the integration for this.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cortez Masto, and thank you for all your help in the CAHOOTS effort, particularly the focus on bringing together law enforcement and mental health folks. Your leadership on that was especially valuable.

All right; now we have Senator Hassan, our colleague from New Hampshire.

Senator HASSAN. Thank you so much, Mr. Chair, and thanks to you and the ranking member for holding this hearing, and thanks to all of our witnesses, not only for being here today, but for the work that you do.

Dr. Keller, I want to start with a question for you.

Too few individuals who have an opioid use disorder are receiving medication-assisted treatment, which is the gold standard for opioid use disorders. Access to treatment is limited by the requirement that providers obtain a special DEA waiver known as the X waiver in order to prescribe buprenorphine. Few providers have opted into this program, leaving even those patients who have insurance unable to access a provider in-network.

So how has the X waiver limited patient access to buprenorphine-prescribing providers?

Dr. KELLER. Well, Senator, thank you for this question, and thank you for your leadership on this issue.

Medication-assisted treatment is the single most effective thing we can do to not just improve treatment, but to save lives. Our modeling has shown that we could save almost every life if we were to extend it out. And the X waiver is the primary barrier to that because it creates additional hassles, that, by the way, those same providers do not have for the prescription of the opioids that caused the addiction. I would also add, though, that if we do not have primary care-based supports like Collaborative Care, primary care-based behavioral health, we will not have the workforce to help them, because it is hard to do MAT.

Senator HASSAN. I appreciate that. I think we are moving—the X waiver is one of the critical barriers, and that is why Senator Murkowski and I have a bipartisan Mainstreaming Addiction Treatment Act which would eliminate the X waiver. So I am going to continue to push for that. But to your point, we obviously need this to be part of an integrated and collaborative care model.

Mr. Williams, because of the pandemic, the Federal Government lifted restrictions on medication-assisted treatment, allowing patients to receive remote care and take home additional doses of medication. How did these flexibilities affect treatment outcomes during the pandemic? And what lessons should we take forward as we consider the future of tele-mental health?

Mr. WILLIAMS. Thank you for that question. We know MAT works. Numerous studies have shown us that. The COVID–19 pandemic gave us an opportunity to see how expanded flexibilities in telemedicine allowed individuals to be screened and put on treatment.

The DEA and SAMHSA also made it easier to initiate and maintain MAT, and that was a way that people were able to access services. We saw that substance use treatment facilities offering telehealth services jumped nearly 30 percent to 60 percent in 2020. For mental health facilities, the share grew from 38 percent to 69 percent.

So there is a real growth in using these tools to access MAT in a more effective way. It is very early to understand the impact of these flexibilities. But we have promising data actually from Texas that shows that telehealth-initiated therapy and the restrictions that were lifted increased the prescription fills for individuals.

So we have good data and evidence that is starting to show us that this may be a new way in which we can make MAT available to individuals. And I think there is a near-term opportunity to build on this progress to ensure that access is for as many people as possible in the field.

Senator HASSAN. Well, thank you for that. And I look forward to seeing us follow the data more and learn more.

Dr. Ratzliff, patients are more likely to receive mental health care when primary care physicians and behavioral health specialists work together under one roof. This care integration breaks down barriers to accessing treatment and improves health outcomes. And I have certainly heard from both primary care docs and patients about the strength of these programs.

What are the key design factors that make integrated care models work? And how can Congress better support those models?

Dr. RATZLIFF. Thank you for this question. I think there are a couple of key things.

The first is that I think we really need a model of how to work together. I think the Collaborative Care Model is a good example, but I would focus on a couple of the principles, because I think there have been questions about broader integrated care models.

I would say one of the foundational pieces that maybe we have not talked about as much is really measuring that the outcomes are actually achieved, and that that is a really important piece that we want to make sure is part of any model of integration; that patients are actually getting the kind of care that will result in meaningful change in their life. So that is a really important piece.

I think it is also important that there are payment mechanisms, and again I applaud Medicare for introducing a mechanism to support Collaborative Care. But that really acknowledged that there is a lot of work in care coordination, in supporting each other as providers, that is really critical to actually pay for. It is not the kind of care that we are used to paying for, where it was only direct services, but I think continuing to think about how to expand mechanisms for practices—you know, especially those that have accomplished good outcomes—to receive payment for that care that they are delivering is important.

Senator HASSAN. Well, thank you. Thank you for your work.

The CHAIRMAN. I thank my colleague for her good work on this. Our next two are going to be Senator Whitehouse and Senator Warren, and that will close the hearing.

Senator Whitehouse?

Senator WHITEHOUSE. Thanks so much, Mr. Chairman, and thanks for holding this conversation. I think it is really important.

Mental health parity has been on the books for years, since my friend and fellow Rhode Islander then, Patrick Kennedy, got the parity bill passed in a father-son team effort with my colleague here in the Senate, Ted Kennedy. And yet here we are, many years later still seeing continued failures in parity.

It strikes me that the enforcement mechanism is spread across multiple agencies, with the result that there is no clear accountability at the end of the day. And I am wondering if the witnesses have thoughts about how best to hold folks accountable for parity violations, whether that enforcement should be located in one place. And I will just note that had we been able to pass Build Back Better, and depending on what comes ahead, there was actually the prospect of civil monetary penalties for these longstanding violations.

I know that underneath it there is a staffing issue that needs to be resolved, but it seems to me that there is also a lack of pressure from the payers to get to where they should be by law.

Let me ask Dr. Ratzliff first.

Dr. RATZLIFF. Well, I do agree that we need to enforce parity. As a provider, I can see the impacts of not doing that. For specific policy recommendations, I think I would defer to my colleague, Dr. Keller.

Senator WHITEHOUSE. That is a hand-off to you, Dr. Keller.

Dr. KELLER. Thank you, Senator. Thank you, Dr. Ratzliff.

So we have to continue enforcement, but I do think that centralizing enforcement responsibility to DOL and both giving them the adequate staff resources and also adding civil penalties would be essential. And I take the point you raise that there has to be a point person on the regulatory side as well.

We found that—you know, we tried to do things in Texas back in 2017, and it is too fragmented. And really it does take, I think, the Federal effort through the Department of Labor to move that forward.

We would also argue, too, that amending ERISA to allow DOL to also directly go after the administrative services organizations, the TPAs, because it is not just the purchasers that should be responsible, the group health plans, but also their administrative entities, because a lot of that advice and guidance and lack of parity is coming from their actions.

Senator WHITEHOUSE. Thank you. If anybody else wants to chime in, I invite you to do that in a response—you know, I will make this a question for the record, and if anybody wishes to follow up in writing, that would be great.

But with 2 minutes left, I wanted to go to another question, which is that in the mental health arena, which is obviously a very broad one, there seem to be three areas where focus would be particularly useful and valuable right now.

One is on children's mental health, as we have seen children's mental health issues explode through COVID.

The second is in the area of addiction and recovery. As the author with Senator Portman of the CARA bill that first put invest-

ment into recovery, I think there is more room for progress in the addiction and recovery space.

And the third is in the area of police encounters with people who are having a mental health crisis of some kind, and how we provide support to police departments so that they can better manage those systems and have the resources that they know they can call on when they understand that that is part of the problem that they are going to address. Very often with these people, it is not the first time there was a call. The police officers are aware that there is a problem, but they just do not have the resources to address it.

So any thoughts on that, I would appreciate, and I guess I will go to Dr. Ratzliff and Dr. Keller first.

Dr. RATZLIFF. Thank you for this question. So I would say I think it is really important that we are thinking about all three of these populations of patients that are in acute need of mental health services. I guess I would go back to focusing on—I think we need immediate support, especially when you think of police encounters. It is important that that person who is meeting a patient out in the community is actually able to interact with them in a different way and actually bring them to treatment, not to incarceration.

I think, though, what you need then is a strong service to actually continue to provide access to care. And right now, the main place that they are going to do that, actually for all three of the issues that you raise, is primary care.

So I guess I will just come back to really that it is so important to invest in really building up that system to be able to deliver care, to be able to bring in a broad workforce to work together in that space, and to be able to provide adequate reimbursement for that coordination and support of treatment.

Senator WHITEHOUSE. My time has run out. So, if anybody else cares to answer, if you could do it in writing as a response to the question for the record, I think the chairman would appreciate me not going on.

[The question appears in the appendix.]

Senator WHITEHOUSE. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Whitehouse, for your good work.

Senator Warren?

Senator WARREN. Thank you, Mr. Chairman.

So in 2020, one in every five adults experienced mental illness. For substance use disorder, the figure was one in seven. And despite the critical need for mental health and substance use disorder services, few Americans get the treatment that they need. If you ask people experiencing mental illness if they got the help they needed, one in three say "no." And just under 10 percent of adults experiencing substance use disorder were able to access treatment.

Now there are a lot of factors that contribute to the degree of unmet behavioral health needs, but one of the most egregious is the way that insurance companies flout Federal laws requiring them to provide this care. And a big way that insurers restrict access to behavioral health care is by more aggressively subjecting these services to what are called non-quantitative treatment limitations, NQTLs. I know you are all familiar with these.

So, Dr. Ratzliff, let me start with you. You have seen this play out in your own practice. Can you explain how insurers use NQTLs to create barriers to behavioral health care? And what effect does this have on your patients?

Dr. RATZLIFF. Yes, I will talk specifically. I have mentioned this example, but I think one of the biggest factors that we have seen is actually having these ghost networks—I mean, really not being able to actually call off the list that you are given and find somebody that you can actually get care from. And this again, I think some people—you know, people are already struggling with depression and anxiety, so it is really hard to call multiple people over and over again and never get an answer or never get a response for treatment.

So I think that is one of the most egregious ways that I have seen that.

Senator WARREN. So, narrower provider networks, more and more phone calls that you have to make in order to get approval. And of course, the response, I assume, is that patients delay care, or give up altogether.

So we have known about this problem for a long time. This is not the first time this has come to our attention. And in 2020, Congress passed legislation to give Federal agencies enforcing our parity laws more tools to evaluate insurance companies' use of these practices.

Now, the law also required regulators to review at least 20 plans each year to assess for compliance. In a report released earlier this year, the Department of Labor, the Department of Health and Human Services, and Treasury stated that the specific plans selected for such review were chosen based on existing investigative leads or open investigations into reported violations.

So, Mr. Dicken, if I can, I want to ask you. You run the healthcare team at the Federal Government's watchdog unit, the Government Accountability Office, and you have looked into this issue.

If we are trying to understand if insurance companies are following Federal parity laws, does it make sense to look only at insurers that have received complaints?

Mr. DICKEN. Thank you, Senator Warren. No, we have raised concerns that by only focusing on either complaints or other targeted reviews of health plans, that that leaves risk that there could be other plans that are not known. There are a number of reasons why consumers may not be making complaints or be aware of the requirements.

Senator WARREN. Well, thank you. You know, I agree with you on this. I agree that we need to monitor all plans for compliance with our parity laws. You know, it is the same reason a teacher might give a pop quiz. Instead of just focusing on a handful of students who did not turn in their homework, you give it to the whole class to find out who is doing great, who is having a little trouble, and who is in big trouble. But you only get that if you are able to reach all the way across.

Now, Dr. Keller, we are not going to make insurance companies take pop quizzes, but we can do randomized audits. So how would requiring Federal enforcers to conduct randomized audits of plans

strengthen efforts to identify and eliminate unequal application of NQTLs?

Dr. KELLER. Well, I think you explained it actually quite well, because I think really these are across the board. And the sad reality is that every plan that has been reviewed so far has dramatic gaps.

So the only way we are going to be able to enforce across all those plans is if all of them know that there is a possibility, and also that they know that there is a significant possibility, of an audit. So I would argue we need to actually do more than 20. We need to also make sure that they are in-depth, and we need to expand the penalties aligned with them so that in addition to having the test, the test has consequences for the final grade.

Senator WARREN. I thank you very much for that answer. Just focusing on the parity violations, we know that these are dramatically under-reported. We cannot rely on complaints as the only signal that an insurer is breaking the law.

I believe in randomized audits. And that is why I will be reintroducing my Behavioral Health Coverage Transparency Act to require Federal enforcement agencies to conduct randomized audits of plans, and at the same time to simplify the complaint process, which makes it easier for patients to report parity violations.

Health care, including behavioral health care, is a human right, and we must ensure that Americans do not face additional barriers to getting the often lifesaving care that they need.

So, thank you all for your work. I very much appreciate it. I know your patients appreciate it. And thank you for being with us today. Thank you.

The CHAIRMAN. Thank you very much, Senator Warren.

And to our guests, how fitting that we close 2½ hours in, after we have focused on ghost networks, with Senator Warren basically offering the second side of the same coin. Ghost networks and treatment limits are the same thing, and this is going to be a debate now about taking on these big insurers and finally getting this fixed.

And for me—and we will excuse you very shortly—the kind of two relevant dates were my brother passing in 2002, and he struggled with schizophrenia for years and years, and essentially his internal organs gave out as a result of all of the medicines, the pounding that so many were taking then. You have heard that every night for years on end, we would worry that he would hurt himself or somebody else who was on the streets.

And then the next big date was 2008 when Paul Wellstone and Pete Domenici, two people who did not see eye to eye on everything—we thought this is it, liberation. People are going to get a fair shake. Mental health and physical health will get treated the same. And I remember my dad and I looking at the newspaper that morning, Senator Warren, and I said, "Good for Paul. Good for Pete Domenici." I was a member of the Senate then, and I said, "This is for Jeff. This is one that is really going to really liberate a lot of people."

And here we are 13 years later, fighting the same problems. The GAO folks told us 2½ hours ago that there are these ghost networks. Well, we can walk through the ghost network, but when you are shoved into a ghost network by an insurance company, you are

not going to be able to get a provider. You are not going to be able to get someone to take your insurance. You are often not getting an accurate directory. So you do not even know who in the hell to call. And then the reimbursement levels are so low that the patient very often gets stuck with the bill.

So we are going to be pushing back on all fronts here. We closed it with another good suggestion from Senator Warren. We have had colleagues raise additional ideas for enforcement. But I want you to know—and, Dr. Ratzliff, your roots in the Pacific Northwest are particularly helpful because Senator Cantwell is going to be a leader in this.

This is the time when we are finally going to take on these big insurance companies, and we are not going to accept the excuses, the stonewalling, and what I saw in Portland, OR, where our premiere institution basically could not even get claims paid until their Senator raised a ruckus in the newspaper, and then all of a sudden, Senator Warren, all the claims got paid.

So we have been fed a lot of baloney about this, and for those who missed it, I particularly focused on the insurance executive who said, "Gee, we're just starting to learn more about this. It's going to take more time to get comfortable with it."

Well, my message to them is, time has run out. Time has run out. We have heard from Senators on both sides of the aisle. There is a commitment to getting it fixed.

So for 2½ hours you gave us a roadmap on how to do it. We thank you. We are going to be calling on you often in the days ahead.

And with that, the Finance Committee is adjourned.

[Whereupon, at 12:32 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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

Thank you, Mr. Chairman, and thank you to our witnesses, some of whom have come from across the country to testify before the committee today.

We have heard from providers across the continuum of care, government officials, and policy experts who have shared a range of thoughtful perspectives and recommendations. This is the fourth mental health hearing that the committee has held this Congress. Despite diverse viewpoints on some policy questions, all have agreed on the profound importance of ensuring all Americans have access to high-quality mental health-care services.

Our country has experienced a challenging couple of years. Even as hospitalizations and deaths caused by COVID–19 continue to decline and stabilize in the United States, the pandemic will have lasting impacts on the Nation's mental health. Lockdowns, school closures, and other government restrictions led to social isolation, new and worsened cases of depression, and widespread anxiety. For many, the pandemic also resulted in tragic personal losses, worsening these and other mental health conditions.

I have also heard from health-care providers across Idaho, where the stress and uncertainty of the pandemic have further exacerbated professional burnout. Onerous regulatory burdens have caused many physicians and allied health professionals to retire early or reduce their hours. The resulting workforce shortage makes it more challenging for patients to access the mental health services they need.

Studies have found that the prevalence of mental health illness is similar between rural and urban areas. Individuals living in rural and frontier areas often face significant barriers in accessing needed mental health services closer to home. On average, rural residents have to travel farther to receive services, and providers are less likely to practice in these communities.

While the pandemic has increased the pervasiveness of mental health concerns, it has also led to innovative solutions that address these challenges, such as the expansion of telehealth services. Telehealth expands access in underserved rural areas, improves care coordination and integration, and provides more privacy to patients to combat stigma.

While there is no easy solution, I am committed to working alongside my colleagues to tackle these challenges in a bipartisan and fiscally responsible way. We cannot simply throw more money at the problem and expect it to solve everything. Instead, we must focus on developing data-driven, innovative, and creative solutions to address these challenges.

I look forward to hearing from today's panel on their ideas to ensure that Americans in need can access timely, high-quality mental health-care services.

PREPARED STATEMENT OF JOHN E. DICKEN, DIRECTOR,
HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

MENTAL HEALTH CARE: CONSUMERS WITH COVERAGE FACE ACCESS CHALLENGES

Chairman Wyden, Ranking Member Crapo, and members of the committee, I am pleased to be here today as you examine issues related to consumer access to behavioral health services. Behavioral health conditions—which include mental health and substance use disorders—affect millions of people in the United States.[1] Additionally, the effects of the COVID–19 pandemic and related economic crisis—such as increased social isolation, stress, and unemployment—have intensified concerns that behavioral health conditions have affected even more people.

We have issued several recent reports addressing various aspects of behavioral health care in the United States. They include three reports issued since the onset of the COVID–19 pandemic that examined, among other things, ways that the pandemic affected behavioral health care.[2] Prior to the pandemic, we issued a report focused on State and Federal oversight of behavioral health parity requirements defined in law.[3] In general, Federal law requires that when certain health plans offer coverage for medical and surgical treatment as well as mental health or substance use disorder treatment, the coverage for mental health and substance use disorder treatment may be no more restrictive than coverage for medical or surgical treatment.[4]

Today we are releasing a report entitled *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts.*[5] As the title indicates, this report focuses on consumers who have coverage for mental health care and the challenges they encounter despite having that coverage. There have been longstanding concerns in the U.S. about the accessibility of mental health services for these consumers. Although approximately 91 percent of the U.S. population is covered by public or private health plans, having such coverage does not guarantee access to mental health services. For example, a 2021 report by Mental Health America (a nonprofit advocacy and research group) estimated that 54 percent of consumers covered by a health plan did not receive the mental health treatment they needed—indicating that ensuring coverage is not the same as ensuring access to mental health care.[6]

My testimony today summarizes the findings from the report released today. Accordingly, my testimony discusses:

1. Challenges that consumers with coverage for mental health services may experience accessing these services; and
2. Ongoing and planned Federal efforts to address these challenges.

For this report we interviewed Federal officials from the Departments of Health and Human Services (HHS) and the Department of Labor (DOL), which share responsibilities for overseeing compliance with mental health parity laws. We also interviewed representatives from 29 stakeholder organizations representing consumers, health plans, providers, insurance regulators, and mental health and Med-

[1] For example, in 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that nearly 74 million adults in the U.S. (29 percent) were reported to have either a mental illness or a substance use disorder. *See* Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results From the 2020 National Survey on Drug Use and Health* (Rockville, MD: October 2021).

[2] *See* GAO, *Behavioral Health and COVID–19: Higher-Risk Populations and Related Federal Relief Funding,* GAO–22–104437 (Washington, DC: December 10, 2021); *Behavioral Health: Patient Access, Provider Claims Payment, and Effect of COVID–19 Pandemic,* GAO–21–437R (Washington, DC: March 31, 2021); and *COVID–19: Urgent Actions Needed to Better Ensure an Effective Federal Response,* GAO–21–191 (Washington, DC: November 30, 2020).

[3] *See* GAO, *Mental Health and Substance Use: State and Federal Oversight of Compliance With Parity Requirements Varies,* GAO–20–150 (Washington, DC: December 13, 2019).

[4] *See* the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110–343, div. C, tit. V, sub. B, §§ 511–12, 122 Stat. 3765, 3881–93 (October 3, 2008). MHPAEA was enacted in 2008 to help address discrepancies in healthcare coverage between mental illnesses and physical illnesses. MHPAEA both strengthened and broadened Federal parity requirements established by the Mental Health Parity Act of 1996, including extending parity to cover the treatment of substance use disorders.

[5] *See* GAO, *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts,* GAO–22–104597 (Washington, DC: March 29, 2022).

[6] M. Reinert, D. Fritze, and T. Nguyen, *The State of Mental Health in America 2022* (Alexandria, VA: Mental Health America, 2021).

icaid agencies.[7] These included national organizations and organizations from four states—Connecticut, Oregon, South Carolina, and Wisconsin—selected based on mental health metrics and geographic variation, among other factors. GAO also reviewed relevant reports obtained from these agencies and organizations and reviewed academic and industry research focused on consumer access to mental health care. More detailed information on our objectives, scope, and methodology can be found in the issued report. Our work was performed in accordance with generally accepted government auditing standards.

CHALLENGES FINDING IN-NETWORK PROVIDERS AND NAVIGATING PLAN DETAILS

In our March 2022 report, we found that consumers experience a variety of challenges accessing mental health benefits provided under their health plans. Some of the challenges occur because of limited access to in-network providers or broader structural issues in the mental health system that make it difficult to access affordable mental health care or certain types of mental health care in a timely manner. Other challenges occur because of processes used by health plans to approve mental health treatment or limitations in services and treatments covered by some health plans—these can delay or limit the course of treatments or make treatments unavailable for certain consumers.

Limited Access to In-Network Providers and Broader Structural Issues

Stakeholders we interviewed told us that limited access to in-network providers can result in consumers seeking care from out-of-network providers, typically resulting in higher costs for the consumer, possible delays in receiving care, or difficulties in finding a provider close to home. Most of the stakeholders we interviewed told us that one factor contributing to this challenge is low reimbursement rates for mental health service providers, which many said can reduce providers' willingness to join plan networks. This point was also supported by reports and research we reviewed.[8] The ability to develop a provider network is also exacerbated by an overall shortage in the mental health workforce. This shortage limits the pool of providers who could join a network and may give existing providers leverage to opt out of networks and receive higher rates for their services than those offered by the plans.

Another challenge for consumers' ability to find in-network providers is inaccurate information in health plans' provider directories. Many stakeholder organizations said that inaccurate directories could create what they referred to as a "ghost network"—in other words, providers who are listed in a directory as participating in the network, but who are either not taking new patients or are not actually in a patient's network. For example, recent studies that evaluated consumers' use of provider directories to schedule outpatient appointments with psychiatrists found that inaccurate or out-of-date information complicated consumers' ability to obtain care.[9]

Representatives from most of the stakeholder organizations we interviewed also identified structural challenges that limit the overall capacity of the mental health system as affecting covered consumers' access to care, and literature we reviewed examined some of these issues.[10] For example, some of the stakeholders noted that the mental health workforce shortage makes it difficult to keep up with the demand for mental health services. Similarly, a shortage of available inpatient treatment

[7] In reporting our findings based on the testimonial evidence collected from the 29 stakeholder organizations, we generally indicate the numbers of organizations that identified specific challenges using indefinite quantifiers as defined in the issued report.

[8] For example, one study that examined provider participation in networks for plans sold on State marketplaces created by the Patient Protection and Affordable Care Act found that only 21.4 percent of mental health-care providers participated in the networks compared to 45.6 percent of primary care providers. The researchers noted that relatively low reimbursement rates for mental health care could be one factor contributing to these differences. *See* J.M. Zhu, Y. Zhang, and D. Polsky, "Networks in ACA Marketplaces Are Narrower for Mental Health Care Than for Primary Care," *Health Affairs,* vol. 36, no. 9 (2017).

[9] *See* M. Malowney, S. Keltz, D. Fischer, and J. Boyd, "Availability of Outpatient Care From Psychiatrists: A Simulated-Patient Study in Three U.S. Cities," *Psychiatric Services,* vol. 66, no.1 (2015): 94–96; S. Cama et al., "Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities," *International Journal of Health Services,* vol. 47, no. 4 (2017): 621–635; and M. Scheeringa, A. Singer, T. Mai, and D. Miron, "Access to Medicaid Providers: Availability of Mental Health Services for Children and Adolescents in Child Welfare in Louisiana," *Journal of Public Child Welfare,* vol. 14, no. 2 (2020): 161–173.

[10] For example, *see,* Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers* (2017), and University of Wisconsin, Population Health Institute, *2019 Wisconsin Behavioral Health Systems GAPs Report* (Madison, WI: Prepared for the Wisconsin Department of Health Services, 2020).

beds limits consumers' access to the treatment they need. Some attributed this shortage to increased demand for services, budget cuts, or staffing issues—in some cases related to the COVID–19 pandemic. In addition, representatives from many of the stakeholder organizations told us that a shortage of intermediate care options, such as residential treatment facilities or intensive outpatient programs, has created challenges for consumers in getting intermediate levels of care.[11]

Representatives from several stakeholder organizations also told us that the lack of access to broadband Internet services, particularly in rural areas, can limit consumers' ability to use telehealth for mental health services. This may make it more difficult to access mental health services, particularly when in-person treatment is unavailable, such as during periods of social distancing during the COVID–19 pandemic or when consumers have to travel long distances to see a provider. Despite broadband Internet limitations in some areas, representatives from most stakeholder organizations we interviewed indicated that enhanced use of telehealth during the pandemic generally helped improve access to mental health care.

Plans' Administrative Approval Processes and Coverage Limitations

Stakeholders we interviewed reported that the need to obtain health plans' approval for certain mental health services, as well as other coverage limitations, can adversely affect access to mental health care. Taken together, these challenges can delay or limit the course of treatments or, in some cases, make treatments unavailable for certain consumers.

Representatives from many stakeholder organizations we interviewed specifically cited non-quantitative treatment limitations (NQTL) used by health plans—such as the need for obtaining prior authorizations—as creating delays in accessing needed treatments or limiting time spent in treatment. For example, representatives from one health system reported that some health plans are less likely to grant prior authorization for mental health hospital stays compared with medical and surgical hospital stays. Some also said plans' processes for determining whether continuing a treatment is medically necessary can limit the duration of a consumer's treatment, even if the provider does not agree that the patient is ready for discharge. In some cases, stakeholders said that health plans are applying these limits to consumers' mental health benefits in more restrictive ways than to medical and surgical benefits, which highlights ongoing mental health parity issues. Some of the reports we reviewed also identified the use of NQTLs by health plans that did not comply with mental health parity standards as presenting a potential challenge to consumers in accessing mental health care.[12]

Representatives from several of the stakeholder organizations also told us that variation in the use of treatment standards can affect covered consumers' access to mental health care. Currently, there is no agreed-upon set of standards used in the U.S. to make mental health treatment decisions. The stakeholder representatives indicated that, absent such standards, it can be difficult for providers and health plans to agree on the treatment a patient may need, and some said health plans may limit a consumer's treatment options. For example, representatives from one provider told us they often feel pressured by health plans to move patients out of hospital-based services to less intensive outpatient treatment. Representatives from another provider said health plans will stop coverage of a suicidal patient's treatments once the patient is stable, even though a provider believes the patient needs continuing care.[13]

Regarding coverage limitations and restrictions, representatives from several stakeholder organizations and reports and research we reviewed identified challenges accessing mental health care faced by consumers with certain forms of coverage. For example, representatives from many of the stakeholder organizations

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[11] Intermediate levels of care are less intensive than inpatient care but more intensive than routine outpatient care, and may consist of acute residential treatment, partial hospitalization programs, intensive outpatient programs, and family stabilization services. Residential treatment programs may offer long-term mental health care in a structured, homelike setting, where the patient stays for the duration of the treatment. Intensive outpatient programs provide weekday treatments under which patients can return home each evening.

[12] For example, *see,* J. Volk et al., *Equal Treatment: A Review of Mental Health Parity Enforcement in California* (California Health Care Foundation, 2020). The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the healthcare delivery system provides care to the people of California.

[13] The issues surrounding a lack of uniform standards of care, and how that can affect treatment decisions for mental health care, have been litigated in Federal court. *See Wit v. United Behavioral Health,* No. 14–cv–02346–JCS, 2019 WL 1033730 (N.D. Cal. 2019).

contended that the scope of mental health services covered by Medicare and commercial plans is generally more limited than Medicaid. As a result, consumers with Medicare or commercial coverage may not have access to the range of mental health services available to consumers with Medicaid. Many stakeholder organizations cited Medicaid's coverage of crisis care and peer support as examples where the services were more comprehensive than Medicare and commercial coverage.[14]

Stakeholder representatives also cited challenges consumers face related to statutory coverage restrictions on federally funded programs, such as Medicare. For example, some told us that Medicare restrictions on the types of providers eligible for reimbursement, including Licensed Professional Counselors and Licensed Marriage and Family Therapists, affect access to mental health services for Medicare enrollees by limiting the pool of accessible providers. In addition, some stakeholders we spoke with highlighted the fact that Medicare has a lifetime limit for enrollees of 190 days of inpatient care in psychiatric hospitals. These stakeholders said that this limit creates barriers and disruptions to care for people with serious mental illnesses who may need more inpatient care.

RELATED FEDERAL EFFORTS MAY ADDRESS ASPECTS OF MENTAL HEALTH ACCESS CHALLENGES

Based on our interviews with agency officials and reviews of agency documentation, we identified various ongoing or planned Federal efforts to address some of the challenges consumers with coverage may experience accessing mental health care. These efforts aim to address challenges related to finding in-network providers, broader structural issues, and health plan administrative approval processes.

Addressing Limited Access to In-Network Providers. DOL and HHS are taking steps to ensure access to in-network mental health providers. For example:

- HHS's Center for Medicare and Medicaid Services requires Medicare Advantage plans to meet a number of network adequacy criteria, such as requirements for plans to demonstrate that their networks do not unduly burden beneficiaries in terms of travel time and distance to network providers or facilities, including inpatient psychiatric facility services and psychiatric services.
- DOL and HHS are implementing requirements for certain health plans to update and maintain provider directories.
- The Health Resources and Services Administration within HHS manages several programs that provide funding intended to increase the mental health workforce.

Addressing Broader Structural Issues. The Substance Abuse and Mental Health Services Administration (SAMHSA) within HHS manages several programs aimed at addressing structural issues that contribute to a lack of capacity in the mental health system. For example:

- Funding 12 grants designed to establish or expand Assertive Community Treatment programs to deliver a mix of individualized, recovery-oriented services to persons living with serious mental illness to help them successfully integrate into the community.
- Overseeing the Certified Community Behavioral Health Clinics expansion grant program. These clinics provide comprehensive, integrated mental health services, such as crisis mental health services and primary care screening and monitoring.

Addressing Issues with Health Plan Administrative Approval Processes. DOL and HHS are taking steps to enhance their oversight of the use of NQTLs by health plans—such as requirements for prior authorization—as part of their broader responsibilities to oversee compliance with mental health parity laws. These steps are being taken, in part, to meet requirements specified in the Consolidated Appro-

[14] According to SAMHSA, crisis services may include crisis telephone lines dispatching support based on the caller's assessed need, mobile crisis teams dispatched to the community where there is a need (*i.e.,* not in a hospital emergency department), and crisis receiving and stabilization facilities that serve patients from all referral services. SAMHSA also defines peer support services as a range of recovery activities and interactions outside of the clinical setting between people who have shared lived experiences with a mental illness. For more information, *see* Substance Abuse and Mental Health Services Administration, *Crisis Service Meeting Needs, Saving Lives: National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit* (Rockville, MD: August 2020) and *Who Are Peer Workers?* (Rockville, MD, September 2021).

priations Act, 2021, which requires group health plans that cover both medical and surgical and mental health and substance use disorder benefits to perform and document comparative analyses of the design and application of NQTLs.[15]

Mr. Chairman and members of the committee, this concludes my prepared statement. I would be pleased to respond to any questions that you or other members of the committee may have at this time.

For future contacts regarding this statement, please contact John E. Dicken at (202) 512–7114 or at dickenj@gao.gov.

QUESTIONS SUBMITTED FOR THE RECORD TO JOHN E. DICKEN

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

HEALTH SERVICES IN SCHOOLS

Question. It is clear that COVID–19 has significantly exacerbated mental health stress on children and youth, highlighting the Nation's acute shortage of mental health services. In my State of Delaware, over 9,000 Delawareans ages 12 through 17 suffer from some sort of depression. However, according to the State, students who have access to mental health resources within schools are 10 times more likely to seek care.

Earlier this year, the Finance Committee heard testimony from the U.S. Surgeon General who stressed that one of the most central tenets in creating accessible and equitable systems of care is to meet people where they are. For most young people, that's right there in schools. And just last week, Secretary of Health and Human Services Xavier Becerra and Secretary of Education Miguel Cardona announced a joint-department effort to expand school-based health services.

It is clear there is growing momentum to recognize the role schools already play in ensuring children have the health services and supports necessary to build resilience and thrive. We know that investing in school and community-based programs has been shown to improve mental health and emotional well-being of children at low cost and high benefit.

How can we improve coordination between primary care and mental health providers to better support our children, including through school-based services?

Do you see a role for the Federal Government beyond providing guidance and technical assistance to State programs?

Answer. While our work did not specifically address issues regarding coordination between primary care and mental health care for children, our work did identify challenges children have in accessing mental health services. For example, in our recent report, we cited research that examined children's access to specialists that found that the percentage of psychiatrists that did not accept public or private insurance was greater than that of other specialties, such as dermatology or neurology. We also reported on mental health workforce shortages, including shortages of available child psychiatrists. For example, a representative from one hospital system we contacted noted they are having trouble finding child psychiatrists and are trying to find contracted care to meet the mental health needs of children.

Regarding coordination between primary care and mental health providers more broadly, and the role of the Federal Government in that regard, in our report, we noted one Federal program that helps community providers deliver integrated care, and thus goes beyond providing guidance and technical assistance. Specifically, we noted that the Substance Abuse and Mental Health Services Administration currently oversees the Certified Community Behavioral Health Clinics (CCBHC) expansion grant program. CCBHCs provide comprehensive, integrated mental health services to individuals in need and receive an enhanced Medicaid reimbursement rate in order to cover the cost of expanding resources to serve clients with complex needs. CCBHCs provide or contract nine types of services, including 24 hours a day, 7 days a week crisis care, evidence-based practices in the treatment of mental and substance abuse disorders, and coordinated care between primary care, hospital facilities, and physical health integration. Under this program, services are also provided to children and adolescents with serious emotional disturbance, thus this pro-

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[15] Pub. L. 116–260, § 203, 134 Stat. at 2900 (2020).

gram has the potential to better support integration of mental health services for children.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

INCREASING ACCESS TO MENTAL HEALTH PROVIDERS IN MEDICARE

Question. As a doctor, I know the importance of improving access to mental health care for all Americans. This is especially important in rural parts of the country, which face some of the largest shortages in the country.

For seniors, finding a mental health provider can be particularly challenging. This is because Medicare restricts certain types of mental health providers from billing the program.

As you noted on page 7 of your testimony, you were told by stakeholders that "Medicare restrictions on the types of providers eligible for reimbursement, including licensed professional counselors and marriage and family therapists, affect access to mental health services for Medicare enrollees by limiting the pool of accessible providers."

Senator Stabenow and I introduced bipartisan legislation to address this issue. S. 828, the Mental Health Access Improvement Act would allow licensed professional counselors and marriage and family therapists to bill Medicare.

This is especially important in Wyoming, where many of our community mental health centers rely on professional counselors and marriage and family therapists to provide care.

Can you please discuss the impact of allowing licensed professional counselors and marriage and family therapists to provide care for Medicare patients?

Answer. Allowing Licensed Professional Counselors and Licensed Marriage and Family Therapists to be eligible for Medicare coverage and payment may expand the pool of accessible providers. According to the Centers for Medicare and Medicaid Services, there is no separately enumerated benefit category under Medicare that provides coverage and payment for the services of licensed professional counselors. As stated in the testimony, some stakeholders told us that Medicare restrictions on the types of providers eligible for reimbursement, including Licensed Professional Counselors and Licensed Marriage and Family Therapists, affects access to mental health services by limiting the pool of accessible providers. For example, representatives from one health system told us that, of the 22 licensed therapists on staff, only three were the types of licensed providers that are eligible for Medicare reimbursement. The representatives said this limitation exacerbated their current capacity issues, as they had over 1,700 patients on a waiting list to see an outpatient provider. As we reported earlier this year, another governmental program—the Veterans Health Administration—has expanded the types of mental health professionals available to veterans, and since 2010, has made an effort to increase its hiring of licensed professional counselors and marriage and family therapists.[1]

TELEHEALTH

Question. Patients in Wyoming are using telehealth to help meet their health-care needs during the pandemic. Members of this committee support making sure telehealth becomes a permanent part of health-care delivery for those patients who want to utilize this service.

Congress, with bipartisan support, has already taken steps to extend telehealth flexibilities for five months following the expiration of the public health emergency.

Can you discuss the importance of telehealth in terms of the delivery of mental health services?

Answer. Reports we reviewed indicated that access to telehealth may improve patient outcomes, and representatives from most stakeholder organizations we interviewed highlighted positive examples of the use of this care during the COVID–19 pandemic. For example, some representatives said that, while demand for mental health services greatly increased during the pandemic, their ability to provide outpatient mental health services through telehealth was a key tool in meeting this in-

[1] *See* GAO, *Veterans Health Care: Efforts to Hire Licensed Professional Mental Health Counselors and Marriage and Family Therapists,* GAO–22–104696 (Washington, DC: March 28, 2022).

creased demand. In addition, some representatives described benefits from telehealth such as patients not having to travel to an in-person appointment during the pandemic and a reduction in appointment no-shows. However, stakeholders from several organizations we interviewed told us the lack of access to broadband, particularly in rural areas, can limit consumers' ability to use telehealth for mental health services.

PREPARED STATEMENT OF ANDY KELLER, PH.D., PRESIDENT AND CEO, AND LINDA PERRYMAN EVANS PRESIDENTIAL CHAIR, MEADOWS MENTAL HEALTH POLICY INSTITUTE

Chair Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for the opportunity to testify today regarding two issues that are integral to the effective treatment of behavioral health disorders: enforcement of behavioral health parity and the integration of behavioral and physical health treatment.

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

AMERICA'S BEHAVIORAL HEALTH IS WORSE THAN EVER, DESPITE DECADES OF BIPARTISAN CONSENSUS ON THE NEED FOR PARITY

America has long faced a behavioral health crisis, one that has been greatly exacerbated by the COVID–19 pandemic:

- While overall rates of death from suicide dropped slightly in the last 2 years after nearly 2 decades of increase,[2] deaths from suicide continued to increase for Black, indigenous, and Hispanic subgroups.[3] Suicide is now the fourth leading cause of life-years lost,[4] resulting in nearly $70 billion per year in medical costs and lost productivity.[5]
- Overdose deaths continue to rise, reaching an all-time high in 2020 of nearly 92,000 deaths, with rates of overdose deaths climbing a staggering 31 percent from 2019 to 2020.[6]
- Underlying indicators of depression increased fourfold during the pandemic, affecting nearly one-third of Americans.[7] Rates are currently three times higher than baseline.[8]

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

[2] Garnett, M.F., Curtin, S.C., and Stone, D.M. Suicide mortality in the United States, 2000–2020. *National Center for Health Statistics Data Brief, 433.* Hyattsville, MD: National Center for Health Statistics, 2022. *https://www.cdc.gov/nchs/data/databriefs/db433.pdf.*

[3] Curtin, S.C., Hedegaard, H., and Ahmad, F.B. Provisional numbers and rates of suicide by month and demographic characteristics: United States, 2020. *Vital Statistics Rapid Release, 16.* Hyattsville, MD: National Center for Health Statistics, 2021. *https://www.cdc.gov/nchs/data/vsrr/VSRR016.pdf.*

[4] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) Years of Potential Life Lost (YPLL) [online] (2020). *https://www.cdc.gov/injury/wisqars/fatal_help/ypll.html.*

[5] Centers for Disease Control and Prevention. (2021, April). Preventing suicide [fact sheet]. *https://www.cdc.gov/suicide/pdf/preventing-suicide-factsheet-2021-508.pdf*.

[6] Hedegaard, H., Miniño, A.M., Spencer, M.R., Warner, M. Drug overdose deaths in the United States, 1999–2020. *National Center for Health Statistics Data Brief, 428.* Hyattsville, MD: National Center for Health Statistics, 2021. *https://www.cdc.gov/nchs/data/databriefs/db428.pdf.*

[7] Santomauro, D.F. et al. (2021). Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID–19 pandemic. *The Lancet,* 398(10312), 1700–1712. *https://doi.org/10.1016/S0140-6736(21)02143-7.*

[8] National Center for Health Statistics. (2022, March 14). *Anxiety and Depression* (Household Pulse Survey). Centers for Disease Control and Prevention. *https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.*

- In late 2021, the U.S. Surgeon General issued America's first ever public health advisory focused on mental health for the Nation's youth.[9] The proportion of youth emergency department visits for mental health needs increased by almost one-third during the COVID–19 pandemic,[10] and by summer 2021 the rate of pediatric emergency room visits for suicide was double pre-pandemic levels.[11]

These consequences fall hardest on Black, Indigenous, Hispanic, and other people of color, who generally receive inequitable and less culturally responsive care, with access to care often frustrated by language and cultural barriers, treatment inaccessibility, and premature care termination.[12] The burden of racism adds yet another insidious and toxic stress that increases risks of poor health for a range of health outcomes, including mental illness and addiction.[13] The COVID–19 pandemic exacerbated these effects, with Black and Hispanic adults more likely to report symptoms of anxiety and depression.[14] People of color have also disproportionately shouldered the burden of negative financial impacts [15, 16, 17] and of grief—a primary driver of mental illness and addiction.[18, 19, 20] The pandemic resulted in the loss of at least 140,000 primary caregivers,[21] with disproportionate losses among American Indian, Black, and Hispanic children.

BEHAVIORAL HEALTH SPENDING HAS CONSISTENTLY FAILED TO KEEP UP WITH NEEDS

The simplest explanation for these consistently worsening behavioral health indicators is that we have dramatically cut spending on behavioral health over the last

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[9] The U.S. Surgeon General's Advisory. (2021). *Protecting youth mental health, https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.*

[10] Leeb, R.T., Bitsko, R.H., Radhakrishnan, L., Martinez, P., Njai, R., and Holland, K.M. (2020). Mental Health-Related Emergency Department Visits Among Children Aged 18 Years During the COVID–19 Pandemic—United States, January 1–October 17, 2020. *MMWR. Morbidity and Mortality Weekly Report,* 69. *https://doi.org/10.15585/mmwr.mm6945a3.*

[11] Yard et al. (2021, June 18). Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID–19 Pandemic—United States, January 2019–May 2021. *Morbidity and Mortality Weekly Report,* U.S. Department of Health and Human Services/Centers for Disease Control and Prevention, 70(24), 888–894. *https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7024e1-H.pdf.*

[12] Substance Abuse and Mental Health Services Administration. (2020). *Double Jeopardy: COVID–19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. (Submitted by OBHE)* (p. 5). *https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf.*

[13] Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., and Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLOS ONE, 10*(9), e0138511. *https://doi.org/10.1371/journal.pone.0138511.*

[14] Vahratian, A., Blumberg, S.J., Terlizzi, E.P., and Schiller, J.S. (2021). Symptoms of anxiety or depressive disorder and use of mental health care among adults during the COVID–19 pandemic—United States, August 2020–February 2021. *MMWR. Morbidity and Mortality Weekly Report,* 70(13), 490–494. *https://doi.org/10.15585/mmwr.mm7013e2.*

[15] Centers for Disease Control and Prevention. (2021). *Health equity considerations and racial and ethnic minority groups,* CDC. *https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.*

[16] Parker, K., Menasce Horowitz, J., and Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID–19, Pew Research Center. *https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/.*

[17] Fairlie, R. (2020). *COVID–19, Small Business Owners, and Racial Inequality.* National Bureau of Economic Research. *https://www.nber.org/reporter/2020number4/covid-19-small-business-owners-and-racial-inequality.*

[18] Kaplow, J.B., Saunders, J., Angold, A., and Costello, E.J. (2010). Psychiatric symptoms in bereaved versus non-bereaved youth and young adults: A longitudinal, epidemiological study, *Journal of the American Academy of Child and Adolescent Psychiatry,* 49, 1145–1154. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2965565/.*

[19] Keyes, K.M., Pratt, C., Galea, S., McLaughlin, K.A., Koenen, K.C., and Shear, M.K. (2014). The Burden of Loss: Unexpected Death of a Loved One and Psychiatric Disorders Across the Life Course in a National Study, *American Journal of Psychiatry,* 171(8), 864–871. *https://doi.org/10.1176/appi.ajp.2014.13081132.*

[20] Verdery, A.M., Smith-Greenaway, E., Margolis, R., and Daw, J. (2020). Tracking the reach of COVID–19 kin loss with a bereavement multiplier applied to the United States. *Proceedings of the National Academy of Sciences of the United States of America,* 117(30), 17695–17701. *https://doi.org/10.1073/pnas.2007476117.*

[21] Hillis, S.D., Blenkinsop, A., Villaveces, A., Annor, F.B., Liburd, L., Massetti, G.M., Demissie, Z., Mercy, J.A., Nelson III, C.A., Cluver, L., Flaxman, S., Sherr, L., Donnelly, C.A., Ratmann, O., and Unwin, H.J.T. (2021). COVID–19—Associated Orphanhood and Caregiver Death in the United States. *Pediatrics,* 148(6), e2021053760. *https://doi.org/10.1542/peds.2021-053760.*

40 years.[22] In 1986, behavioral health represented 9.3 percent of all medical spending. But a host of policy decisions, including the shift among insurers to manage behavioral health as a cost-center separate from other health conditions, led to extensive spending reductions. By 1998, behavioral health spending had been reduced by at least 20 percent more than other health-care spending, to just 7.4 percent of all medical spending, and these decreased spending levels held constant going forward.

The budget of the Substance Abuse and Mental Health Services Administration (SAMHSA) is also illustrative. Between FY 2007 and FY 2017, SAMHSA's budget hovered between $3.2 billion and $3.6 billion a year. Since then, recognition of the unprecedented surge in substance use disorders and mental health needs has driven Federal and State spending upwards. The FY 2022 SAMHSA budget is nearly $6 billion higher—an exponential increase in funding in 5 years.

However, nearly 4 decades of services erosion cannot be fixed overnight, and to offset the trajectory we are on, we will need both the public and private sectors as part of the solution.

BEHAVIORAL HEALTH PARITY IS A LONGSTANDING AND ONGOING CONCERN

It has been more than 25 years since President Bill Clinton signed the Mental Health Parity Act, providing the first parity protections for people with mental health conditions. And it was almost exactly 20 years ago that President George W. Bush's New Freedom Commission on Mental Health called out "the unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance."[23] Those efforts culminated with the passage of the groundbreaking Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act (MHPAEA) in 2008. President Barack Obama expanded these protections across all private payers in 2010 with the Affordable Care Act.

Unfortunately, despite attention from Congress and presidential administrations for decades, parity implementation gaps persist, with millions of Americans unable to access needed behavioral health services. A 2019 Milliman research report detailed widespread network adequacy and reimbursement parity concerns for commercially insured consumers:[24]

- Commercially insured individuals were between five and six times more likely to use out-of-network providers for their behavioral health needs than for other health care.
- Primary care reimbursements were 19.8 to 28.3 percent higher than behavioral health reimbursements, and medical/surgical specialty visits were 17.0 to 18.9 percent higher.

And in January of this year, the Department of Labor (DOL), Department of Health and Human Services (HHS), and the Treasury released *The Report to Congress on Implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.*[25] In what the three departments termed "a failure to deliver parity," the report found broad non-compliance with MHPAEA's requirements among health insurance plans, with all 58 plans reviewed failing to meet requirements. Specific alarms were raised regarding the use of non-quantitative treatment limitations (NQTLs),[26] which are non-numerical limits on the scope or duration of benefits for treatment (such as pre-authorization require-

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[22] Mark, T.L., Yee, T., Levit, K.R., Camacho-Cook, J., Cutler, E., and Carroll, C.D. (2016). Insurance financing increased for mental health conditions but not for substance use disorders, 1986–2014. *Health Affairs,* 35(6), 958–965. *https://doi.org/10.1377/hlthaff.2016.0002.*

[23] President's New Freedom Commission on Mental Health. (n.d.). *Achieving the Promise: Transforming Mental Health Care in America.* Retrieved March 28, 2022, from *https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm.*

[24] Melek, S., Davenport, S., and Gray, T.J. (2019). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement* (Milliman Research Report, p. 140). *https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx.*

[25] MHPAEA. (2022). *Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage* (2022 MHPAEA Report to Congress, p. 54). *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.*

[26] Employee Benefits Security Administration. (2022). *U.S. Departments of Labor, Health and Human Services, Treasury Issue 2022 Mental Health Parity and Addiction Equity Act Report to Congress.* U.S. Department of Labor. *https://www.dol.gov/newsroom/releases/ebsa/ebsa20220125.*

ments, differences in provider availability, and application of medical necessity standards).

The report emphasized many specific examples of the inappropriate use of NQTLs, including the exclusion of certain medicines as treatment for substance use disorder conditions and requiring pre-certification for all mental health and substance use disorder outpatient services as opposed to only for a limited range of medical/surgical outpatient care.

While it is important to acknowledge that insurers face systemic challenges in meeting network adequacy requirements for behavioral health care, the data clearly show that they are able to do so for all other medical/surgical specialties. While there is work to be done to improve consensus on standards and further clarity both reporting and parity requirements themselves, the simple fact that every single plan failed to meet expectations underscores the wide gulf between the promise of parity and the realities facing Americans in need of mental health and substance use disorder care today.

The Meadows Institute supports the departments' call for enhanced MHPAEA enforcement and recognizes the need for regulators, effected consumers, and the insurance industry to continue to improve reporting processes and agreed-upon practices. Additionally, the Meadows Institute encourages Congress to vest DOL with the authority to assess civil monetary penalties for parity violations and to amend The Employee Retirement Income Security Act of 1974 (ERISA) to expressly provide DOL with the authority to directly pursue parity violations by entities that provide administrative services to ERISA group health plans.

MEDICARE-SPECIFIC PARITY CONCERNS

These failures also affect Medicare beneficiaries. In 2020, Medicare spending reached $829.5 billion, accounting for 20 percent of total national health-care expenditures.[27] Despite this, Medicare beneficiaries served through both fee-for-service and stand-alone Medicare Advantage plans do not enjoy the protections of MHPAEA. Consequently, the approximately one in four Medicare beneficiaries estimated to have a mental illness are subject to a range of behavioral health treatment limitations that do not apply to Medicare-covered medical/surgical services.[28] These limitations also have broader systematic consequences beyond their direct impact on Medicare beneficiaries, because Medicare also plays an important role in setting rates, benchmarks, and codes for other health coverages.

Medicare imposes both quantitative and non-quantitative treatment limitations. Arguably, the most glaring example of a discriminatory quantitative Medicare limitation is the 190-day lifetime limit on inpatient psychiatric care. This discriminatory limitation restricts a Medicare beneficiary to just 190 days of inpatient care in their lifetime—without consideration of treatment necessity. A Medicare beneficiary disabled because of a chronic serious mental illness may easily exceed the 190-day lifetime limit, especially if they gain Medicare coverage at a younger age. **We support the Medicare Mental Health Inpatient Equity Act (H.R. 5674/S. 3061), which would remove the artificial 190-day limitation.**

Network Adequacy: The data show that Medicare Advantage (MA) beneficiaries often lack access to in-network mental health providers, and metrics are often insufficient to ensure an adequate network of providers. This forces participants to turn to higher-cost, out-of-network care or to forego care entirely. A Kaiser Family Foundation analysis found that, on average, MA plans included less than one-quarter of psychiatrists in a county, and more than a third included less than 10 percent of psychiatrists in their county.[29] Medicare also imposes numerous NQTLs that would otherwise violate MHPAEA, including prior authorization requirements and limitations on providers and behavioral health services. As seen with the commercial plans, administrative burdens posed by NQTLs are often just as significant a barrier as low reimbursement rates.

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[27] Health Affairs Forefront. (2021). National Health Spending in 2020. *Health Affairs.* Retrieved March 28, 2022, from *https://www.healthaffairs.org/do/10.1377/forefront.20211214.144442/full/*.

[28] Beth McGinty. (2020). *Medicare's Mental Health Coverage: How COVID–19 Highlights Gaps and Opportunities for Improvement, https://doi.org/10.26099/sp60-3p16.*

[29] Jacobson, G., Rae, M., Neuman, T., Orgera, K., and Boccuti, C. (2017). Medicare Advantage: How robust are plans' physician networks? Kaiser Family Foundation. *https://www.kff.org/report-section/medicare-advantage-how-robust-are-plans-physician-networks-report/*.

Prior Authorizations: MA plans are often subject to burdensome, unnecessary prior authorization requirements. According to the Kaiser Family Foundation, four in five MA enrollees are in plans that require prior authorization for some services, and more than half of enrollees are in plans that require prior authorization for mental health services.[30] The prior authorization process has been shown to be wasteful and to potentially contribute to clinician burnout.[31] A 2017 American Medical Association survey of 1,000 physicians further noted that 92 percent of those surveyed reported that prior authorizations have a negative impact on patient clinical outcomes.[32]

Evidence-Based Care for Severe Needs: Medicare, along with most commercial plans and many Medicaid plans, also fail to cover a number of evidence-based, multidisciplinary team interventions for people with the most severe mental health and substance use disorders. This includes Coordinated Specialty Care for early psychosis and Assertive Community Treatment (ACT) teams for people with persistently severe needs. The value and cost savings associated with the use of ACT teams has been established over decades of research.[33, 34] Coordinated Specialty Care (CSC) has been shown to produce greater improvement in clinical and functional outcomes as compared with standard care for those experiencing first-episode psychosis.[35, 36]

Crisis Care: Medicare also fails to cover mental health crisis services, a failure mirrored in commercial coverage. As we roll out the 988 crisis number nationally and as communities across the Nation work to establish a full continuum of crisis services, that failure is unacceptable. Earlier this year, we joined RI International and the National Association of State Mental Health Program Directors to publish *Sustainable Funding for Mental Health Crisis Services,* which identifies standardized existing health-care codes that every insurer should reimburse, including Medicare.[37] The Meadows Institute is very appreciative to Senator Wyden for his continued leadership on the need to adequately fund and support crisis care and to Senators Cornyn and Cortez Masto for focusing on the important role that insurance coverage must play in supporting crisis care. **We strongly support Senators Cornyn and Cortez Masto's Behavioral Health Crisis Services Expansion Act (S. 1902), which would expand reimbursement for the full spectrum of crisis services under Medicare and other payers.**

Peer Support: Similarly, peer support services are not covered within Medicare. Peer support services are provided by people with lived experience of a mental illness or substance use disorder who have completed specialized training and are certified to deliver support services under appropriate State or national certification standards. A 2018 analysis showed that providers with peer services had 2.9 fewer hospitalizations per year and saved an average of $2,138 per Medicaid enrolled

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[30] Jacobson, G., and Neuman, T. (2018). Prior authorization in Medicare Advantage plans: How often is it used? Kaiser Family Foundation. *https://www.kff.org/medicare/issue-brief/prior-authorization-in-medicare-advantage-plans-how-often-is-it-used/*.

[31] Colligan, L., Sinsky, C., Goeders, L., Schmidt-Bowman, M., and Tutty, M. (2016). Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews. American Medical Association. *https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ps2/ps2-dartmouth-study-111016.pdf*.

[32] American Medical Association. (2018). 2017 AMA prior authorization physician survey. *https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf*.

[33] The Lewin Group. (2000). Assertive community treatment literature review. From SAMHSA Implementation Toolkits website: *http://media.shs.net/ken/pdf/toolkits/community/13.ACT_Tips_PMHA_Pt2.pdf*.

[34] Bond, G.R., Drake, R.E., Mueser, K.T., and Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management and Health Outcomes,* 9, 141–159. *https://link.springer.com/article/10.2165/00115677-200109030-00003.*

[35] Rosenheck, R. et al. (2016). Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE early treatment program. *Schizophrenia Bulletin,* 42(4), 896–906. *https://academic.oup.com/schizophreniabulletin/article/42/4/896/2413925.*

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

[37] Crisis Now. (2022). *Sustainable Funding for Mental Health Crisis Services. https://crisisnow.com/wp-content/uploads/2022/01/Sustainable-Funding-Crisis-Coding-Billing-2022.pdf.*

month in Medicaid expenditures.[38] **We support Senators Cortez Masto and Cassidy's PEERS Act of 2021 (H.R.2767/ S. 2144), which would specify that peer support specialists may participate in the provision of behavioral health integration services with the supervision of a physician or other entity under Medicare.**

Substance Use Disorder Care: There are also major gaps in access to substance use disorder (SUD) care in Medicare, Medicaid, and commercial plans. Broadly speaking, we support the positions set forth by the Medicare Addiction Parity Project. Despite a significant number of Medicare beneficiaries requiring SUD treatment, Medicare simply does not adequately cover most essential SUD benefits and services. SUD services within MA, especially services and medications for opioid use disorders (OUD), are disproportionately subject to burdensome and unnecessary prior authorization requirements and other limitations that hinder timely access to appropriate medications and services.

There is also a significant issue with SUD network adequacy and a lack of SUD providers covered by Medicare. Providers that are not covered by Medicare include Licensed Professional Counselors, Licensed Addiction Counselors, Certified Alcohol and Drug Counselors, and Peer Support Specialists. As a result, many patients who seek treatment are unable to access it.

For Medicare and commercial health plans alike, we are particularly concerned about barriers to access for Medication-Assisted Treatment (MAT). An analysis we conducted in August 2020 showed that universal access to MAT could have saved almost at least 24,000 lives annually from overdose.[39] There are also coverage, prior authorization, and network adequacy barriers to MAT in essentially all health plans.

THE MOST IMPORTANT REFORM: INTEGRATION OF BEHAVIORAL HEALTH INTO PRIMARY CARE

The primary impediment to parity is the lack of providers to deliver care cost-effectively, and integration of behavioral health providers and care deliver into primary care offers the only path to removing this barrier. To adequately address the magnitude of behavioral health need in America, we must combine enhanced parity enforcement with an aggressive effort to integrate behavioral health into primary care. Broad scale adoption of evidence-based primary care interventions for mental health and substance use disorders are essential to realizing the promise of parity for two reasons. First, decades of research and over 90 randomized control trials have clearly shown that the two-thirds of needs which fall into the mild to moderate range can be better treated in primary care than in specialty care.[40] Second, serving most people in primary care would allow America's limited specialty care workforce to focus on people with more severe and complex needs.

Currently, our behavioral health workforce is not well-deployed upstream in U.S. primary care settings as compared to other industrialized nations.[41] This is a major reason why we fail to detect and treat mental health needs until 8 to 10 years after symptoms emerge.[42] But America faced this same challenge with heart disease and cancer and successfully turned the tide on both by leveraging primary care over the last 4 decades. Until the 1980s, we identified heart disease primarily when a person had a heart attack, and we began treatment then, after the heart was damaged, to resuscitate the person and prevent a recurrence. We would also wait to detect cancer until it resulted in functional impairment—a broken bone, coughing up blood—with devastating consequences and higher mortality rates. Today, we have systems in place in primary care to detect and treat most heart disease and many cancers

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[38] Bouchery, E., Barna, M., Babalola, E., Friend, D., Brown, J., Blyler, C., Ireys, H., The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization, Psychiatric Services, August 2018.

[39] *https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf.*

[40] Carlo, A.D., Barnett, B.S., and Unützer, J. (2021). Harnessing collaborative care to meet mental health demands in the era of COVID–19. *JAMA Psychiatry,* 78(4), 355. *https://doi.org/10.1001/jamapsychiatry.2020.3216.*

[41] Tikkanen, R., Fields, K., Williams III, R.D., and Abrams, M.K. (2020). Mental health conditions and substance use: Comparing U.S. needs and treatment capacity with those in other high-income countries. The Commonwealth Fund. *https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries.*

[42] American Academy of Child and Adolescent Psychiatry. (2012). Best principles for integration of child psychiatry into the pediatric health home. *https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf.*

much earlier, when they are easier to address successfully, much less likely to be disabling and burdensome to the person receiving care, and less costly to society.

Two models best represent the promise of reaching people in primary care rather than referring them to overwhelmed and understaffed specialty care systems: (1) the Collaborative Care Model (CoCM) and (2) Primary Care Behavioral Health (PCBH). CoCM and PCBH each have the potential to magnify the reach of our limited workforce many times over, and analysis carried out by the Meadows Institute shows that CoCM can leverage psychiatrist time 3.5 times over and PCBH can leverage other licensed practitioner time 2.65 times over.[43] In early 2021, comprehensive studies through both RAND and the Bipartisan Policy Center endorsed these strategies,[44] and RAND offered specific recommendations for scaling them nationwide.

CoCM is the most extensively researched and evidence-based integration strategy to detect and treat mental health and substance use disorders before they become crises,[45] and it is now being implemented at scale in health systems serving millions of Texans.[46] The potential cost-savings of widespread implementation are considerable: a pivotal 2013 study found Medicare and Medicaid savings of up to six-to-one in total medical costs and estimated $15 billion in Medicaid savings if only 20 percent of beneficiaries with depression received it,[47] and the RAND report cited a 13:1 return on investment. Importantly, CoCM is proven to work just as well for Black, Hispanic, and other communities of color,[48] and PCBH has shown growing promise with pediatric populations.[49]

Though certain distinctions exist between the two approaches, both effectively address pediatric workforce shortages by: (a) sharing an interdisciplinary team-based structure, (b) treating a wide array of behavioral health presentations, (c) leading to stigma-reduction, (d) utilizing evidence-based measures to guide treatment planning and monitoring, (e) having dedicated insurance billing codes for long-term financial sustainability for practices, (f) allowing for real-time availability of behavioral health care, and (g) employing brief, evidence-based interventions in a short-term care format to help patients access care sooner. Both CoCM and PCBH rely on approved existing billing codes that are reimbursed by Medicare, most major commercial insurance plans, and most States' Medicaid plans. Texas, of note, is expected to activate Medicaid reimbursement for CoCM in CY 2022, which is helping to drive implementation of CoCM and integration broadly.

However, coverage alone is not enough. As the RAND report previously noted, CoCM and PCBH are not available in most primary care settings today, with "implementation of models like CoCM . . . underwhelming and largely confined to academic medical centers." Given this, the RAND report recommends a nationwide effort to provide technical assistance and financial incentives scaled in the hundreds of millions of dollars to help the hundreds of thousands of primary care practitioners across the Nation rapidly adopt these models.

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[43] Meadows Mental Health Policy Institute. (2022). Integration and the pediatric behavioral health workforce. *https://mmhpi.org/wp-content/uploads/2022/03/Briefing-Summary_BHI_Workforce_Pediatrics_March2022.pdf.*

[44] McBain, R.K., Eberhart, N.K., Breslau, J., Frank, L., Burnam, M.A., Kareddy, V., and Simmons, M.M. (2021). *How to transform the U.S. mental health system: Evidence-based recommendations.* RAND Corporation. *https://www.rand.org/pubs/research_reports/RRA889-1.html;* BPC Behavioral Health Integration Task Force. (2021). *Tackling America's mental health and addiction crisis through primary care integration: Task force recommendations.* Bipartisan Policy Center. *https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf.*

[45] Carlo, A.D., Barnett, B.S., and Unützer, J. (2021). Previously cited.

[46] Meadows Mental Health Policy Institute. (2021). *Lone star depression challenge. https://mmhpi.org/the-lone-star-depression-challenge/.*

[47] Unützer, J., Harbin, H., Schoenbaum, M., and Druss, B. (2013, May). The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. Health Home Information Resource Center. *http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf.*

[48] Wells, K., Sherbourne, C., Schoenbaum, M., Ettner, S., Duan, N., Miranda, J., Unützer, J., and Rubenstein, L. (2004, April). Five-year impact of quality improvement for depression: Results of a group-level randomized controlled trial. *Archives of General Psychiatry,* 61(4), 378–386. *https://pubmed.ncbi.nlm.nih.gov/15066896/.* Ell, K., Aranda, M.P., Xie, B., Lee, P-J., and Chou, C-P. (2010, June). Collaborative depression treatment in older and younger adults with physical illness: Pooled comparative analysis of three randomized clinical trials. *American Journal of Geriatric Psychiatry,* 18(6), 520–530. *https://pubmed.ncbi.nlm.nih.gov/20220588/.*

[49] Remoue Gonzales, S., and Higgs, J. (2020). Perspectives on integrated behavioral health in pediatric care with immigrant children and adolescents in a Federally Qualified Health Center in Texas. *Clinical Child Psychology and Psychiatry,* 25(3), 625–635. *https://journals.sagepub.com/doi/10.1177/1359104520914724.*

Only a national effort of this magnitude can turn the tide on rising deaths from suicide and overdose. America faced this same challenge 15 years ago regarding the adoption and meaningful use of electronic health records, and we employed technical assistance and financial incentives to scale their availability nationally in just a few years. If we wait 20 years, this will be the standard of care nationwide, but in the meantime we will lose over two million more Americans to suicide and overdose and relegate tens of millions more to poor access, delayed care, and a range of tragic outcomes.

Today in Texas we are showing that such a rapid transition is possible. Over the next 5 years, the Meadows Institute and our partners are using the $10 million Lone Star Prize awarded by Lyda Hill Philanthropies to bring this care to over 10 million Texans.[50] In addition, Texas is deploying $7 million in American Rescue Plan Act (ARPA) funds to accelerate implementation of integration in pediatric settings to increase access across 18 Texas health systems.

Congressional efforts such as the Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) by Rep. Fletcher (D–TX) and Rep. Herrera Beutler (R–WA) could form the basis for such action, and this effort is supported by every major medical association.[51] To address the magnitude of the national crisis facing us today, this legislation should be broadened to include PCBH and scaled up to funding levels sufficient for national scaling such as those recommended by RAND.

The Meadows Institute encourages the committee to support large-scale efforts to build integrated care infrastructure and widescale adoption of models such as CoCM. We also encourage the committee to support the Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) to help primary care providers implement integrated behavioral health and primary care models, but broaden it to cover models such as PCBH and expand its reach by funding it at levels suggested by the RAND report as necessary for widescale adoption.

QUESTIONS SUBMITTED FOR THE RECORD TO ANDY KELLER, PH.D.

QUESTIONS SUBMITTED BY HON. RON WYDEN

INTEGRATED CARE AT INDEPENDENT PRACTICES

Question. Testimony at the Finance Committee's March 30th hearing on mental health parity and integration of care made clear that there is potential for integrated care teams to help patients get the behavioral health care that they need, when they need it. As the Finance Committee examines opportunities to improve the take-up rate of integrated care models in physician practices, it will be vital to ensure that behavioral health integration models can work for physician practices of all shapes and sizes—and not just large physician practices that are affiliated with major health systems.

Are there approaches to care integration that you have seen that show the most promise for being implemented in smaller and independent primary care practices?

Answer. We strongly agree that this Senate should prioritize an urgent national effort to rapidly expand access to behavioral health integration models that engages physician (and other primary care provider) practices of all shapes and sizes, just as we have done in Texas. As a base for this effort, we strongly support H.R. 5218, the Collaborate in an Orderly and Cohesive Manner Act, which would provide grant-funded support and technical assistance to exactly the kinds of smaller, independent practices you are asking about in order to facilitate their use of the Collaborative Care Model (CoCM). However, the ambition of that legislation is too small given the scope of our national mental health and addiction crisis (we are spending $30 million in Texas alone with our philanthropic efforts to expand access to about half the State), and if the scope can be expanded, the bill should also support implementation of the Primary Care Behavioral Health (PCBH) model (in addition to CoCM).

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[50] Meadows Mental Health Policy Institute. (2021). *Lone star depression challenge. https://mmhpi.org/the-lone-star-depression-challenge/.*

[51] American Psychiatric Association. (2021). Eighteen organizations express support for the Collaborate in an Orderly and Cohesive Manner (COCM) Act which would bolster innovative model of provision of mental health care. *https://www.psychiatry.org/newsroom/news-releases/eighteen-organizations-express-support-for-the-collaborate-in-an-orderly-and-cohesive-manner-cocm-act-which-would-bolster-innovative-model-of-provision-of-mental-health-care.*

Expanding access to CoCM is the best practice for integrating behavioral health with primary care and one of the most important things we can do to improve care and save countless lives for people struggling with mental health conditions or substance use disorder (SUD). CoCM is a proven tool to detect and treat mental health and substance use concerns in primary care settings before they become crises. The model is a team-based [1] approach to care that routinely measures both clinical outcomes and a patient's goals over time to increase the effectiveness of mental health and SUD treatment in primary care settings.[2, 3] CoCM is also the only evidence-based medical procedure currently reimbursable in primary care. It has been covered by Medicare since 2017 [4] and by nearly all commercial payers since 2019 [5]—and has strong evidence of cost savings.[6, 7, 8] The potential for cost savings with widespread implementation is considerable; a 2013 study found a six-to-one cost savings in total medical costs in Medicare and Medicaid settings and estimated $15 billion in Medicaid savings if just 20 percent of beneficiaries with depression receive CoCM services.[9]

Most importantly, CoCM is effective across a variety of settings and clinic practices. In smaller practices, contracting with offsite telemedicine-based collaborative care teams can relieve some of the complexity of implementing CoCM and, in rural settings in particular, can ameliorate challenges of finding staff based locally.[10] Numerous studies demonstrate the effectiveness of the Collaborative Care Model in Federally Qualified Health Centers (FQHCs) and community-based clinics for adults with depression,[11] anxiety,[12] opioid and alcohol use disorders,[13] and also for specific

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

[2] Nafziger, M., and Miller, M. (2013). *Collaborative primary care: Preliminary findings for depression and anxiety,* Washington State Institute for Public Policy. *http://www.wsipp.wa.gov/ReportFile/1546/Wsipp_Collaborative-Primary-Care-Preliminary-Findings-forDepression-and-Anxiety_Preliminary-Report.pdf.*

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

[4] Centers for Medicare and Medicaid Services. (2022). *Behavioral health integration services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf.*

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

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

[7] Press, M.J., Howe, R., Schoenbaum, M., Cavanaugh, S., Marshall, A., Baldwin, L., and Conway, P.H. (2017). Medicare payment for behavioral health integration. *The New England Journal of Medicine,* 376, 405–407. *https://www.nejm.org/doi/10.1056/NEJMp1614134.*

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

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

[10] Fortney, J.C., Pyne, J.M., Mouden, S.B., Mittal, D., Hudson, T.J., Schroeder, G.W., Williams, D.K., Bynum, C.A., Mattox, R., and Rost, K.M. (2013). Practice-Based Versus Telemedicine-Based Collaborative Care for Depression in Rural Federally Qualified Health Centers: A Pragmatic Randomized Comparative Effectiveness Trial. *American Journal of Psychiatry,* 170(4), 414–425. *https://doi.org/10.1176/appi.ajp.2012.12050696.*

[11] Carlo, A.D., Jeng, P.J., Bao, Y., and Unützer, J. (2019). The Learning Curve After Implementation of Collaborative Care in a State Mental Health Integration Program. *Psychiatric Services,* 70(2), 139–142. *https://doi.org/10.1176/appi.ps.201800249.*

[12] Bauer, A.M., Azzone, V., Goldman, H.H., Alexander, L., Unützer, J., Coleman-Beattie, B., and Frank, R.G. (2011). Implementation of Collaborative Depression Management at Community-Based Primary Care Clinics: An Evaluation. *Psychiatric Services,* 62(9), 1047–1053. *https://doi.org/10.1176/ps.62.9.pss6209_1047.*

[13] Watkins, K.E., Ober, A.J., Lamp, K., Lind, M., Setodji, C., Osilla, K.C., Hunter, S.B., McCullough, C.M., Becker, K., Iyiewuare, P.O., Diamant, A., Heinzerling, K., and Pincus, H.A. (2017). Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care: The SUMMIT Randomized Clinical Trial. *JAMA Internal Medicine,* 177(10), 1480. *https://doi.org/10.1001/jamainternmed.2017.3947.*

populations, including Black and Hispanic communities [14] and pregnant women.[15] Additionally, early evidence suggests that CoCM implemented in FQHCs also improves outcomes for child and youth patients.[16]

However, implementing this model beyond the research setting in real-world practices continues to be an ongoing challenge, largely due to start-up costs and the need for technical assistance. The Meadows Mental Health Policy Institute (the Meadows Institute) is currently the lead on a 5 year, $10 million effort called the Lone Star Depression Challenge. This effort has acquired additional philanthropic support totaling nearly $15 million more to expand and accelerate its reach, and the State of Texas recently added $7 million in American Rescue Plan Act (ARPA) funds to include more pediatric practices. One key part of this expansion involves work with the Amarillo Area Foundation to provide technical assistance and remove obstacles associated with implementation of integrated behavioral health care for the rural and frontier practices in the 26 northern-most counties of the Texas Panhandle that it serves. So, Texans are showing how even the most remote practices can benefit from CoCM and overcome their implementation barriers with start-up grants and technical assistance.

Additionally, gaps in integrated care implementation have caught the attention of the private sector where technology companies' investments have been focused on the need to provide technical assistance in implementing CoCM. Specifically, companies such as Neuroflow and Concert Health have partnered with small independent practices with success. Neuroflow's health technology platform and management services work well for small and solo primary care practices by facilitating and automating workflows that would otherwise by prohibitively time consuming and expensive for practices with limited administrative support. In addition, Concert Health has seen smaller practices implement CoCM more rapidly with their support because of their ability to engage staff at all levels, from the practice owner to frontline professionals. And they have seen smaller practices successfully reach more than 100 patients at any given time through CoCM.

COVERAGE AND PAYMENT FOR MOBILE CRISIS TEAMS

Question. Too often, children and adults in crisis are unable to get access to the behavioral health care they urgently need, leading individuals to seek care in emergency departments, face encounters with law enforcement, or become incarcerated in jails. To help these individuals receive the timely care they need, some communities and programs, including the CAHOOTS program in Oregon, have explored strategies using health professionals as first responders when individuals experience a mental health or substance use related crisis. The American Rescue Plan Act (ARPA) provided Medicaid programs with enhanced Federal funding to support these innovative approaches. However, challenges remain in fostering broader coverage for these crisis programs across payers over the long term.

Can you provide details on how the Centers for Medicare and Medicaid Services (CMS) could structure coverage and payment for mobile crisis teams within the Medicare program?

Answer. Medicare fails to cover any of the most important mental health crisis services, a failure mirrored in most commercial coverage as well. As the 988 dialing code is rolled out nationally, and as communities across the Nation work to establish a full continuum of crisis services, that failure is no longer tolerable. Earlier this year, we joined RI International and the National Association of State Mental Health Program Directors to publish *Sustainable Funding for Mental Health Crisis Services,* which identifies standardized existing health-care codes that every insurer should reimburse, including Medicare.

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[14] Lagomasino, I.T., Dwight-Johnson, M., Green, J.M., Tang, L., Zhang, L., Duan, N., and Miranda, J. (2017). Effectiveness of Collaborative Care for Depression in Public-Sector Primary Care Clinics Serving Latinos. *Psychiatric Services,* 68(4), 353–359. *https://doi.org/10.1176/appi.ps.201600187.*

[15] Grote, N.K., Katon, W.J., Russo, J.E., Lohr, M.J., Curran, M., Galvin, E., and Carson, K. (2015). Collaborative Care for Perinatal Depression in Socioeconmically Disadvantaged Women: A randomized trial; Research Article: Collaborative Care for Perinatal Depression. *Depression and Anxiety,* 32(11), 821–834. *https://doi.org/10.1002/da.22405.*

[16] Sheldrick, R.C., Bair-Merritt, M.H., Durham, M.P., Rosenberg, J., Tamene, M., Bonacci, C., Daftary, G., Tang, M.H., Sengupta, N., Morris, A., and Feinberg, E. (2022). Integrating Pediatric Universal Behavioral Health Care at Federally Qualified Health Centers. *Pediatrics,* 149(4), e2021051822. *https://doi.org/10.1542/peds.2021-051822.*

The Meadows Institute is also very appreciative of Senator Wyden for his continued leadership on the need to adequately fund and support crisis care and of Senators Cornyn and Cortez Masto for focusing on the important role that insurance coverage must play in supporting crisis care. We strongly support Senators Cornyn and Cortez Masto's Behavioral Health Crisis Services Expansion Act (S. 1902), which would expand reimbursement for the full spectrum of crisis services under Medicare and other payers.

The Meadows Institute also supports the recommendations of the 2021 NASMHPD Technical Assistance Collaborative Paper, *Funding Opportunities for Expanding Crisis Stabilization Systems and Services.* Specifically, CMS and State officials should encourage crisis stabilization providers to bill Medicare for covered services provided to Medicare beneficiaries. Medicare covers crisis psychotherapy (CPT codes 90839 and 90840) and CPT code 90839 is one of the most commonly used codes for billing Medicare for mental health services.[17] Although only certain provider types are eligible to bill these codes, CMS and State officials should encourage providers to utilize telehealth, including audio-only, psychotherapy and "incident to" billing policies for higher credentialed providers whenever possible. The "incident to" policy allows Medicare-enrolled providers to bill for services technically provided by an employee whom they supervise, allowing Medicare to reimburse for services provided by a broader array of practitioners.

Question. Can you describe which elements of mobile crisis care are most critical, and the types of professionals involved in effective mobile crisis team models?

Answer. Historically (and still in most communities across the United States), mental health emergency calls for service often result in a public safety or police-driven response, rather than in an emergency medical services response like other health-care emergencies. In addition to the potential for injury and death that this poses to the individual (especially people of color), even in the best circumstances these encounters routinely result in an array of bad outcome for the individual in crisis, as law enforcement officers are often forced to choose between three largely ineffective and inappropriate options: (1) arrest the individual; (2) transport the individual to a hospital emergency department where there is likely to be an extended wait; or (3) inaction, which leaves the vulnerable individual with no connection to care.[18]

The Meadows Institute strongly supports this committee's work to create and strengthen alternative options for individuals in crisis. Evidence is emerging on the utility of alternative models of crisis response to reduce police involvement in subsets of 911 calls. For example, the noted CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Eugene, OR has a proven track record of delivering much-needed care to people in crisis situations. Civilian-only response teams, such as the CAHOOTS team, provide a valuable service by replacing law enforcement responses for crisis calls that do not pose a public safety risk. Such teams can also help to address many calls of lower acuity originating from the soon-to-be-established 988 alternative crisis line.

However, by design, these teams are unable to address the wider range of 911 calls that involve a mental health emergency and do pose a public safety risk, expressly reference a risk of violence, or pose a level of actual or perceived risk that cannot be determined with certainty until the response to the emergency occurs. In many communities, civilian-only response teams also do not have the ability to initiate involuntary psychiatric commitments, again relegating these needs to an unreformed response option.

To meet the needs of individuals in crisis regardless of their perceived risk of violence or level of acuity, we strongly support supplementing civilian-only teams such as CAHOOTS with the multidisciplinary response team (MDRT) model that incorporates public safety.[19] An MDRT is a community-based paramedicine approach with an integrated team comprised of a community paramedic, a specially trained

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[17] Beronio, K.K. (2021, September). Funding opportunities for expanding crisis stabilization systems and services. National Association of State Mental Health Program Directors. *https://www.nasmhpd.org/sites/default/files/8_FundingCrisisServices_508.pdf.*

[18] Munetz, M.R., Griffin, P.A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services,* 57(4), 544–549. *https://pubmed.ncbi.nlm.nih.gov/16603751/.*

[19] Meadows Mental Health Policy Institute (2021). *Multi-Disciplinary Response Teams: Transforming Emergency Mental Health Response in Texas.* Dallas, TX: Meadows Mental Health Policy Institute. *mmhpi.org.*

law enforcement officer, and a licensed mental health professional able to make definitive diagnoses and treatment decisions in the field. The team can respond to all calls, including high-acuity mental health emergency calls for service.[20]

The components of the MDRT model include: (1) data linkage to facilitate rapid identification of mental health calls and real-time data on past mental health services to inform team decision-making; (2) a paramedic-led multidisciplinary co-response team that deploys a paramedic, a behavioral health clinician, and a police officer to respond as one integrated, co-trained unit to mental health calls; and (3) a clinically informed dispatch system in which a clinician is embedded in the dispatch call center either in person or virtually to triage mental health calls.

As we have explained more fully in a recent paper we released as part of a project funded by the Pew Charitable Trusts, MDRTs are expressly designed to be able to respond to mental health calls involving higher levels of acuity, including calls that may require medical treatment, reference a weapon or threat of violence, involve unknown or perceived risks, involve overdose or the need for substance use disorder care, and/or potentially necessitate involuntary commitment.

Implementing an MDRT as an alternative first response also allows traditional police resources to remain in service while leveraging the unique skill sets of the MDRT to resolve a mental health emergency. The MDRT approach integrates both law enforcement and civilian response in ways that address the multiple issues often raised in a single 911 call, including calls involving a mental health crisis that presents a public safety risk. The City of Dallas has been able to use its full scale MDRT program to redeploy officers to more focused public safety work, and we believe that this has been one contributor to the City's success in both reducing use of police to respond to mental health emergencies and reduce violent crime at the same time.

Leveraging the MDRT model can also help begin to address concerns around introducing bias in our crisis response system, particularly around inequitable treatment responses that can come from segregating responses as "violent" versus "nonviolent." As Kevin Martone of the Technical Assistance Collaborative recently explained, calls for service are typically made by third parties, which means call takers and operators depend on information shaped by a caller's perceptions and biases of the person they're calling about.[21] He asked a salient question, "[W]ill a 911 call about a Black man experiencing the same stay with 911 and result in police dispatch because the caller perceives the man to be dangerous?" Researchers note that these concerns may be valid; for example, a study published in 2017 revealed that people often misperceive Black men to be larger and more threatening than White men of the same size.[22] Utilizing an MDRT model with the ability to respond to all calls regardless of perceived risk of danger could help ameliorate potential issues that may arise from dispatching different service types based on an artificial distinction of a "violent" versus "nonviolent" crisis call. Our overarching goal should always be to avoid situations in which communities of color are more likely to receive a police response than other communities simply because their crises are more likely to be coded as "violent."

Question. How can emergency medical technicians (EMTs) be incorporated into mobile crisis response teams?

Answer. As detailed in our response to the question just above, we strongly support both civilian-only models that do so (like B–HEARD in New York City) and models that incorporate a public safety component, like the MDRT model, which fully integrates community paramedics into a team response to crises.

Support for civilian-only models incorporating paramedics like B-HEARD is well established, and the Meadows Institute fully supports their use. But there has been less attention on models that deploy community paramedics on a team that can address public safety concerns. To meet the needs of individuals in crisis regardless of their perceived risk of violence or level of acuity, we strongly support the MDRT model. An MDRT is a community-based paramedicine approach with an integrated

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[20] U.S. Department of Health and Human Services, Health Resources and Services Administration, and Office of Rural Health Policy. (2012). *Community paramedicine: Evaluation tool. https://www.hrsa.gov/sites/default/files/ruralhealth/pdf/paramedicevaltool.pdf.*

[21] Hepburn, S. (2022). Homelessness and crisis: Who will answer the call? #CrisisTalk. *https://talk.crisisnow.com/homelessness-and-crisis-who-will-answer-the-call/.*

[22] American Psychological Association. (2017). People see Black men as larger, more threatening than same-sized White men [Press release]. American Psychological Association. *https://www.apa.org/news/press/releases/2017/03/black-men-threatening.*

team comprised of a community paramedic, a specially trained law enforcement officer, and a licensed mental health professional able to make definitive diagnoses and treatment decisions in the field. The team can respond to all calls, including high-acuity mental health emergency calls for service.[23]

MDRTs operate on the principles of community paramedicine, which entails functioning as a single integrated unit, relying on shared knowledge and experience, and responding as a team.[24] The lead paramedic is a community health paramedic (CHP) who has special training to provide individualized care to patients who are at risk of preventable hospital admission or readmission based on chronic care needs. A CHP receives training on patient navigation, referral to resources, and identification of health-related risk factors for hospital or emergency care recidivism. This level of training and focus on individualized patient care is a departure from the typical acute stabilization and transport training a medic receives, and is vital to successful triage, treatment, care linkage, and preventative care services. In Dallas, the RIGHT Care team paramedic continues to monitor care of the individual and assess significant changes to the person's physical condition on the scene and after a transfer of care.

Question. Rural and underserved areas may face particular barriers related to workforce capacity and the ability to quickly connect people in crisis to care. Can you describe how these models can be best implemented in these settings?

Answer. It is important to remember that telehealth services in a mental health context were initially designed to reach clients in underserved areas, whether that was due to geographic constraints or a lack of resources for health care.[25] Telehealth services, especially those made available to first responders, drastically reduce the "time to treatment" for high acuity patients.[26] Effectively utilizing telehealth can alleviate the burden on first responders, allowing for rapid response during a mental health emergency.

Telehealth in mental health emergency response rapidly brings services to patients, relieving the burden on overtaxed systems. Telehealth also ensures equity in mental health response, allowing for higher-acuity patients to be triaged by qualified mental health professionals if the situation demands it. Incorporating telehealth services into an MDRT furthers the goal of rapid-response mental health care in order to divert vulnerable individuals from the criminal justice system while also easing the burden on under-resourced systems.

Communities in Texas are incorporating telehealth services when responding to mental health calls for service, whether as part of an MDRT approach or as a stand-alone tool for law enforcement officers. For example, the City of Abilene is using telemedicine to facilitate pre-hospital care, with a repurposed military MRAP vehicle functioning as a mobile hospital equipped with secure video conferencing software to triage critical patients more effectively and direct them to the appropriate resource for care.[27]

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[23] U.S. Department of Health and Human Services, Health Resources and Services Administration, and Office of Rural Health Policy. (2012). *Community paramedicine: Evaluation tool. Community paramedicine: Evaluation tool. https://www.hrsa.gov/sites/default/files/ruralhealth/pdf/paramedicevaltool.pdf.*

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

[25] Bashshur, R.L., Shannon, G.W., Bashshur, N., and Yellowlees, P.M. (2016). The Empirical Evidence for Telemedicine Interventions in Mental Disorders. *Telemedicine journal and e-health: The official journal of the American Telemedicine Association,* 22(2), 87–113. *https://doi.org/10.1089/tmj.2015.0206.*

[26] Simon, L.E., Shan, J., Rauchwerger S.A., Reed, M.E., Warton, M.E., Vinson, D.R., Konik, Z.I., Vlahos, J., Groves, K. and Ballard, D.W. (2020). *Paramedic's perspectives on telemedicine in the ambulance: A survey study. https://www.jems.com/patient-care/perspectives-on-telemedicine/.*

[27] Philips, B.U. "Current Programs and Innovations in Telemedicine." Texas Tech University Health Sciences Center. *https://capitol.texas.gov/tlodocs/84R/handouts/C4102016021009001/3c5178d7-355d-4418-a50c-58b2b296f2fd.PDF.*

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

HEALTH SERVICES IN SCHOOLS

Question. It is clear that COVID–19 has significantly exacerbated mental health stress on children and youth, highlighting the Nation's acute shortage of mental health services. In my State of Delaware, over 9,000 Delawareans ages 12 through 17 suffer from some sort of depression. However, according to the State, students who have access to mental health resources within schools are 10 times more likely to seek care.

Earlier this year, the Finance Committee heard testimony from the U.S. Surgeon General who stressed that one of the most central tenets in creating accessible and equitable systems of care is to meet people where they are. For most young people, that's right there in schools. And just last week, Secretary of Health and Human Services Xavier Becerra and Secretary of Education Miguel Cardona announced a joint-department effort to expand school-based health services.

It is clear there is growing momentum to recognize the role schools already play in ensuring children have the health services and supports necessary to build resilience and thrive. We know that investing in school and community-based programs have been shown to improve mental health and emotional well-being of children at low cost and high benefit.

How can we improve coordination between primary care and mental health providers to better support our children, including through school-based services?

Answer. As Surgeon General, Dr. Vivek Murthy warned late last year in America's first-ever public health advisory focused on mental health, even before COVID–19, mental illness among America's youth was already at a crisis point, and the pandemic has made it much worse.[28] While that historic advisory emphasized the need to address the workforce, it perhaps understated the degree of the United States' overstretched and misdeployed workforce. Recent estimates predict provider shortages across six behavioral health subspecialties surpassing a quarter of a million full-time employees (FTEs) by 2025.[29] More alarmingly, the pediatric mental health workforce shortage will lead to long-term negative outcomes across countless dimensions, particularly in underserved communities and with pronounced inequities across communities of color.[30, 31, 32, 33]

In addition to shortages, our pediatric mental health workforce is not well deployed upstream in U.S. primary care settings when compared to other industrialized nations.[34] This is a major reason why we do not detect and treat mental health needs until 8–10 years after symptoms emerge.[35] In addition, pediatric

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[28] The U.S. Surgeon General's Advisory. (2021). *Protecting youth mental health. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.*

[29] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, and National Center for Health Workforce Analysis. (2020). *Using HRSA's health workforce simulation model to estimate the rural and non-rural health workforce. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/hwsm-rural-urban-methodology.pdf.*

[30] Ramchand, R., Gordon, J.A., and Pearson, J.L. (2021). Trends in suicide rates by race and ethnicity in the United States. *JAMA Network Open,* 4(5), e2111563. *https://doi.org/10.1001/jamanetworkopen.2021.11563.*

[31] Panchal, N., Kamal, R., Cox, C., and Garfield, R. (2021). *The implications of COVID–19 for mental health and substance use.* Kaiser Family Foundation. *https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.*

[32] Kuchment, A., Hacker, H.K., Solis, D. (2020). COVID's "untold story": Texas Blacks and Latinos are dying in the prime of their lives. *The Dallas Morning News. https://www.dallasnews.com/news/2020/12/19/covids-untold-story-texas-blacks-and-latinos-are-dying-in-the-prime-of-their-lives/.*

[33] Hillis, S.D., Blenkinsop, A., Villaveces, A., Annor, F.B., Liburd, L., Massetti, G.M., Demissie, Z., Mercy, J.A., Nelson III, C.A., Cluver, L., Flaxman, S., Sherr, L., Donnelly, C.A., Ratmann, O., and Unwin, H.J.T. (2021). COVID–19—associated orphanhood and caregiver death in the United States. *Pediatrics,* 148(6), e2021053760. *https://doi.org/10.1542/peds.2021-053760.*

[34] Tikkanen, R., Fields, K., Williams III, R.D., and Abrams, M.K. (2020). *Mental health conditions and substance use: Comparing U.S. needs and treatment capacity with those in other high-income countries.* The Commonwealth Fund. *https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries.*

[35] American Academy of Child and Adolescent Psychiatry. (2012). *Best principles for integration of child psychiatry into the pediatric health home. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf.*

health-care expenses are higher in the U.S. than in almost all other industrialized countries,[36] while research consistently suggests that U.S. pediatric health outcomes fall far below those of average citizens living in other developed nations.[37]

Integration of mental health and substance use treatment is the strategy with the most potential to address pediatric workforce challenges by better leveraging both the pediatric primary care and behavioral health specialty care workforces.[38] In early 2021, comprehensive studies through both RAND[39] and the Bipartisan Policy Center[40] endorsed these strategies, including through specific recommendations consistent with what we propose below that could serve as the basis for a rapid, emergency retooling of the Nation's primary care practices to address the out-of-control mental health crisis facing America's youth and young adults today. In particular, the comprehensive 2021 RAND study offered specific recommendations likely to cost under $1 billion total for rapidly deploying them nationwide through: (1) incentive grants to overcome start-up costs, and (2) and technical assistance to access existing billing codes that can cover ongoing costs.

By treating patients in primary care instead of referring them to overwhelmed and understaffed specialty care systems, the Collaborative Care Model has the potential to magnify the reach of our limited workforce many times over (CoCM can leverage a psychiatrist's time 3.5 times over). CoCM is the most extensively researched and evidence-based integration strategy to detect and treat mental health and substance use disorders before they become crises,[41] and it is now being implemented to scale in health-care systems serving millions of Texans.[42] Importantly, CoCM is proven to work just as well for Black, Hispanic, and other communities of color as it does for White individuals.[43] And other models such as Primary Care Behavioral Health (PCBH) show promise for children and youth, with the potential to leverage other licensed practitioner time 2.65 times over.

And it is also possible to expand access by aligning existing resources with public health priorities like integrated pediatric care and school-based services. In 2020, the Meadows Institute helped Texas medical schools and health systems launch nation-leading supports with pediatricians, primary care providers, and schools. The centerpiece of these efforts was the launch of the Texas Child Mental Health Care Consortium (Consortium). The Consortium was created and funded in 2019 by the Texas legislature,[44] launched in May 2020, and now serves thousands of primary care practices and over two million students in schools across the State.[45]

Its flagship initiatives are as follows:

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[36] Squires, D., and Anderson, C. (2015). *U.S. health care from a global perspective: Spending, use of services, prices, and health in 13 countries.* Commonwealth Fund, 15, 1–15. *https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2015_oct_1819_squires_us_hlt_care_global_perspective_oecd_intl_brief_v3.pdf.*

[37] Emanuel, E.J., Gudbranson, E., Van Parys, J., Gørtz, M., Helgeland, J., and Skinner, J. (2021). Comparing health outcomes of privileged U.S. citizens with those of average residents of other developed countries. *JAMA Internal Medicine,* 181(3), 339. *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2774561.*

[38] Asarnow, J.R., Rozenman, M., Wiblin, J., and Zeltzer, L. (2015). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics,* 169(10), 929. *https://jamanetwork.com/journals/jamapediatrics/fullarticle/2422331.*

[39] McBain, R.K., Eberhart, N.K., Breslau, J., Frank, L., Burnam, M.A., Kareddy, V., and Simmons, M.M. (2021). *How to transform the U.S. mental health system: Evidence-based recommendations.* RAND Corporation. *https://doi.org/10.7249/RRA889-1.*

[40] BPC Behavioral Health Integration Task Force. (2021). *Tackling America's mental health and addiction crisis through primary care integration: Task force recommendations.* Bipartisan Policy Center. *https://bipartisanpolicy.org/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R01.pdf.*

[41] Carlo, A.D., Barnett, B.S., and Unützer, J. (2021). Harnessing collaborative care to meet mental health demands in the era of COVID–19. *JAMA Psychiatry,* 78(4), 355. *https://doi.org/10.1001/jamapsychiatry.2020.3216.*

[42] Meadows Mental Health Policy Institute. (2021). *Lone star depression challenge. https://mmhpi.org/the-lone-star-depression-challenge/.*

[43] Wells, K., Sherbourne, C., Schoenbaum, M., Ettner, S., Duan, N., Miranda, J., Unutzer, J., and Rubenstein, L. (2004). Five-year impact of quality improvement for depression: Results of a group-level randomized controlled trial. *Archives of General Psychiatry,* 61(4), 378–386. *https://pubmed.ncbi.nlm.nih.gov/15066896/.*

[44] Texas Child Mental Health Care Consortium, An Act of May 26, 2019, 86 Leg., R.S., ch. 7, §C 2019 Tex. Edu. Code. *https://capitol.texas.gov/tlodocs/86R/billtext/html/SB00011F.HTM.*

[45] The University of Texas System. (n.d.). Texas Child Mental Health Care Consortium. *https://tcmhcc.utsystem.edu.*

- **The Consortium's Texas Child Health Access Through Telemedicine (TCHATT)** program provides schools with no-cost support from Texas medical schools by assessing the urgent psychiatric needs of students and providing them with a limited number of mental health visits. TCHATT also provides students with linkages to ongoing services through their pediatric primary care providers with support from CPAN and or referrals to other community mental health specialists. In schools with existing school-based mental health programs, TCHATT has been able to support students with the most urgent psychiatric needs and assist the schools in developing a crisis and ongoing plan of care along with providing expertise and training to school personnel on mental health best practices.[46]
- **The Consortium's Child Psychiatry Access Network (CPAN)** connects pediatricians and primary care providers with expert treatment guidance and training from consultation hubs located in Texas medical schools across the State at no cost to providers.[47]
- **The Consortium's Pediatric Collaborative Care Model Implementation** will deploy $7 million in American Rescue Plan Act (ARPA) funds in 2022 through partnerships with the Meadows Institute and nine Texas medical schools to accelerate implementation and integration of mental health care in pediatric settings using the Collaborative Care model (CoCM) to increase access across 18 Texas health systems.

Question. Do you see a role for the Federal Government beyond providing guidance and technical assistance to State programs?

Answer. We agree that the Federal Government plays an important role in providing guidance and technical assistance to State programs, but more can be done. The Federal Government is also uniquely positioned to facilitate coordination and to identify and scale innovative programs to reduce duplication of efforts and support partnerships. In doing so, the Federal Government's role is not to innovate, but to support innovation that facilitates long-term, sustainable program design and implementation. Additionally, the Federal Government is not doing enough to evaluate programs through research and program effectiveness studies. These data can provide invaluable information for communities that otherwise may have difficulty evaluating and comparing programs.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What are your recommendations for Congress to address the following mental health issues?

Children's mental health crises.

Answer. Even before COVID–19, the mental health of children suffered, worsening dramatically over the past decade. Suicide is now the second leading cause of death for youth and young adults and, in the 12 years prior to the pandemic,[48] the rate of death from suicide for youth increased over 55 percent.[49] Health providers, schools, and families alike were feeling increasingly overwhelmed, and the pandemic brought these longstanding issues to an unprecedented crisis point. The spike in need began early in the pandemic with the proportion of mental health-related emergency department visits increasing 31 percent among adolescents ages 12–17.[50] After stabilizing somewhat in the latter part of 2020, rates shot back up again and have continued to slowly rise at crisis levels. The rate of pediatric emer-

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[46] The University of Texas System. (n.d.). Texas Child Mental Health Care Consortium. *https://tcmhcc.utsystem.edu/tchatt/*.

[47] The University of Texas System. (n.d.). Texas Child Mental Health Care Consortium. *https://tcmhcc.utsystem.edu/cpan/*.

[48] Stone, D.M., Jones, C.M., and Mack, K.A. (2021). Changes in suicide rates—United States, 2018–2019. *Morbidity and Mortality Weekly Report (MMWR),* 70(8), 261–268. *https://doi.org/10.15585/mmwr.mm7008a1.*

[49] Curtin, S.C., and Heron, M. (2019, October). *Death rates due to suicide and homicide among persons aged 10–24: United States, 2000–2017.* National Center for Health Research. *https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf.*

[50] Leeb, R.T., Bitsko, R.H., Radhakrishnan, L., Martinez, P., Njai, R., and Holland, K.M. (2020). Mental health-related emergency department visits among children aged 18 years during the COVID–19 pandemic—United States, January 1–October 17, 2020. *Morbidity and Mortality Weekly Report (MMWR),* 69(45), 1675–1680. *https://doi.org/10.15585/mmwr.mm6945a3.*

gency room visits related to suicide is now double the pre-pandemic levels[51] and children in the Texas foster care system are at highest risk in the State.

Parents are also being affected by the burden of caregiving during the pandemic and, as compared to non-parents, are more likely to suffer from depression and about 50-percent more likely to experience serious suicidal ideation, making them less able to care for their children in need.[52] These trends are affecting all youth, but the burden is falling more heavily on two groups primarily: (1) girls and young women and (2) children of color.

Without alternatives, young people experiencing mental health crises are increasingly showing up in emergency rooms, a reality that led the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association to declare a National State of Emergency in Child and Adolescent Mental Health. Ideally, children's hospitals and other facilities would have additional inpatient capacity to care for the increase of children in need. However, it takes years to establish and start a new hospital, and it may not make sense to surge resources over the long term if we do not expect the current surge in demand to continue indefinitely.

To bridge the gap, we strongly support the funding of on-the-ground crisis supports that meet the unique needs of children during this time. Current crisis services do not function as a coordinated system, which prevents children and youth from getting the services they need when and where they need them. Although we ideally want children and youth in crisis to be served in the community, emergency departments and law enforcement are often the first point of entry into the mental health system. Importantly, crisis services and interventions to de-escalate a crisis for children and youth are different than those provided to adults. However, emergency departments and law enforcement often lack the specialized expertise or resources needed to effectively respond to pediatric mental health crises.[53]

This specialized capacity is essential because current crisis responders may lack the information and expertise to effectively serve young people in crises, often resulting in children and youth being prescribed the wrong medications, including too much medication at times, or nothing at all.

Assessments by the Meadows Institute across Texas have found that the biggest gap in crisis systems is for specialized crisis response teams for children. As far as we are aware, no provider in Texas operates one, and most providers lack the specialized staff to do so. Research clearly shows that the single best service to reduce pressure on foster care systems and hospital emergency rooms is a pediatric crisis stabilization and response team (PCSRT). We strongly encourage this committee to support the establishment of PCSRTs and to ensure that SAMHSA and CMS prioritize their inclusion, funding, and support in their 988 rollout-related activities.

PCSRTs differ from traditional mobile crisis outreach teams (MCOTs) in two major ways. First, they are staffed by people who know how to work with families (rather than just individuals) and child-serving systems, especially child welfare, schools, and juvenile justice settings (rather than people who primarily know how to work with adult-serving systems like jails and homeless shelters). Second, PCSRTs are staffed much more intensively (*i.e.,* with capacity to provide dozens of

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[51] Yard, E., Radhakrishnan, L., Ballesteros, M.F., Sheppard, M., Gates, A., Stein, Z., Hartnett, K., Kite-Powell, A., Rodgers, L., Adjemian, J., Ehlman, D.C., Holland, K., Idaikkadar, N., Ivey-Stephenson, A., Martinez, P., Law, R., and Stone, D. (2021, June 18). Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID–19 Pandemic—United States, January 2019–May 2021. *Morbidly and Mortality Weekly Report, U.S. Department of Health and Human Services/Centers for Disease Control and Prevention,* 70(24), 888–894. *https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7024e1-H.pdf.*

[52] Czeisler, M.E., Rohan, E.A., Melillo, S., Matjasko, J.L., DePadilla, L., Patel, C.G., Weaver, M.D., Drane, A., Winnay, S.S., Capodilup, E.R., Robbins, R., Wiley, J.F., Facer-Childs, E.R., Barger, L.K., Czeisler, C.A., Howard, M.E. and Rajaratnam, S.M.W. (2021). Mental health among parents of children aged less than 18 years and unpaid caregivers of adults during the COVID–19 pandemic—United States, December 2020 and February–March 2021. *Morbidity and Mortality Weekly Report (MMWR),* 70(40), 888–894. *https://doi.org/10.15585/mmwr.mm7024a3.*

[53] National Association of State Mental Health Program Directors. (2018). *Making the case for a comprehensive children's crisis continuum of care.* National Association of State Mental Health Program Directors. *https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf.*

hours of care over time as opposed to less than 10 hours on average) to go beyond initial crisis stabilization and follow-up with specialized features:[54]

- **Ability to respond proactively to an urgent need** that is escalating, rather than simply in response to a crisis when an out-of-home placement or inpatient stay is unavoidable.
- **Ongoing 24/7 availability of comprehensive in-home supports.** PCSRTs must continue to be available to needs 24/7 post-crisis. It's not enough just to provide linkages to community clinics; the teams must be able to come onsite repeatedly to provide supports and treatment, including medication monitoring, which can be via portable telehealth units the teams bring with them.
- **Prioritizing children in foster care.** The teams should be required to prioritize children and families in the child welfare system with urgent or severe mental health needs, but also be available community-wide to reduce the burden on hospitals and residential facilities for children and youth.
- **Available to serve every child with an urgent need,** and not just children in poverty or enrolled in the Medicaid program.

Question. Addiction and recovery.

Answer. Despite the effectiveness of medication-assisted treatment (MAT), less than half of people with OUD receive MAT. An analysis by the national nonprofit Shatterproof found that 39 percent of counties in the United States do not have access to buprenorphine, the gold standard MAT.[55] Less than 6 percent of providers have received the waiver necessary to prescribe buprenorphine. Many prescribers do not pursue a waiver due to time constraints, inadequate education about addiction medicine, or concern about OUD-related stigma.

The Meadows Institute urges Congress to pass the Mainstreaming Addiction Treatment (MAT) Act of 2021 (S. 445/H.R. 1384), bipartisan legislation that would eliminate the requirement that practitioners apply for a waiver through the DEA to prescribe buprenorphine for SUD treatment. The legislation also directs SAMHSA to conduct a national campaign to educate health-care practitioners and encourage them to integrate substance use disorder treatment into their practices. The reality is that there are few restrictions on the ability to prescribe opioids, thus it makes little sense to restrict the ability to prescribe medications to combat the OUD crisis.

As we have repeatedly emphasized in our testimony and in these answers to QFRs, the key to addressing SUD is to integrate behavioral health into primary care through the use of Collaborative Care Models and by building on and expanding legislation such as the Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) to help primary care providers implement integrated behavioral health and primary care models. However, the ambition of that legislation is too small given the scope of our national mental health and addiction crisis (we are spending $30 million in Texas alone with our philanthropic efforts to expand access to about half the State), and if the scope can be expanded, the bill should also support implementation of the Primary Care Behavioral Health (PCBH) model (in addition to CoCM).

We must end the artificial bifurcation of treatment for these illnesses and ensure intervention and treatment begins as early as possible. Intervening early results in better outcomes, especially when patients can receive the care they need in their primary care provider's office. At the Meadows Institute, we have modeled that universal access in primary care settings across America to the Collaborative Care Model (CoCM) and Medication-Assisted Treatment (MAT)—could save almost 40,000 lives a year from suicide (14,500) and overdose (24,000).[56]

Question. Crisis intervention, including support for law enforcement responding to mental health incidents.

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[54] Children's Mental Health Campaign. (2022). *Pediatric behavioral health urgent care. https://www.childrensmentalhealthcampaign.org/pediatric-bh-urgent-care/.*

[55] Shatterproof, A Report: County Buprenorphine Access in the United States, *https://www.shatterproof.org/sites/default/files/2020-04/Shatterproof%20OUD%20Brief_R03_42220.pdf.*

[56] Meadows Mental Health Policy Institute. (2020). COVID–19 Briefing: Modeling the Effects of Collaborative Care and Medication-Assisted Treatment to Prevent COVID-Related Suicide and Overdose Deaths. *https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUD Prevention.pdf.*

Answer. We strongly encourage this committee to consider the lessons learned from the process the Texas legislature utilized to redesign crisis services and intervention services more than a decade ago. Through a series of strategic investments every biennium and implementation efforts focused on local communities' needs, Texas crisis redesign has become a national model of reform. Critical to this effort was the passage of Texas Senate Bill 292 in 2017, which included a State-local partnership, a model that we strongly encourage this committee to consider.

S.B. 292 created the Mental Health Grant Program for Justice-Involved Individuals. The program provides grant funding to community collaboratives to reduce the frequency of arrests and incarceration of individuals with mental illness and to reduce wait times for forensic commitment of individuals with mental illness to a State hospital.

The key feature of the model is the state-local partnership in which a county-based collaborative designs a program and draws down State grant funds. The local collaborative must also provide matching funds from non-State sources equal to a percentage of the State grant amount. The matching amount is on a sliding scale based on the population of the county where the program is proposed, ranging from 100 percent of the grant amount down to 25 percent of the grant amount. For the 2022–23 biennium, the Texas legislature appropriated $60 million in State grant funds in this program.

Among the acceptable uses for the grant money is the establishment of interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies. As detailed above, this option, more commonly known as Multi-Disciplinary Response Teams (MDRTs), such as RIGHT Care in Dallas, shows how communities are coming together to design effective health-care responses to crisis calls.

The MDRT model is chiefly designed to divert people with mental illness from unnecessary arrest and connect them with community-based treatment, while reducing law enforcement's role and footprint in crisis services. The components of the MDRT model include: (1) data linkage to facilitate rapid identification of mental health calls and real-time data on past mental health services to inform team decision making; (2) a paramedic-led multidisciplinary co-response team that deploys a law enforcement officer, a behavioral health clinician, and a paramedic to respond as one unit to mental health calls; and (3) a clinically informed dispatch system in which a clinician is embedded in the dispatch call center either in person or virtually to triage mental health calls.

With the rollout of 988 and the need to design more robust crisis systems in communities of all sizes, Congress should look to Texas as a model for crisis reform and funding models that provide communities with the flexibility to design a medically facing response to crisis that relieves the current burden that falls on law enforcement.

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. During the hearing, I mentioned that 3 years ago, Senator Bennet and I passed the Advancing Care for Exceptional Kids Act, or ACE Kids. ACE Kids establishes a pediatric health home for kids with complex medical conditions. This better aligns Medicaid rules and payment to incentivize care coordination, including mental health care. These kids often see five to six specialists and 20 to 30 health professionals—care coordination is critical. This October, the Centers for Medicare and Medicaid Services (CMS) will fully implement ACE Kids. State Medicaid programs will have the tools to better coordinate care for these kids, rather than facing barriers to care and red tape. We know that kids with complex medical needs are more at-risk for mental illness. One study suggests 38 percent have a mental health diagnosis and many face challenges in accessing mental health care. Their parents are five times more likely to have poor mental health. It's important CMS implements ACE Kids timely, but Congress must also build upon this law by passing the Accelerating Kids' Access to Care. This bill will streamline the screening and enrollment process for out-of-State pediatric care providers. I hope this bipartisan bill will be in the committee's mental health package. The bill will improve the mental health of kids with complex medical needs. Given my longstanding work on both laws and pending legislation to improve a kid's ability to access care out-of-State when needed, I know it is not uncommon for children with complex medical conditions to have associated mental or behavioral health needs. I would welcome your

thoughts as to how best to meet mental health needs in complex cases like these, including in particular situations when a child needs to receive treatment out-of-State, such as a complex surgery or organ transplant, and ways to ensure coordination between a child's primary providers and out-of-State specialists. I understand you have provided technical assistance to localities in Texas in setting up programs to assist law enforcement handling mental health crises while on the job. In South Dakota, Avel eCARE started a program in 2020 that helps law enforcement connect into Avel's vast telehealth network for assistance so law enforcement is not driving all over South Dakota to find services.

Are there policy actions we should be considering that haven't already been taken?

Answer. The Meadows Institute strongly agrees that service coordination is key to ensuring the health of children with complex medical needs. The STAR Kids Medicaid managed care model in Texas includes numerous requirements related to service coordination that exemplify these supports.

The higher level of complexity, the more comprehensive and consistent service coordination should be. For example, if the child needs to travel distances for appropriate services, they should have a named and dedicated service provider who helps line up the services and who follows up afterward. Although service coordination is frequently offered in name, there is a lot of room to improve current models. Ideally, service coordinators should not be in a position to approve or deny care and should have mental health training.

Strengths and goals and transitions should in incorporated into service planning. If the screening indicates a potential mental health need, an appropriate assessment should be conducted quickly, and service coordinators should assist the family in connecting with appropriate providers. Transition planning, a formal process for transitioning from pediatric care and school to adult services and systems must start early (by age 14), be a joint effort with the young person, their family, school, health providers, etc. Service coordinators should also play an active role in this process.

Trauma is also something that can easily be overlooked and sadly, children and youth with disabilities are more likely to have experienced traumatic events. Sometimes behaviors that might trigger a trauma screening in other groups of young people are overlooked because of a child's complex needs or disability, but it is extremely important to identify and address past trauma. Frequent assessments to determine if there has been trauma and the use of something like the Trauma Symptom Inventory (TSI) for parents and the CAPS–CA–5 for children are worthy of consideration (for example, the National Childhood Traumatic Stress Network also has a repository of trauma assessments for kids).

Parents and caregivers also need support. Caring for a child with medical complexity is extremely taxing. Doing so can also have a huge cost economically, can create challenges with employers, and present unique challenges to families and to marriages. Providing resources and support to parents and caregivers can help promote safety and stability for everyone, including the young person. Utilizing Certified Family Partners and billing the costs through Medicaid is another way to support families.

As discussed throughout our answers to these QFRs, expanded and well-resourced telehealth services could go a long way to addressing the mental health needs of children with complex needs, particularly for families who must go out of State. Issues such as licensing reciprocity across states impact a child's ability to travel for treatment and still safely (and ethically) maintain continuity of treatment with their home-State providers via teletherapy.

Finally, we strongly support this Congress's work to support the use of technology to simplify and improve care coordination and record keeping. Parents and caregivers of children with medical and behavioral complexity have traditionally relied on overfilled notebooks to manage all the records, eligibility documents, referrals, and appointments for their child. The right technologies could make this part much simpler. A technology platform created in concert with caregivers in these situations could provide a single place for tracking appointments, diagnostic information, provider notes, etc. Privacy features should also be incorporated to determine records access so caregivers could enable more provider peer sharing of relevant information if desired.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. I understand you have provided technical assistance to localities in Texas in setting up programs to assist law enforcement handling mental health crises while on the job. In South Dakota, Avel eCARE started a program in 2020 that helps law enforcement connect into Avel's vast telehealth network for assistance so law enforcement is not driving all over South Dakota to find services.

What have you seen from your experiences coordinating law enforcement and mental health care? I hope it's not only a help to our police, but also results in better outcomes for patients.

Answer. Telehealth services, especially those made available to assist first responders, drastically reduce the "time to treatment" for high acuity patients.[57] Effectively utilizing telehealth can alleviate the burden on first responders, allowing for rapid response during a mental health emergency.

Telehealth services in a mental health context were initially designed to reach clients in underserved areas, whether that was due to geographic constraints or a lack of resources for health care.[58] With access to mental health care becoming increasingly difficult, individuals seeking mental health care have had increased interactions with the criminal justice system; many patients with severe conditions become criminalized as a consequence of receiving inadequate or no treatment for their illness.[59]

In the city of Austin in Texas, clinicians have been embedded into the 911 communications center to assist call takers and dispatchers by triaging incoming mental health calls for service. Call Center Clinicians (C3s) can speak to first responders to guide them through the call, allowing them to divert the individual in crisis safely and efficiently away from the criminal justice system as well as away from the overburdened hospital system.[60] The Austin Police Department has defined telehealth as a primary service citywide, in partnership with the local mental health authority, Integral Care, to use iPads to connect with the Enhanced Mobile Community Outreach Team (EMCOT). Licensed clinicians are assigned to the 911 communications center and are available to assist law enforcement officers with mental health calls for service, including speaking to the patient via telehealth software.[61]

Telehealth in mental health emergency response rapidly brings services to patients, alleviating the burden on an overtaxed emergency departments and hospital systems. Telehealth can also help ensure equity in mental health response, allowing for higher-acuity patients to be triaged by qualified mental health professionals and for the engagement of culturally competent providers who might otherwise be unavailable. Incorporating telehealth services into a multi-disciplinary response team furthers the goal of rapid-response mental health care in order to divert vulnerable individuals from the criminal justice system while also easing the burden on under-resourced systems.

Communities in Texas are incorporating telehealth services when responding to mental health calls for service, whether as part of an MDRT approach or as a standalone tool for law enforcement officers. Examples of communities in Texas using telehealth for a variety of reasons include Harris County, which is currently the largest telehealth program in the country, boasting 250 deputies with tablet computers responding to emergency calls for service that have a mental or behavioral

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[57] Simon, L.E., Shan, J., Rauchwerger S.A., Reed, M.E., Warton, M.E., Vinson, D.R., Konik, Z.I., Vlahos, J., Groves, K. and Ballard, D.W. (2020). *Paramedic's perspectives on telemedicine in the ambulance: A survey study. https://www.jems.com/patient-care/perspectives-on-telemedicine/.*

[58] Bashshur, R.L., Shannon, G.W., Bashshur, N., and Yellowlees, P.M. (2016). The empirical evidence for telemedicine interventions in mental disorders. *Telemedicine and e-Health: The official journal of the American Telemedicine Association,* 22(2), 87–113. *https://doi.org/10.1089/tmj.2015.0206.*

[59] Torrey, E.F., Zdanowicz, M.T., Kennard, A.D., Lamb, H.R., Eslinger, D.F., Biasotto, M.C., Fuller, D.A. (2014). *The treatment of persons with mental illness in prisons and jails: A state survey.* Treatment Advocacy Center. *https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.*

[60] Meadows Mental Health Policy Institute. (2021). *Implementation status of the Austin CARES Program: Final report: City of Austin. https://mmhpi.org/.*

[61] Meadows Mental Health Policy Institute. (2022). *Implementation status of the Austin CARES Program: Interim report: City of Austin. https://austintexas.gov/edims/pio/document.cfm?id=363545.*

health component.[62] Mental health clinicians working remotely are able to assist officers in 20 minutes on average and have the ability to connect to the patient in just 1 minute.

In 2012, the city of Abilene effectively utilized telehealth to provide much-needed health care to HIV+ patients without health insurance, connecting patients to providers via secure video conferencing. Providers were able to discuss lab results and prescribe medication to patients, who otherwise would not receive care—the last full-time infectious disease physician left the area in 2013. This project, coordinated by the Texas Tech University Health Sciences Center, provided care to patients in a 19-county service area, who otherwise would not have had access to regular, ongoing care.

The city of Abilene also engaged telemedicine for pre-hospital care, with a repurposed military MRAP vehicle functioning as a mobile hospital equipped with secure video conferencing software to triage critical patients more effectively and direct them to the appropriate resources for care.[63]

Telehealth services in crisis settings are becoming more widely deployed across Texas, and are being taken up by communities of all sizes, including Plano, McKinney, Allen, Frisco, Wylie, Dallas, Brazoria County, and Harris County (which includes the city of Houston.)

Question. You mentioned challenges with prior authorization in Medicare Advantage. This is an issue Senators Brown, Marshall, Sinema, and I are working on. We think it will make more sense for both patients and providers to streamline and simplify the prior authorization process, make it electronic, and set some clear standards.

Do you think this would help improve patient and provider experience?

Answer. We strongly support this committee's work to address the burdens and obstacles created by the Medicare Advantage pre-authorization process, and we believe it will improve the experience of both the patient and the provider in various ways. Medicare Advantage plans are often subject to unnecessary prior authorization requirements. According to the Kaiser Family Foundation, four in five Medicare Advantage enrollees are in plans that require prior authorization for some services, and more than half of enrollees are in plans that require prior authorization for mental health services.[64] This authorization process has been shown to be wasteful and potentially contributes to clinician burnout.[65] A 2017 American Medical Association survey of 1,000 physicians further noted that 92 percent of those surveyed reported that prior authorizations have a negative impact on their patients' clinical outcomes.[66]

And this negative experience leads many providers to simply opt not to participate. The data show that Medicare Advantage (MA) beneficiaries often lack access to in-network mental health providers, and metrics are often insufficient to ensure an adequate network of providers. This forces participants to turn to higher-cost, out-of-network care or to forego care entirely. A Kaiser Family Foundation analysis found that, on average, MA plans included less than one-quarter of psychiatrists in a county, and more than a third included less than 10 percent of psychiatrists in their county.[67]

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[62] Harris County Sheriff's Office (HCSO). (n.d.). *Telehealth: Technology in Law Enforcement. http://www.harriscountycit.org/telehealth-jump-two/.*

[63] Philips, B.U. (n.d.). Current programs and innovations in telemedicine [PowerPoint slides]. Texas Tech University Health Sciences Center. *https://capitol.texas.gov/tlodocs/84R/handouts/C4102016021009001/3c5178d7-355d-4418-a50c-58b2b296f2fd.PDF.*

[64] Jacobson, G., and Neuman, T. (2018). *Prior authorization in Medicare Advantage plans: How often is it used?* Kaiser Family Foundation. *https://www.kff.org/medicare/issue-brief/prior-authorization-in-medicare-advantage-plans-how-often-is-it-used/.*

[65] Colligan, L., Sinsky, C., Goeders, L., Schmidt-Bowman, and Tutty, M. (2016). *Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews.* American Medical Association. *http://sbrisendine.com/wp-content/uploads/2017/03/ps2-dartmouth-study-111016-1.pdf.*

[66] American Medical Association. (2018). 2017 AMA prior authorization physician survey. American Medical Association. *https://www.amaassn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf.*

[67] Jacobson, G., Rae, M., Neuman, T., Orgera, K., and Boccuti, C. (2017). *Medicare Advantage: How robust are plans' physician networks?* Kaiser Family Foundation. *https://www.kff.org/report-section/medicare-advantage-how-robust-are-plans-physician-networks-report/.*

QUESTION SUBMITTED BY HON. TIM SCOTT

MENTAL HEALTH VS. PHYSICAL HEALTH

Question. Today, our health-care system often reinforces the bias of physical health over mental health—sacrificing one on the altar of the other. However, this is a false choice that often leads to adverse outcomes. Nowhere is this more evident than with COVID–19 lockdowns. In fact, researchers at Johns Hopkins University, the same university whose COVID–19 data tracker has been widely considered to be the gold standard, published a study earlier this year indicating that lockdowns did little to reduce COVID–19 deaths, but instead, caused enormous damage to society, especially with regard to mental health and substance use disorders.

How might policymakers better align taxpayer investment in public health that doesn't create conflicts between physical health and mental health and undermine efforts to create parity between both?

Answer. The Meadows Institute strongly agrees with Senator Scott's sentiment that mental health is simply an aspect of physical health we must eliminate the bias of against mental health versus other components of our physical health. Accordingly, the most important thing that our Nation can do to address the mental health and substance use disorder crisis is to treat these illnesses as the health conditions that they are.

In November of 2021, our CEO, Andy Keller, co-authored an op-ed in Stat with Thomas R. Insel that highlighted an especially salient example of the consequences of this artificial distinction. Drs. Keller and Insel assailed the fact the CDC had delayed the inclusion of mental health conditions in its list of medical conditions that contribute to worse outcomes with COVID–19 infection—despite having nearly a year's worth of scientific reports from around the world demonstrating higher rates of hospitalization and death from COVID–19 in people with serious mental illness.

We have seen similar issues with the CDC's failure to prioritize the collection of statistics on death by suicide. While the CDC reports out on infectious disease deaths across the country weekly, suicide death statistics have, until recently, lagged by 2 years. In fact, this Congress's Consolidated Appropriations Act of 2022 directed the CDC for the first time to "expand and enhance its emergency department syndromic surveillance on suicidal behavior and nonfatal suicide-related outcomes to provide near real-time data on suicidal ideation and attempts, disaggregated by race and ethnicity, age, disability status, and sex, in order to inform community-based suicide prevention efforts."

More broadly, deaths of despair—deaths from suicide, overdose, and alcohol-related disease—likely surpassed 175,000 in 2020, more than deaths from any infectious disease (except COVID–19) and any form of cancer (except lung cancer).[68] This number is a rough estimate that has likely been even higher each year of the past 2 years. Unfortunately, because there is no rigorous, real-time surveillance system for tracking deaths of despair, our ability to monitor and respond is greatly diminished. Again, the artificial distinction between mental health and physical health is harming our Nation's citizens and we are not yet doing enough to prioritize solutions to address it.

We also support the recommendations of the Brookings Institutions' July 2021 report, *Addressing America's crisis of despair and economic recovery: A call for a coordinated effort.* The report calls for a new Federal interagency task force to prioritize and address our Nation's crisis of despair. It notes further that there is no Federal-level entity to provide vulnerable individuals with financial or logistical support, nor is there a system that can disseminate relevant information to other communities seeking solutions. And as detailed above, the CDC may track mortality trends generally, but there is no system to track the underlying causes of these deaths. In contrast, many countries, such as the U.K. and New Zealand, track trends in well-being and ill-being as part of their routine national statistics collection and have key leadership positions focused exclusively on these issues. A new U.S. task force could both monitor trends and coordinate Federal and local efforts in this arena.

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[68] Centers for Disease Control and Prevention and National Center for Health Statistics. (2021). *Drug overdose deaths in the U.S. up 30 percent in 2020.* National Center for Health Statistics. *https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20210714.htm.*

QUESTION SUBMITTED BY HON. STEVE DAINES

Question. While there is still a long way to go to ensure individuals struggling with addiction have access to the treatment they need, medication assisted treatment, or MAT, has helped to limit the number of overdose deaths and improve rehabilitation outcomes. In your testimony, you mentioned there are barriers to MAT in many health plans.

When it comes to Medicare, can you describe what those barriers are and what actions Congress could take to address these issues?

Answer. We applaud this Congress for focusing on the need to increase the availability of MAT in response to the sharp increase in U.S. opioid overdoses and deaths our Nation has experienced in recent years. However, we note that a recent OIG report found that less than 16 percent of the 1 million Medicare beneficiaries diagnosed with an opioid use disorder in 2020 received medication to treat their opioid use disorder.[69] Even more concerning, less than half of the beneficiaries who did receive medication to treat their opioid use disorder also received behavioral therapy. This is a particular concern for the Meadows Institute, since beneficiaries in Texas were even less likely to receive medication for their opioid use disorder than those nationwide.

As we highlighted in our testimony, these failures can be directly traced to the fact that Medicare is not bound by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which prohibits insurers from covering behavioral health services more restrictively than those in the medical and surgical realm. As a consequence, most community-based services delivered by substance use disorder (SUD) treatment facilities are not reimbursed by Medicare and many clinician types that provide SUD treatment—such as Licensed Professional Counselors, Licensed Addiction Counselors, Certified Alcohol and Drug Counselors, and Peer Support Specialists—are not authorized Medicare providers. This results in SUD network adequacy problems and a lack of SUD providers covered by Medicare.

Given these realities, the findings of recent research by RTI International and the Legal Action Center are deeply disappointing but not surprising. These nonprofits found that just 11 percent of the 1.7 million Medicare beneficiaries estimated to have SUDs between 2015 and 2019 received SUD treatment.[70] Financial barriers were the most common reason cited for not receiving SUD treatment.

It is not hyperbole to note this is a matter of life and death. An analysis our organization conducted showed that universal access to MAT could have saved almost at least 24,000 lives nationwide over the course of a single year, including 1,600 drug overdose deaths in Texas.[71]

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

INCREASING ACCESS TO MENTAL HEALTH PROVIDERS IN MEDICARE

Question. As a doctor, I know the importance of improving access to mental health care for all Americans. This is especially important in rural parts of the country, which face some of the largest shortages in the country. For seniors, finding a mental health provider can be particularly challenging. This is because Medicare restricts certain types of mental health providers from billing the program. Senator Stabenow and I introduced bipartisan legislation to address this issue. S. 828, the Mental Health Access Improvement Act would allow licensed professional counselors and marriage and family therapists to bill Medicare. This is especially important in Wyoming, where many of our community mental health centers rely on professional counselors and marriage and family therapists to provide care.

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[69] U.S. Department of Health and Human Services. (2021). *Many Medicare beneficiaries are not receiving medication to treat their opioid use disorder.* Office of Inspector General. https://oig.hhs.gov/oei/reports/OEI-02-20-00390.pdf.

[70] Parish, W.J., Mark, T.L., Weber, E., and Steinberg, D. (2021). *Substance use disorders among Medicare beneficiaries: Insights from analysis of the National Survey of Drug Use and Health.* Working paper.

[71] Meadows Mental Health Policy Institute. (2020). *COVID–19 briefing: Modeling the effects of collaborative care and medication-assisted treatment to prevent COVID-related suicide and overdose deaths. https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf.*

I'm sure the committee would like to hear from anyone else who wants to discuss the importance of increasing access to these professionals.

Answer. There is no question that our Nation is facing a provider shortage. Too many people in need deteriorate to crisis as a direct result of a mental health system that is unable to provide necessary services to those who require them. The Meadows Institute is strongly in favor of efforts to ensure there is an expanded workforce that can meet the Nation's mental health needs and that deploys every type of professional, from peer specialists to physicians, in a way that optimizes their response to this national emergency. This includes licensed professional counselors and marriage and family therapists.

Toward that end, we believe that every mental health and addiction professional should practice at the maximum boundary of the scope for which they were trained. We also believe that parity and financing obstacles should never be a barrier to providing such care, and coverage by Medicare for all professionals able to provide Medicare-covered benefits is essential to reducing such barriers. We understand that there may be specific issues around particular aspects of the treatment process, such as ensuring professionals are not asked to practice beyond the scope of their training, and we are encouraged that this committee is prioritizing these issues and working to address these pressing needs.

TELEHEALTH

Question. Patients in Wyoming are using telehealth to help meet their health-care needs during the pandemic. Members of this committee support making sure telehealth becomes a permanent part of health-care delivery for those patients who want to utilize this service. Congress, with bipartisan support, has already taken steps to extend telehealth flexibilities for 5 months following the expiration of the public health emergency.

Can you discuss the importance of telehealth in terms of the delivery of mental health services?

Answer. The COVID–19 pandemic confirmed the utility of telehealth to serve people with mental health needs within a variety of environments. The Meadows Institute strongly supports this Congress' efforts to make regulatory relief for telehealth—including audio-only telehealth—permanent and we encourage this committee to support the innovative efforts of states like Texas to expand options and opportunities to meet the needs of its citizens through telemedicine.

Telehealth expansion has enjoyed broad bipartisan support in Texas, as evidenced by the passage of Texas House Bill 4 in 2021, which made permanent the State's emergency telehealth waivers that had been temporarily granted during the COVID–19 pandemic. The ongoing COVID–19 pandemic spurred an unprecedented shift to the delivery of care through telemedicine, telehealth, and telephone (audio-only) across the State, alleviating mental health professional shortages by making services more accessible for people in need, including those in rural and underserved areas.

Accessing tele-behavioral services has also been a vital strategy to mitigate the spread of COVID–19. Audio-only services ensure that behavioral health providers can provide treatment to people who have no access to broadband or other technology—a common concern in rural and underserved communities. We encourage this committee to support policies to ensure recipients can access much-needed mental health and SUD treatment through telehealth, including audio-only options, on a permanent basis. Returning to the pre-COVID–19 status quo will lead to higher costs through delays in treatment and worsening conditions.

Expanded telehealth options have been integral to implementing innovations to serve the behavioral health needs of children and adolescents in Texas, such as the Texas Child Health Access Through Telemedicine (TCHATT) program discussed previously in this response. In the TCHATT program, multidisciplinary providers at participating medical schools provide telemedicine and telehealth services to public school students experiencing a mental health crisis at no cost to school districts. Providers work collaboratively with each other, family members, and school counselors to assess, triage, and stabilize a student prior to connecting them with providers in their communities for ongoing support. More than 2 million Texas students now have access to TCHATT services.

Expanded telehealth access has also allowed Texas to implement innovative crisis response solutions. Because of the unpredictable nature of police calls for service,

crisis workers may not be able to deploy to every call where they may benefit a situation. In Texas and in cities across the country, mobile telehealth is proving to be a workforce multiplier, significantly enhancing systems and making it possible to immediately connect people to crisis and health services.

Telehealth in mental health emergency response rapidly brings services to patients, alleviating the burden on overtaxed emergency departments and hospital systems. Telehealth can also help ensure equity in mental health response, allowing for higher-acuity patients to be triaged by qualified mental health professionals and for the engagement of culturally competent providers who might otherwise be unavailable. Incorporating telehealth services into a multi-disciplinary response team furthers the goal of rapid-response mental health care in order to divert vulnerable individuals from the criminal justice system while also easing the burden on under-resourced hospital systems.

One example is the city of Austin, where clinicians have been embedded into the 911 communications center to assist call takers and dispatchers by triaging incoming mental health calls for service. Call Center Clinicians (C3s) can speak to first responders to guide them through the call, allowing them to divert the individual in crisis safely and efficiently away from the criminal justice system as well as away from the overburdened hospital system.[72] The Austin Police Department has defined telehealth as a primary service citywide, in partnership with the local mental health authority, Integral Care, to use iPads to connect with the Enhanced Mobile Community Outreach Team (EMCOT). Licensed clinicians are assigned to the 911 communications center and are available to assist law enforcement officers with mental health calls for service, including speaking to the patient via telehealth software.[73]

In April of 2022, Austin reported that, as a result of the embedded clinicians, the city is on track to divert nearly 8,000 calls away from a law enforcement response to clinicians for the year. Further analysis of Austin's information sharing procedures found that, when officers were aware of a mental health crisis component, arrest rates were 45 percent lower and use of force was as much as 56.3 percent lower.

Other good examples of communities in Texas using telehealth to assist in crisis response include Harris County, which is currently the largest telehealth program in the country, boasting 250 deputies with tablet computers who are responding to emergency calls for service that have a mental or behavioral health component.[74] Mental health clinicians working remotely are able to assist officers in 20 minutes on average and have the ability to connect to the patient in just one minute.

CARE INTEGRATION

Question. Thank you for your thoughtful testimony today. In particular, I appreciated your written testimony regarding the importance of integrating primary care and behavioral health.

I was able to visit with representatives from the Wyoming Psychological Association. They agree with you that making mental health care better integrated and coordinated with physical health care is an important priority. The problem in Wyoming and other parts of rural America is we simply lack the mental health providers to provide care.

Can you discuss the ways we can better integrate behavioral health into primary care?

Answer. Success against any disease depends on these three factors: (1) detection as early as possible; (2) evidence-driven treatment as early as possible; and (3) prevention. In under a year, United States researchers and health systems learned to do all three well against COVID–19. We had previously used these approaches to make historic gains for other diseases, including heart disease and cancer. We have yet to do this for mental illness and addiction. Today in Texas and across the United States more broadly, we do not detect and treat mental illness—to the extent we detect and treat it at all—until 8–10 years after symptoms emerge. Instead, we wait until suffering becomes obvious to the person (or the people around them), too often

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[72] Meadows Mental Health Policy Institute (2021) *Implementation Status of the Austin CARES Program: Final Report: City of Austin. mmhpi.org.*

[73] Meadows Mental Health Policy Institute (2022). *Implementation status of the Austin CARES Program: Interim report: City of Austin. https://austintexas.gov/edims/pio/document.cfm?id=363545.*

[74] Harris County Sheriff's Office (HCSO). (n.d.). Telehealth: Technology in Law Enforcement. *http://www.harriscountycit.org/telehealth-jump-two/.*

in the form of a crisis that leads to an emergency room, hospital, or—particularly for Black and Indigenous people, other people of color, and people in poverty—a criminal justice setting. To focus in on just one major mental illness, depression: less than 1 in 15 of the over 1.5 million Texans suffering from depression each year receive the care needed to achieve symptom remission, and nearly 4,000 die annually from suicide, even though efficacy rates for available depression treatments are over 60 percent.[75]

The primary lesson that needs to be learned from the COVID–19 pandemic is that the Nation can rapidly scale up and deliver early detection, treatment, and prevention if we pair the will to act with the necessary resources. American researchers and health-care systems have successfully turned the tide on heart disease and cancer using the same approaches. Until the 1980s, we identified heart disease primarily when a person had a heart attack, and we began treatment then, after the heart was damaged, to resuscitate the person and prevent a recurrence. We also used to wait to detect cancer until it resulted in functional impairment—a broken bone, coughing up blood—with devastating consequences and higher mortality rates. Today, we have systems in place in primary care and the community that detect most heart disease and many cancers much earlier, when they are easier to treat successfully, much less likely to be disabling and burdensome to the person receiving care, and less costly to society. Fortunately, this is much easier to do for mental illness and addiction because we already know how to successfully detect and treat most of these conditions. We just need to do it.

Today in Texas, we are showing that rapid scaling up and transition is possible. The Meadows Institute is currently the lead on a 5 year, $10 million effort called the Lone Star Depression Challenge. This effort has acquired additional philanthropic support totaling nearly $15 million more to expand and accelerate its reach, and the State of Texas recently added $7 million in American Rescue Plan Act (ARPA) funds to accelerate the implementation and integration of mental health care in pediatric settings to increase access across 18 more Texas health systems.

The clinical components of the Lone Star Depression Challenge center on scaling mental health detection and treatment in primary care using two proven approaches: (1) Measurement-Based Care (MBC), the systematic use of repeated, validated measures to track symptoms and functional outcomes in clinical settings, and (2) the Collaborative Care Model (CoCM), an approach to the treatment of depression pioneered by the AIMS Center at the University of Washington and refined over the last 3 decades that involves the integration of care managers and consultant psychiatrists directly within primary care settings to provide care that can help over 40 percent of people treated in primary care achieve full remission and another 25 percent achieve substantial relief.[76]

CoCM is well established with over 80 randomized control trials documenting its efficacy, and its ability to improve health outcomes overall has been proven to bend the cost curve with a six-to-one cost savings primarily derived by improvements in comorbid diseases that depression worsens, like diabetes and hypertension. Studies have also demonstrated Improved outcomes for opioid use disorders.[77] Just as importantly, Cloudbreak is based on an approach (CoCM) proven to work just as well for Black and Latino communities and other communities of color.[78, 79, 80]

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[75] Pence, B.W., O'Donnell, J.K., and Gaynes, B.N. (2012). The depression treatment cascade in primary care: A public health perspective. *Current Psychiatry Reports,* 14(4), 328–335. *https://doi.org/10.1007/s11920-012-0274-y.*

[76] Carlo, A.D., Barnett, B.S., and Unützer, J. (2021). Harnessing collaborative care to meet mental health demands in the era of COVID–19. *JAMA Psychiatry,* 78(4), 355. *https://doi.org/10.1001/jamapsychiatry.2020.3216.*

[77] Read more about Cloudbreak here: *https://mmhpi.org/the-cloudbreak-initiative/.*

[78] Wells, K., Sherbourne, C., Schoenbaum, M., Ettner, S., Duan, N., Miranda, J., Unützer, J., and Rubenstein, L. (2004). Five-year impact of quality improvement for depression: Results of a group-level randomized controlled trial. *Archives of General Psychiatry,* 61(4), 378–386. *https://pubmed.ncbi.nlm.nih.gov/15066896/.*

[79] Areán, P.A., Ayalon, L., Hunkeler, E., Lin, E.H.B., Tang, L., Harpole, L., Williams, J.W., Unützer, J., and IMPACT Investigators. (2005). Improving depression care for older, minority patients in primary care. *Medical Care,* 43(4), 381–390. *https://pubmed.ncbi.nlm.nih.gov/15778641/.*

[80] Ell, K., Aranda, M.P., Xie, B., Lee, P-J., and Chou, C-P. (2010). Collaborative depression treatment in older and younger adults with physical illness: Pooled comparative analysis of three randomized clinical trials. *American Journal of Geriatric Psychiatry,* 18(6), 520–530. *https://pubmed.ncbi.nlm.nih.gov/20220588/.*

CoCM is also the only evidence-based medical procedure currently reimbursable in primary care, including by Medicare, nearly all commercial payers,[81] and an increasing number of Medicaid programs. Leading employer and private-sector purchasing groups are also calling for its expansion. The potential cost savings of widespread implementation are considerable: a pivotal 2013 study found Medicare and Medicaid savings of up to six-to-one in total medical costs and an estimated $15 billion in Medicaid savings if only 20 percent of beneficiaries with depression received CoCM services.[82] The primary barriers to adoption are start-up costs and the need for technical assistance.

As detailed in our testimony, the Meadows Institute encourages the committee to support large-scale efforts to build integrated care infrastructure and widescale adoption of models such as CoCM. We also encourage the committee to support the Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) as a base for a rapid, emergency re-tooling of the Nation's primary care practices to address the out-of-control mental health and addiction crisis facing America today, especially among the Nation's youth and young adults. We believe that the ambition of that legislation is too small given the scope of this crisis (we are spending $30 million in Texas alone with our philanthropic efforts to expand access to about half the State), and if the scope can be expanded, the bill should also support implementation of the Primary Care Behavioral Health (PCBH) model (in addition to CoCM). A comprehensive 2021 RAND study[83] offered specific recommendations similar to those in H.R. 5218 likely to cost under $1 billion total for rapidly scaling CoCM (and related practices) nationwide through: (1) incentive grants to overcome start-up costs, and (2) and technical assistance to access existing billing codes that can cover ongoing costs.

PREPARED STATEMENT OF ANNA RATZLIFF, M.D., PH.D., CO-DIRECTOR, ADVANCING INTEGRATED MENTAL HEALTH SOLUTIONS (AIMS) CENTER; AND PROFESSOR, UNIVERSITY OF WASHINGTON

Chairman Wyden and Ranking Member Crapo, thank you for conducting the hearing today entitled, "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration."

My name is Dr. Anna D. Ratzliff. I am a psychiatrist and Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington where I am a national expert on the Collaborative Care Model and specifically, on training teams to implement and deliver mental health treatment in primary care settings. I have developed additional expertise in suicide prevention training, mental health workforce development, adult learning best practices, and mentorship. I am the director of the UW Psychiatry Resident Training Program at UW Medicine, co-director of the AIMS Center (Advancing Integrated Mental Health Solutions) and director of the UW Integrated Care Training Program for residents and fellows. As a member of the American Psychiatric Association (APA), I have partnered closely with the APA to disseminate and promote improved access to care through behavioral health delivery in primary care settings or integrated care and to advocate for policies that would support deployment of this model more broadly.

I thank you for having me here today to address the myriad issues surrounding the state of our Nation's mental health.

I sit here before you today because the COVID–19 pandemic continues to exacerbate mental health conditions, including substance use disorders (MH/SUD). Data show that COVID–19 has impacted almost every single aspect of our lives, from job security to health equity, health outcomes and beyond. Though, as we near the particularly grim number of losing a million Americans to the pandemic, being a part of this panel here today makes me hopeful that Congress and our Nation will do the difficult work of addressing the MH/SUD pandemic that we are facing.

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[81] Alter, C., Carlo, A., Henry Harbin, and Schoenbaum, M. (2019). Wider Implementation of Collaborative Care Is Inevitable. *Psychiatrics News. https://doi.org/10.1176/appi.pn.2019.6b7.*

[82] Unützer, J., Harbin, H., Schoenbaum, M., and Druss, B. (2013, May). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes.* Health Home Information Resource Center. *http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf.*

[83] McBain, R.K., Eberhart, N.K., Breslau, J., Frank, L., Burnam, M.A., Kareddy, V., and Simmons, M.M. (2021). *How to transform the U.S. mental health system: Evidence-based recommendations.* RAND Corporation. *https://www.rand.org/pubs/research_reports/RRA889-1.html.*

Before I get into the policy recommendations of my testimony, it is important to stress that as psychiatrists, we often see patients who cannot advocate for themselves. As such, it is our professional responsibility to speak for our patients by promoting policies that help them get access to lifesaving care. I will reference a handful of my patients in my testimony here today along with the many ways that Congress can help promote policies to improve access to help patients like mine.

These policies include incentivizing the integration of behavioral health care into primary care, addressing health equity, and increasing access to telehealth. Championing evidence-based policies that ensure that our patients receive the mental health and substance use disorder care that they need will save lives and reduce overall health costs. I will detail these policy proposals throughout my testimony below.

INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE

As we continue to build our workforce pipeline and as our health-care system moves toward value-based integrated care, the most promising near-term and immediate strategy for providing prevention, early intervention and timely treatment of mental illness and substance use disorders is the implementation of evidence-based integrated care models using a population-based approach. **The Collaborative Care Model (CoCM)** is a specific model of integrated care developed at the University of Washington to treat common and persistent mental health conditions such as depression and anxiety. **The CoCM is an evidence-based integrated care model with over 90 validated studies to show its effectiveness and has been recognized by the Centers for Medicare and Medicaid Services (CMS) with specific billing codes introduced in 2017.** This approach provides MH/SUD treatment in a primary care office through consultation between a primary care clinician (PCP) working collaboratively with a psychiatric consultant and a behavioral health-care manager to manage the clinical care of behavioral health patient caseloads.

One of my patients, Daniel, who has given me permission to share his story, represents the advantages of integrated behavioral health care, specifically the CoCM, as an access point to care. Daniel struggled with untreated mental health symptoms in young adulthood, eventually leading to a suicide attempt. He sought treatment in primary care and at his first visit with his new PCP, she recognized that he was struggling with mental health symptoms and referred him to a behavioral health-care manger whose office was just down the hall. Daniel's PCP was able to walk with him to meet the behavioral health provider that day and to schedule an intake appointment the same week. As the psychiatric consultant, I was able to review his case within a few days during my regular meeting with the behavioral health-care manager. This consultation was conducted using telepsychiatry since my office was not located in the primary care setting and allowed me to review multiple patients at that clinic in the time I would normally only be able to see one patient. We were able to determine his diagnosis, and I provided recommendations for medications for the primary care provider to prescribe and behavioral treatments, like behavioral activation, for the behavioral health-care manager to deliver when she met with Daniel about every other week. Within weeks, he was feeling better, and he enrolled in local community college. He eventually was able to successfully complete his training to become a medical assistant. This example is important because Daniel said that he never would have sought mental health care if it had not been so seamless, especially when it was early in his treatment. His mother feels that this access saved his life.

Though Daniel's is just one story, the CoCM is population-based, facilitating treatment for many more patients, and dramatically improving patient access in comparison to integrated models that use one-to-one care. This innovative model allows patients to receive behavioral health care through their PCPs, often alleviating the need for referrals, which frequently take months and too often result in patients receiving no care. This is especially important as studies slow only 50 percent of patients who receive a referral for specialty mental health care ever follow through with the referral. Among those who do, many do not have more than one visit.

Implementation of the CoCM is a critical strategy to quickly improve access for patients by extending the current workforce, especially given the shortage of all mental health clinicians. This evidence-based model of integrated care allows for the early diagnosis and intervention of mental health conditions in the primary care setting and is proven to prevent emergency room visits and/or hospitalizations. **More widespread use of the model can help to alleviate a portion of the current**

psychiatric workforce shortage by leveraging the expertise of the psychiatric consultant to be able to provide treatment recommendations to the PCP on a panel of patients, generally 60–80 patients, in as little as 1–2 hours a week. This is possible because the CoCM is a team-based approach in which the psychiatric consultant prioritizes their attention only to the patients that need their expertise. Given the ability for the psychiatric consultant to provide treatment recommendations to the PCP on multiple patients versus seeing these patients 1:1, the CoCM is a superior model for improving access to MH/SUD care quickly and more effectively to a broader population versus colocation models of integrated care.

Further, the CoCM uses measurement-based care, which means that the patient's progress is tracked regularly, and treatment is adjusted if clinically indicated. This means that practices can easily identify patients that are getting better and patients who may need to access more intensive services, strategically allocating resources so that each patient is able to receive just the right amount of care.

Serving Rural Communities

In my work supporting clinics to implement integrated care, I have had the opportunity to work to adapt this model to serve rural communities. I partnered with one of our Washington rural access hospitals that had an active primary care clinic. In this setting, the clinic employed a behavioral health-care manager who could work closely with a psychiatric consultant located at UW Medicine on the other side of the State. This approach allowed patients to receive care without fear of stigma and to avoid spending potentially hours in the car to travel to a behavioral health prescriber. With our partnership, the primary care providers also felt better supported to deliver appropriate MH/SUD care to their communities. This example demonstrates the power of integrated care to leverage scarce psychiatric expertise to serve all our communities.

These stories from my practice show that the CoCM can work in discrete exemplar settings. However, the data on the model's effectiveness show more broadly that implementing the CoCM can more than double the chance that a patient will have a meaningful response to MH/SUD treatment. In addition, studies show that the CoCM can improve access to care for patients in rural or underserved areas. Because consultations between the team members can be provided remotely, the model addresses the uneven distribution of the mental health workforce and leverages the scarce psychiatric workforce.

Addressing Health Equity

In my role as a psychiatric consultant, I have had the opportunity to work with a primary care clinic that provided culturally and linguistically appropriate health care to a population in which six out of seven patients were Black, Indigenous, People of Color (BIPOC). In this clinic, I worked with a woman who had recently had her second child and developed postpartum depression. She was able to meet with her behavioral health-care manager, was diagnosed with major depressive disorder and was able to work with the CoCM team members to choose the best treatment for her from a range of evidence-based options from medications prescribed by the primary care provider to brief behavioral interventions delivered by the behavioral health-care manager. All of these treatments were immediately available without any need for a referral. For this patient, evidence-based therapy was her preferred treatment and an approach that was more culturally acceptable to her. The team was able to monitor her symptoms in response to treatment to make sure that she got better.

This example is consistent with studies that compared depression outcomes in BIPOC and white patients who received treatment with the Collaborative Care Model, with results showing either equivalent or significantly better outcomes for BIPOC patients. This makes the CoCM an important strategy to improve behavioral health equity.

Financial Considerations

Expanding the use of the CoCM can also help reduce health-care costs. The CoCM is currently being implemented in many large health-care systems and practices, and is also reimbursed by Medicare, most private insurers, and numerous State Medicaid programs. According to the University of Washington AIMS Center, long term analyses of the CoCM have demonstrated that every $1 spent on CoCM saves $6.50 in health-care costs—a return on investment of over six to one. In this research, the health-care savings came from across all categories, including inpatient/outpatient medical, inpatient/outpatient psychiatry, and pharmacy. Though implementing the CoCM makes sense from the perspective of expanded ac-

cess, improved outcomes, and long-term financial savings, unfortunately, the requisite start-up costs have proven to be a barrier to its adoption by many primary care practices. Implementing the CoCM requires up-front investments by primary care offices to upgrade their electronic medical records, hire behavioral health-care managers, etc.

Policy Considerations

In my role as the AIMS Center co-director, I have worked to implement the Collaborative Care Model at hundreds of clinics nationally and internationally. I have also partnered closely with the APA to deliver training and technical assistance as part of a large 4-year project in which we trained approximately 10 percent of U.S. psychiatrists in the skills needed to deliver Collaborative Care. This work in settings across the U.S. has informed the specific recommendations outlined below. **I encourage the committee to consider the following policy recommendations that the APA has outlined to further the adoption of the CoCM:**

- Fund primary care offices to assist with the implementation of the Collaborative Care Model.
- Eliminate the patient cost-sharing requirement under Medicare to remove an additional barrier to care for Medicare beneficiaries. Practices that have implemented the CoCM have seen patient attrition because of the cost-sharing requirements despite patients reporting benefits of the CoCM model.
- Increase the current reimbursement for CPT codes for the CoCM to more appropriately reflect the value and benefits of services and care being provided to patients with MH/SUD needs and to incentivize primary care to invest in the model that has proven health-care savings.

TELEHEALTH

I have learned in my clinical experiences, telehealth is an important strategy to increase access to general psychiatric care and also supports and complements integrated care. I want to acknowledge and express my appreciation of how the rapid expansion of telepsychiatry authorized by Congress and the last two administrations has significantly enhanced patient access to care. In the practices that I currently support, I have seen numerous examples of patients with mental health disorders continuing to access much-needed therapy and medications and patients with opiate-use disorder being able to continue to receive medications that have been demonstrated to save lives. As the pandemic evolves, many patients continue to receive care via telehealth who otherwise may not have initially received or continued care if telehealth were not available. The progress we have made in reaching more patients through telehealth and coordinating care with other systems of support has been a literal lifeline for our patients.

Prior to COVID–19, substance use disorders and co-occurring mental health services were exempt from geographic and site of service restrictions under Medicare, but mental health treatment services alone were not. At the end of 2020, Congress took the important step of permanently waiving these restrictions for mental health. However, Congress also passed requirements for patients receiving care via telehealth to have an in-person evaluation with their mental health provider within the 6-month period prior to their first telehealth visit and at subsequent periods as required by the Secretary. This arbitrary requirement, which does not apply to those with SUDs or co-occurring MH/SUDs who see their clinicians via telehealth, creates an unnecessary and difficult barrier to needed care for Medicare patients with a mental health diagnosis. Whether a patient needs to be seen in person is a clinical decision that should be made together by a patient and their clinician at the appropriate time.

Policy Considerations

I encourage the committee to consider the following policy recommendations, endorsed by the APA, that would address the current challenges with access to telehealth services for behavioral health-care needs:

- Remove the 6-month in-person requirement for mental health treatment to ensure that mental health and substance use disorder services furnished via telehealth are treated equally.
- Expand telehealth flexibilities afforded to providers under the COVID–19 Public Health Emergency, including lifting of site of service and geographic restrictions as well as allowing for the use of audio-only telehealth services when clinically appropriate or when no other alternative exists.

CLOSING

In closing, I want to reiterate how encouraged I am by the bipartisan, bicameral support we're seeing from Congress and in particular this committee regarding addressing our most pressing mental health and substance use disorder needs. I thank you for extending to me the opportunity to testify before you here today and look forward to both hearing my colleagues on the panel testify and to answering each of your questions.

QUESTIONS SUBMITTED FOR THE RECORD TO ANNA RATZLIFF, M.D., PH.D.

QUESTIONS SUBMITTED BY HON. RON WYDEN

RURAL BEHAVIORAL HEALTH ACCESS

Question. For many years, the Finance Committee has been focused on ensuring that patients in rural areas have access to the care they need. This question is especially important for mental health services because mental health practitioners tend to be located in urban and suburban areas. As the Finance Committee considers options for improving integration of behavioral health care and primary care, it will be important to better understand whether innovative care models, such as the Collaborative Care Model, can improve access to mental health care and substance use disorder services in rural areas.

How have you approached implementing the Collaborative Care Model in rural areas?

Answer. The UW Medicine AIMS Center, which I co-direct, has had extensive experience implementing Collaborative Care at over 30 rural practices. I also have had the opportunity to directly work with several rural practices as the psychiatric consultant. My experience is that rural practices can be successful in implementing the Collaborative Care Model, especially when supported by practice coaching and technical assistance. Some practices may need to innovate in the workforce that is hired to serve in the behavioral health-care manager role, for example sometimes teaming a care navigator with a provider who can deliver therapy. Another important adaptation is to have one Collaborative Care team serve several smaller practices. These practices also benefit from being able to access psychiatric expertise through both direct telehealth services and the use of telehealth to support the indirect case consultation which is a core function of the Collaborative Care Model. For example, I partnered with one of our Washington rural access hospitals that had an active primary care clinic. In this setting, the clinic integrated a behavioral health-care manager who could work closely with a psychiatric consultant located at the University of Washington on the other side of the State.

Published studies about implementation of Collaborative Care demonstrate that patients in rural practices can achieve depression outcomes that are equal to or better those practices in non-rural settings. In my personal experience, I heard from patients and providers that this approach allowed patients to receive care without fear of stigma and to avoid spending potentially hours in the car to travel to a behavioral health prescriber. The primary care providers also feel better supported to deliver care to their communities.

Several of the policy recommendations discussed in the hearing are especially important to support rural practices. Specifically:

- Expand the types of professionals that can be reimbursed by Medicare for the delivery of psychotherapy services, for example the work that members of this committee have already championed in the S. 828, the Mental Health Access Improvement Act which would allow licensed professional counselors and marriage and family therapists to bill Medicare.
- Provide Federal support to help practices implement Collaborative Care with funding the implementation of Collaborative Care and a focus to make sure rural practices are supported to access this funding.
- Support funding of training and technical assistance, especially ensuring these resources are familiar with the unique needs of rural practices.
- Increase reimbursement rates for the Medicare Collaborative Care Codes to fully support the costs of a team to deliver this important care.

DISPARITIES IN BEHAVIORAL HEALTH ACCESS AND OUTCOMES

Question. In the Finance Committee's hearing on youth behavioral health with the U.S. Surgeon General, Dr. Vivek Murthy sounded the alarm about the deep and pervasive racial and ethnic disparities that exist during the mental health crisis. A number of studies have found that more than half of people who need behavioral health care do not receive it, with higher rates of unmet need for racial and ethnic minority populations: 63 percent of African Americans, 65 percent of Hispanics, 80 percent of Asian and Pacific Islanders do not receive care when needed. Better integrating primary care with behavioral health may provide a critical access point for underserved populations and reduce racial and ethnic disparities.

In your experience, how has the integration of behavioral health and primary care helped to improve access to care and health outcomes for racial and ethnic minorities and underserved populations?

Answer. The UW Medicine AIMS Center has contributed to several important studies demonstrating that Black, Latinx, Asian, and American Indian or Alaska Native persons who received Collaborative Care achieved equivalent clinical outcomes as compared to white persons, and these data were also described in a recent systematic review of Collaborative Care Model for racial and ethnic minority populations. In my own practice, I have seen the benefit of implementing Collaborative Care in practices where Black, Indigenous, People of Color (BIPOC) patients can work with a trusted provider and receive culturally sensitive care. For example, I have had the opportunity to work with a primary care clinic that provided culturally and linguistically appropriate health care to a population in which six out of seven patients identified as BIPOC. In this clinic, I worked with a woman who had recently had her second child and developed postpartum depression. This patient was able to receive treatments that were culturally acceptable to her. The team was able to monitor her symptoms in response to treatment to make sure that she got better.

INTEGRATED CARE AT INDEPENDENT PRACTICES

Question. Testimony at the Finance Committee's March 30th hearing on mental health parity and integration of care made clear that there is potential for integrated care teams to help patients get the behavioral health care that they need, when they need it. As the Finance Committee examines opportunities to improve the take-up rate of integrated care models in physician practices, it will be vital to ensure that behavioral health integration models can work for physician practices of all shapes and sizes—and not just large physician practices that are affiliated with major health systems.

How can Congress make sure that the Collaborative Care Model and others like it can work in small physician practices that are not part of major health systems?

Answer. There is clear evidence that a Collaborative Care team can provide effective care using a centralized behavioral health-care manager and psychiatric consultant. This approach could be helpful to small practices which could pool resources to create a hub to serve several small practices. Additionally, in my experience smaller practices can implement Collaborative Care. Even in a population of approximately 5,000 patients there are enough mental health needs to support a team of a behavioral health-care manager and limited psychiatric consultant time.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

HEALTH SERVICES IN SCHOOLS

Question. It is clear that COVID–19 has significantly exacerbated mental health stress on children and youth, highlighting the Nation's acute shortage of mental health services. In my State of Delaware, over 9,000 Delawareans ages 12 through 17 suffer from some sort of depression. However, according to the State, students who have access to mental health resources within schools are 10 times more likely to seek care.

Earlier this year, the Finance Committee heard testimony from the U.S. Surgeon General who stressed that one of the most central tenets in creating accessible and equitable systems of care is to meet people where they are. For most young people, that's right there in schools. And just last week, Secretary of Health and Human Services Xavier Becerra and Secretary of Education Miguel Cardona announced a joint-department effort to expand school-based health services.

It is clear there is growing momentum to recognize the role schools already play in ensuring children have the health services and supports necessary to build resilience and thrive. We know that investing in school and community-based programs have been shown to improve mental health and emotional well-being of children at low cost and high benefit.

How can we improve coordination between primary care and mental health providers to better support our children, including through school-based services?

Answer. I think there several potential strategies to increase the coordination of primary care and mental health. One model is for schools that offer school-based health clinics, there is an easy opportunity to also implement the Collaborative Care Model, which is effective in treating adolescent depression and pediatric ADHD. I personally supported the implementation of the Collaborative Care Model in a school-based clinic in Mississippi. The providers there were able to provide holistic care to meet social needs as well as both physical and mental health services of the students they served.

Another model is to create a close partnership between the schools and a local primary care practice that offers youth mental health services, utilizing a facilitated referral process to support the connection of youth that to primary care. There are also promising practices which use a peer youth workforce to help engage at risk youth in mental health services. Finally, continuing to create access to telehealth services, which can be delivered to school-based settings, could increase access for youth.

One important consideration is that the workforce involved in the delivery of youth services need specialized training in evidence-based psychotherapies for common mental health disorders in children and adolescents and to have skill in engaging youth and families.

Question. Do you see a role for the Federal Government beyond providing guidance and technical assistance to State programs?

Answer. There are several other areas that may support improved access to quality mental health for youth. Specifically, this is an area that may benefit from funding to evaluate the promising approaches outlined above. Policy can promote workforce development in the specialized training in evidence-based treatments shown to be effective to improve patient outcomes in youth.

Many children and adolescents that need access to mental health services are utilizing Medicaid benefits. Congress should consider policy which would incentivize states to expand their Medicaid coverage of MH/SUD services by providing a corresponding raise in the Federal Medical Assistance Percentage (FMAP) matching rate for behavioral health services.

Several of the policy changes already proposed to generally support the Collaborative Care Model would also benefit access to care for youth, including funding the implementation of the Collaborative Care Model in pediatric practices and primary care offices that serve children. Finally, it is important to continue to support availability of access to mental health services through telehealth.

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. During the hearing, I mentioned that 3 years ago, Senator Bennet and I passed the Advancing Care for Exceptional Kids Act, or ACE Kids. ACE Kids establishes a pediatric health home for kids with complex medical conditions. This better aligns Medicaid rules and payment to incentivize care coordination, including mental health care. These kids often see five to six specialists and 20 to 30 health professionals—care coordination is critical. This October, the Centers for Medicare and Medicaid Services (CMS) will fully implement ACE Kids. State Medicaid programs will have the tools to better coordinate care for these kids, rather than facing barriers to care and red tape. We know that kids with complex medical needs are more at-risk for mental illness. One study suggests 38 percent have a mental health diagnosis and many face challenges in accessing mental health care. Their parents are five times more likely to have poor mental health. It's important CMS implements ACE Kids timely, but Congress must also build upon this law by passing the Accelerating Kids' Access to Care. This bill will streamline the screening and enrollment process for out-of-State pediatric care providers. I hope this bipartisan bill will be in the committee's mental health package. The bill will improve the mental health of kids with complex medical needs. Given my longstanding work on both

laws and pending legislation to improve a kid's ability to access care out-of-State when needed, I know it is not uncommon for children with complex medical conditions to have associated mental or behavioral health needs. I would welcome your thoughts as to how best to meet mental health needs in complex cases like these, including in particular situations when a child needs to receive treatment out-of-State, such as a complex surgery or organ transplant, and ways to ensure coordination between a child's primary providers and out-of-State specialists.

Are there policy actions we should be considering that haven't already been taken?

Answer. I applaud the work that has already been done in this area to improve access to care for youth, especially making sure children can use their medical benefits for out-of-State care. Additionally, the policy recommendations outlined to support the Collaborative Care Model could improve mental health access for medically complex kids, since this is one model by which access to mental health care is improved, including for kids such as those targeted by his ACE program.

QUESTION SUBMITTED BY HON. JOHN THUNE

Question. In your testimony, you discussed your work on integrating behavioral health into the primary care setting in rural communities. I know everyone faces workforce challenges now, but it's especially difficult in rural areas.

Sanford Health serving in South Dakota, North Dakota, and Minnesota implemented a program to bring behavioral health into primary care that involved some initial seed money from a CMMI demonstration. While that funding has lapsed they have prioritized keeping this running, and use providers via telehealth to serve multiple facilities. Sanford reports improved outcomes in both behavioral health and chronic disease management.

From your perspective, what policies do Congress and CMS need to consider to help create the right environment for more rural providers to adopt an integrated model?

Answer. Several of the policy recommendations discussed in the hearing are especially important to support rural practices. Specifically:

- Expand the types of professionals that can be reimbursed by Medicare for the delivery of psychotherapy services, for example the work that members of this committee have already championed in the S. 828, the Mental Health Access Improvement Act which would allow licensed professional counselors and marriage and family therapists to bill Medicare.
- Provide Federal support to help practices implement Collaborative Care with a focus to make sure rural practices are supported to access this funding.
- Support funding of training and technical assistance, especially ensuring these resources are familiar with the unique needs of rural practices.
- Increase reimbursement rates for the Medicare Collaborative Care codes to fully support the costs of a team to deliver this important care.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

TELEHEALTH MODERNIZATION ACT

Question. Thanks to the waiver authority initiated under the previous administration, telehealth has provided a critical way for Medicare patients to continue to access needed care, including mental health counseling, throughout the pandemic. However, without congressional action, telehealth flexibilities provided by the waiver will expire following the end of the public health emergency. My bipartisan Telehealth Modernization Act will maintain these flexibilities to ensure Medicare patients, especially those in rural areas of my State of South Carolina, are able to continue to access their lifeline.

How important has telehealth been to helping to address health-care workforce gaps, especially mental and behavioral health counselors serving Medicare patients, during COVID–19?

Answer. The most important benefit of telehealth to address workforce needs is the ability to redistribute a limited workforce to serve all our communities. This is

especially important for Medicare as the behavioral health workforce that accepts Medicare is more limited.

Question. Has the telehealth genie left the bottle—in other words, while there was a shift to virtual during the pandemic, has this shift fundamentally changed patients' expectations and preferences regarding how these services can be accessed?

Answer. I believe both patients and providers have appreciated the flexibilities that mental health treatment accessed through telehealth affords. This flexibility allows the patient and their mental health provider to share the decision of what type of access would support their treatment. For example, a patient who worked in a large factory could previously have had to take off almost a half a day to access mental health services (time to get out of the factory, travel time to the appointment, the appointment time, travel time back from the appointment and time to make it into their workstation). Now with access to telehealth, all this person would need is a private space with video access and they would be able to get the help they need in under an hour. This example illustrates not only the benefit of this access to the patient but also the functional benefit of the flexibility to our communities. In this example, the provider and patient still have the option to utilize a face-to-face visit but can do this more strategically based on clinical need. Recent survey data would support the idea that there is a strong preference of both providers and patients to maintain the flexibility of access with telehealth availability.

In order to maximize this flexibility, the committee should consider the following policy changes:

- Remove the 6-month in-person requirement for mental health treatment to ensure that mental health and substance use disorder services furnished via telehealth are treated equally.
- Continue the expanded telehealth flexibilities afforded to providers under the COVID–19 Public Health Emergency, including lifting of site of service and geographic restrictions and allowing for the use of audio-only telehealth services when clinically appropriate or when no other alternative exists.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

INCREASING ACCESS TO MENTAL HEALTH PROVIDERS IN MEDICARE

Question. As a doctor, I know the importance of improving access to mental health care for all Americans. This is especially important in rural parts of the country, which face some of the largest shortages in the country.

For seniors, finding a mental health provider can be particularly challenging. This is because Medicare restricts certain types of mental health providers from billing the program.

Senator Stabenow and I introduced bipartisan legislation to address this issue. S. 828, the Mental Health Access Improvement Act would allow licensed professional counselors and marriage and family therapists to bill Medicare.

This is especially important in Wyoming, where many of our community mental health centers rely on professional counselors and marriage and family therapists to provide care.

I'm sure the committee would like to hear from anyone else who wants to discuss the importance of increasing access to these professionals.

Answer. I fully support the inclusion of a broader behavioral health workforce to allow licensed professional counselors and marriage and family therapists to bill Medicare. Many of the practices I have worked with have successfully used a range of licensed mental health professionals, including licensed professional counselors and marriage and family therapists, to serve in integrated settings as well as offer specialty mental health services.

An additional consideration to support workforce and increase access to effective mental health care for Medicare recipients is to increase the value of reimbursement for mental health services for this critical workforce.

TELEHEALTH

Question. Patients in Wyoming are using telehealth to help meet their health-care needs during the pandemic. Members of this committee support making sure telehealth becomes a permanent part of health-care delivery for those patients who

want to utilize this service. Congress, with bipartisan support, has already taken steps to extend telehealth flexibilities for five months following the expiration of the public health emergency.

Can you discuss the importance of telehealth in terms of the delivery of mental health services?

Answer. I have learned in my clinical experience that telehealth is an important strategy to increase access to general psychiatric care and supports and complements integrated care. The progress we have made in reaching more patients through telehealth and coordinating care with other systems of support has been a literal lifeline for our patients.

Prior to COVID–19, substance use disorders and co-occurring mental health services were exempt from geographic and site of service restrictions under Medicare, but mental health treatment services alone were not. At the end of 2020, Congress took the important step of permanently waiving these restrictions for mental health. However, Congress also passed requirements for patients receiving care via telehealth to have an in-person evaluation with their mental health provider within the 6-month period prior to their first telehealth visit and at subsequent periods as required by the Secretary. This arbitrary requirement, which does not apply to those with substance use disorders or co-occurring mental health and substance use disorders who see their clinicians via telehealth, creates an unnecessary and difficult barrier to needed care for Medicare patients with a mental health diagnosis. Whether a patient needs to be seen in person is a clinical decision that should be made together by a patient and their clinician at the appropriate time.

I encourage the committee to consider the following policy recommendations that would address the current challenges with access to telehealth services for behavioral healthcare needs:

- Remove the 6-month in-person requirement for mental health treatment to ensure that mental health and substance use disorder services furnished via telehealth are treated equally.
- Expand telehealth flexibilities afforded to providers under the COVID–19 Public Health Emergency, including lifting of site of service and geographic restrictions and allowing the use of audio-only telehealth services when clinically appropriate or when no other alternative exists.

EXPANDING PHYSICIAN TRAINING

Question. The University of Washington has a special relationship with Wyoming through the WWAMI program. For those of you who do not know, WWAMI is a one-of-a-kind, multi-State medical education program. The acronym stands for the States served by UWs medical school—Washington, Wyoming, Alaska, Montana, and Idaho.

I try to speak with Wyoming's WWAMI students every year. It is always a pleasure to hear about their experience at the University of Washington and the rotations they are completing in the WWAMI region.

As director of the University of Washington's Psychiatry Resident Training Program, I know you share my passion for expanding the number of psychiatrists, especially those serving in rural communities.

Can you please discuss how your program exposes residents to rural communities?

Answer. UW Medicine currently supports two innovative rural tracks as part of our program. In this model, residents spend 2 years at our University of Washington Seattle-based residency then complete 2 years of training in either Boise, ID or Billings, MT. Local programs offer the opportunity for training to serve a broader range of communities, including rural communities.

This is an important model for academic programs to support the development of local community-based programs. In fact, our Boise, Idaho program is now a 4-year independent program with their first class that started in this academic year. These efforts also help recruit and retain a psychiatric workforce with over 80 percent of our residents taking their first job after residency in the Pacific Northwest.

Question. Can you discuss ways psychiatric residency programs can expand their training sites outside of traditional academic medical centers?

Answer. There are several other training strategies that can be helpful to support the training of residents to work in diverse communities. One approach is to partner

with community settings to offer elective training experiences in a different community. For example, our UW Medicine Seattle Residency offers elective opportunities both to travel to and provide clinical care in a one-month onsite program in Alaska.

We also have begun to leverage telehealth training as another approach to serve community settings and populations outside the Seattle area. We have partnered with the Lummi Tribal Clinic to offer elective training to serve this community about 3 hours outside the Seattle area. This is a hybrid care delivery and training approach. Our trainees travel to spend time in the clinic at the start of the rotation and then continue to deliver care through telehealth over the following 6 months.

Both of these approaches have required additional funding resources, which can be a significant barrier to broader expansion of these models.

PREPARED STATEMENT OF REGINALD D. WILLIAMS II, VICE PRESIDENT, INTERNATIONAL HEALTH POLICY AND PRACTICE INNOVATIONS, COMMONWEALTH FUND

FORMAL GREETING

Good morning. Thank you, members of the Senate Finance Committee, for inviting me to speak today on the critical topic of ensuring that behavioral health services are accessible to people residing in the United States. Chairman Wyden and Ranking Member Crapo, you have both been leaders on this pressing issue, and I am hopeful that your bipartisan commitment to advancing solutions will lead to progress.

PERSONAL STORY AND BACKGROUND

I am Reggie Williams, and I lead the International Health Policy and Practice Innovations Program at the Commonwealth Fund. I also co-lead our work on behavioral health, which includes a focus on mental health and substance use.

For over 10 years, I have also volunteered my time in the mental health community—currently serving on the boards of the Youth Mental Health Project and Fountain House and, in the past, chairing the board of directors of Mental Health America. My focus has been on improving the systems—or lack thereof—that people and families are forced to navigate to achieve the lives they want to live.

I testify today not only as someone who has spent more than 20 years in health policy but also as a Black man who strives to manage his own mental health—and as someone who has personally witnessed the impacts of mental health and substance use on my family, friends, coworkers, and my greater community.

MAGNITUDE OF THE CRISIS

There is a behavioral health crisis in the United States. When I say behavioral health, I mean the promotion of mental health, resilience, and well-being; the prevention, early identification, and treatment of mental illness and substance use; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

The crisis is being felt nationwide, without regard for political affiliation, economic prosperity, or education level—but, like so many other areas of our healthcare system, it is particularly acute for economically disadvantaged and underserved communities. The crisis predates COVID–19 but was exacerbated by the social isolation, economic disruption, and upheaval of the U.S. health system that accompanied the pandemic. At the core of the crisis is unmet need.

There have been incredible strides made toward closing the coverage gap and achieving mental health parity with the passage of the Affordable Care Act in 2010. Access to behavioral care and treatment, however, remains a major issue in the U.S., especially for Black and Hispanic populations, for youth, and for Medicare and Medicaid beneficiaries.[1]

Data from U.S. Department of Substance Abuse and Mental Health Services Administration (SAMSHA) show that among adults age 18 or older in 2020, 21 percent (or 52.9 million people) had any mental illness (AMI) and 5.6 percent (or 14.2 million people) had serious mental illness (SMI) in the past year. In 2020, 40.3 million

[1] Jesse C. Baumgartner, Gabriella N. Aboulafia, and Audrey McIntosh, "The ACA at 10: How Has It Impacted Mental Health Care?" *To the Point* (blog), Commonwealth Fund, April 3, 2020, *https://www.commonwealthfund.org/blog/2020/aca-10-how-has-it-impacted-mental-health-care.*

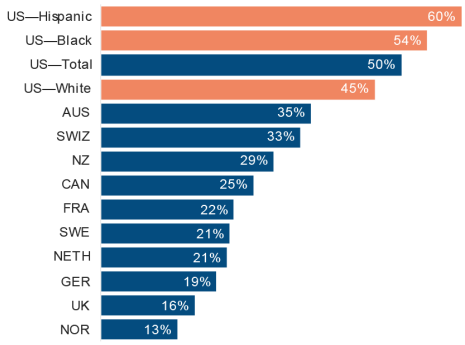
people age 12 or older (or 14.5 percent) had a substance use disorder (SUD) in the past year, including 28.3 million who had alcohol use disorder.[2]

There is a mismatch between the demand among people seeking behavioral care and the supply of behavioral health providers. Some 142 million people in the U.S. live in one of the 6,127 mental health professional shortage areas, with an estimated 7,400 behavioral health providers needed.[3]

When compared to other high-income countries, the U.S. is an outlier in access to behavioral health services. The 2020 Commonwealth Fund International Health Policy Survey revealed that U.S. respondents with mental health needs were more likely than respondents in other countries to face access barriers. Analysis of the responses further revealed that Black and Hispanic Americans faced even greater access problems. In totality, these data draw attention to the need for continued investment in our Nation's behavioral health system.[4]

Exhibit 1. Black and Hispanic Americans Were Most Likely to Report Cost-related Problems Accessing Health Care

Percentage of adults age 18+ with a mental health need who reported any cost-related access problem



The Commonwealth Fund

Cost-related access problem: Respondent either 1) had a medical problem but did not consult with or visit a doctor because cost, 2) skipped a medical test, treatment, or follow-up that was recommended by a doctor because of the cost, or 3) did not fill or had a prescription for medicine or skipped doses of their medicine because of the cost.

Population: Among respondents who reported they had ever been told they had depression, anxiety, or other mental health condi said there was a time in the past 12 months they wanted to talk with a health care professional about their mental health.

Data: 2020 Commonwealth Fund International Health Policy Survey.

The current behavioral health crisis is particularly notable for its impact on our Nation's youth. Late last year, the U.S. Surgeon General issued a crisis advisory for children's mental health.[5] In 2020, less than half of adolescents (42 percent) with depression in the past year reported receiving any treatment, with Black and Indigenous people and youth of color having even worse access to care (only 37 percent of Hispanic youth reported accessing care) than White young people, teenagers, or adolescents. Among young adults with mental illness, 47 percent reported unmet needs for mental health care.[6] Hospitals are reporting more emergency department

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[2] SAMHSA, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health," U.S. Department of Health and Human Services, October 2021, *https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf.*

[3] HRSA, "Shortage Areas," U.S. Department of Health and Human Services, March 2022, *https://data.hrsa.gov/topics/health-workforce/shortage-areas.*

[4] Reginald D. Williams II and Arnav Shah, *Mental Health Care Needs in the U.S. and 10 Other High-Income Countries: Findings from the 2020 Commonwealth Fund International Health Policy Survey* (Commonwealth Fund, October 2021), *https://www.commonwealthfund.org/publications/surveys/2021/oct/mental-health-care-needs-us-10-other-high-income-countries-survey.*

[5] Office of the Surgeon General, "Youth Mental Health Reports and Publications," U.S. Department of Health and Human Services, December 2021, *https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html.*

[6] *Highlights for the 2020 National Survey on Drug Use and Health* (SAMHSA, 2021), *https://www.samhsa.gov/data/sites/default/files/2021-10/2020_NSDUH_Highlights.pd.*

(ED) visits among adolescents due to mental health and substance use issues as well as waits in the ED of days, sometimes even weeks, before treatment options become available.[7]

The Medicaid program serves as the single largest provider of behavioral health services in the U.S., and yet half of all Medicaid members (50 percent) with serious mental illness, and nearly 70 percent of Medicaid members with an opioid use disorder, have reported not receiving treatment.[8]

One-quarter of all Medicare beneficiaries have mental illness. Analysis from the Commonwealth Fund shows that, compared to adults over age 65 in other high-income countries, Medicare beneficiaries are the most likely to see a health-care professional to manage their depression or anxiety—and the most likely to report having cost-related access problems or stress about paying for food, rent, or utilities.[9] The prevalence of mental illness is greatest among beneficiaries under 65 who qualify for Medicare because of disability, as well as among low-income beneficiaries who are dually eligible for Medicare and Medicaid.[10]

Nearly one-third of individuals dually eligible for Medicare and Medicaid have been diagnosed with a serious mental illness such as schizophrenia, bipolar disorder, or major depressive disorder, a rate nearly three times higher than for non-dually eligible Medicare beneficiaries.[11]

Prior to the pandemic, 22 percent of U.S. adults were experiencing social isolation or loneliness. Organizations across the globe have been implementing programs to curtail the effect of growing isolation.[12] The COVID–19 pandemic only intensified the unmet need for services and gaps in access to care for behavioral health services, with a higher percentage of adults in the U.S. reporting mental health concerns, as well as difficulty accessing services, than adults in other high-income countries.[13]

The problem is big and complex. However, there are tools that can be leveraged to make meaningful change in people's lives. Here's what we can do:

1. Increase access to behavioral health services by integrating mental health and substance use treatment and services with primary care. This includes supporting integration and care coordination with innovative payment approaches.
2. Expand and diversify the behavioral health workforce, by engaging a wide variety of providers to meet people's unique needs.
3. Leverage the potential of health technology to fill gaps and meet unfulfilled needs with telemedicine and digital health solutions.

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[7] Rebecca T. Leeb et al., *Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the COVID–19 Pandemic—United States, January 1–October 17, 2020* (CDC, November 2020), *https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm.*

[8] NAMD, "Federal Policy Briefs: Behavioral Health Integration," National Association of Medical Directors, 2022, *https://medicaiddirectors.org/wp-content/uploads/2022/02/Federal-Policy-Brief-Integration_updated-link-1.pdf.*

[9] Munira Z. Gunja, Arnav Shah, and Reginald D. Williams II, *Comparing Older Adults' Mental Health Needs and Access to Treatment in the U.S. and Other High-Income Countries* (Commonwealth Fund, January 2022), *https://www.commonwealthfund.org/publications/issue-briefs/2022/jan/comparing-older-adults-mental-health-needs-and-access-treatment.*

[10] Beth McGinty, *Medicare's Mental Health Coverage: How COVID–19 Highlights Gaps and Opportunities for Improvement* (Commonwealth Fund, July 2020), *https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities.*

[11] Logan Kelly, *Coordinating Physical and Behavioral Health Services for Dually Eligible Members with Serious Mental Illness* (Center for Health Care Strategies, December 2019), *https://www.chcs.org/resource/coordinating-physical-and-behavioral-health-services-for-dually-eligible-members-with-serious-mental-illness/.*

[12] Laura Shields-Zeeman et al., "Addressing Social Isolation and Loneliness: Lessons from Around the World," *To the Point* (blog), Commonwealth Fund, January 27, 2021, *https://www.commonwealthfund.org/blog/2021/addressing-social-isolation-and-loneliness-lessons-around-world;* Melinda K. Abrams et al., "Solutions from Around the World: Tackling Loneliness and Social Isolation During COVID–19," *To the Point* (blog), Commonwealth Fund, April 30, 2020, *https://www.commonwealthfund.org/blog/2020/solutions-around-world-tackling-loneliness-and-social-isolation-during-covid-19.*

[13] Reginald D. Williams II et al., *Do Americans Face Greater Mental Health and Economic Consequences from COVID–19? Comparing the U.S. with Other High-Income Countries* (Commonwealth Fund, August 2020), *https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/americans-mental-health-and-economic-consequences-COVID19.*

INTEGRATE MENTAL HEALTH AND SUBSTANCE USE TREATMENT AND SERVICES INTO PRIMARY CARE

Expanding the capacity of primary care providers to meet the behavioral health needs of their patients provides an opportunity to increase access to early intervention and treatment as well as to promote social connectedness and suicide prevention. Compared to other countries, the U.S. has a smaller workforce dedicated to meeting mental health needs. Countries like the Netherlands, Sweden, and Australia more frequently include mental health providers on primary care teams.[14] This compounds the comparative underinvestment in primary care teams in the U.S., which spends 5 percent to 7 percent on primary care as a share of total healthcare spending, compared to 14 percent in other countries belonging to the Organisation for Economic Co-operation and Development (OECD).[15]

Studies repeatedly show that patients view primary care providers as trusted sources of information. For example, in recent history, primary care providers ranked as the preferred source of information around COVID–19 vaccination for all age groups, races, and geographical location—regardless of political party.[16] This trusted environment also offers an opportunity to combat stigma associated with discussing mental health and substance use and seeking treatment.

U.S. primary care providers are making strides in treating the behavioral health needs of their patients, but they are often working without necessary resources and supports. And they are working within a health-care system that does not yet fully support providing integrated care. As many as 80 percent of people with behavioral health needs present in emergency departments and primary care settings; between 60 percent and 70 percent of these individuals leave without treatment for their conditions.[17] Primary care providers see 45 percent of people within 30 days of a suicide attempt, and data show the primary care providers have an opportunity to intervene with routine depression screening and treatment to prevent suicides.[18]

The Case for Primary Care and Behavioral Health Integration

The term "integration" describes the bringing together of various providers and services. Integration has been used to reference everything from consultation to collocation to a setting of shared health goals around treating the whole person without clear boundaries.[19] It is helpful to view models of care delivery as spanning a continuum of ways to integrate physical and behavioral health care (both mental health and substance use).[20]

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[14] Eric C. Schneider et al., *Mirror, Mirror 2021—Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, August 2021), *https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly;* and Molly FitzGerald, Munira Z. Gunja, and Roosa Tikkanen, *Primary Care in High-Income Countries: How the United States Compares* (Commonwealth Fund, March 2022), *https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/primary-care-high-income-countries-how-united-states-compares.*

[15] Yalda Jabbarpour et al., *Investing in Primary Care: A State-Level Analysis* (Patient-Centered Primary Care Collaborative, July 2019), *https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019.pdf.*

[16] "American COVID–19 Vaccine Poll" (African American Research Collaborative, 2021), *https://africanamericanresearch.us/covid-poll-methodology/.*

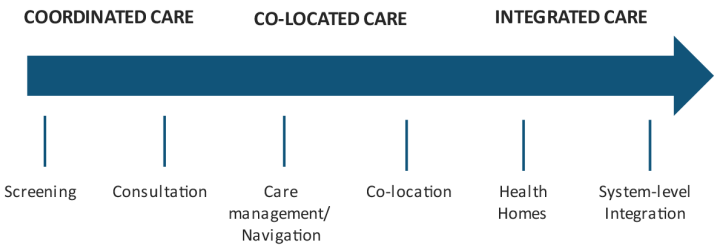
[17] Sarah Klein and Martha Hostetter, "In Focus: Integrating Behavioral Health and Primary Care," *Newsletter Article,* Commonwealth Fund, August 28, 2014, *https://www.commonwealthfund.org/publications/newsletter-article/2014/aug/focus-integrating-behavioral-health-and-primary-care.*

[18] *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration* (Bipartisan Policy Center, March 2021), *https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf.*

[19] *A Standard Framework for Levels of Integrated Healthcare* (SAMHSA-HRSA Center for Integrated Health Solutions, April 2013), *https://www.pcpcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf.*

[20] *Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care* (Center for Health Care Strategies, Inc., August 2019), *https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf.*

Exhibit 2. Continuum of Physical and Behavioral Health Care Integration



The Commonwealth Fund

Source: *Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care* (Center for Health Care Strategies, Inc., Aug. 2019).

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Exhibit 3. Spectrum of Payment Models

Category 1: Fee for Service – No Link to Quality & Value	Category 2: Fee for Service – Link to Quality & Value	Category 3: Alternative Payment Models Built on Fee -for-Service Architecture	Category 4: Population-Based Payment
Behavioral Health Integration Codes	Incentives for participating in learning collaboratives on BH integration	Accountable care organization incentives focused on structural measures of behavioral health integration and outcomes	Total capitation at the primary care or accountable care organization -level with strong incentives for behavioral health outcomes
Additional Evaluation & Management Payments to Support Behavioral Health Integration Infrastructure	Incentives for achieving certain BH integration milestones		
	A Merit-based Incentive Payment System (MIPS) value pathway dedicated to integrated behavioral health		

The Commonwealth Fund

Adapted from Alternative Payment Model (APM) Framework (The Health Care Payment Learning & Action Network 2017).

3

It has been projected that effective medical and behavioral health service integration that includes a focus on primary care could generate nearly $70 billion in U.S. health-care costs savings annually.[21]

Support Innovative Payment Approaches

New approaches to payment policies, including models that hold providers accountable for improving quality and controlling overall costs, and programs led by Medicaid and Medicare, offer promising approaches to encouraging integration.

Approaches that can be used to pay for integrated care include: (1) new fee-for-services billing codes (*e.g.,* Washington State's Collaborative Care Model codes); (2) care management payments (*e.g.,* New York's case rates for qualified Collaborative Care Model providers); (3) bundled payments (*e.g.,* Minnesota's Diamond model); and (4) primary care capitation (*e.g.,* Rhode Island's primary care capitation framework).[22] Each of these payment approaches can also be tied to value-based incentives around progress toward evidence-based behavioral health-care integration or quality performance, depending on which program is being implemented.

Implementation can be further supported by financing evidence-based learning collaboratives for providers, in addition to financing integrated care directly.

Collaboratives help build practices' capacity to adapt to new work streams, team-based care, and digital technologies and improve integration with community resources.

As policymakers are contemplating ways to support the Centers for Medicare and Medicaid Services (CMS) and the States, there are many promising models to consider in support of the integration of behavioral health with primary care.

Illustrative models include:

- Providing incentives for providers to achieve quality performance milestones related to behavioral health-care integration and participate in quality improvement collaboratives, as Arizona did with its Targeted Investments Program, part of a Medicaid waiver program. Evaluation reports found a general increase in integration levels across all participating providers.[23]
- Integrating substance use disorder services within an existing primary care setting, as the Southwest Montana Community Health Center, a Federally Qualified Health Center (FQHC) in Butte, MT does. This health center links people to counseling and other community programs by deploying evidence-based models like screening, brief intervention, and referral to treatment (SBIRT). In a large study of SBIRT outcomes, at 6-month follow-up, illicit drug use was 68-percent lower and heavy alcohol consumption was 39-percent lower among individuals who had screened positive for hazardous drug and alcohol use.[24]
- Addressing isolation through psychosocial rehabilitation, as Fountain House does. Health and wellness programming ensures people with SMI can access primary and psychiatric care, care management, and home and community-based services, which have been shown to reduce hospitalizations and decrease costs for Medicaid.[25]
- Embedding mental health teams with primary care practices to build stronger local service provider relationships that are responsive to community Australia's GP Clinic does. To improve access to primary health care, a multi-

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[21] "Potential economic impact of integrated medical-behavioral health care," Milliman Research Report, January 2018, *https://www.milliman.com/en/insight/potential-economic-impact-of-integrated-medical-behavioral-healthcare-updated-projections.*

[22] *Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care* (Center for Health Care Strategies, Inc., August 2019), *https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf.*

[23] "Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration," Bipartisan Policy Center, March 2021, *https://bipartisanpolicy.org/event/tackling-americas-mental-health-and-addiction-crisis-through-primary-care-integration/.*

[24] "Integration of Mental Health Services in Primary Care Settings," Rural Health Information Hub, 2022; Suneel M. Agerwala and Elinore F. McCance-Katz, M.D., "Integrating Screening, Brief Intervention, and Referral to Treatment (SBIRT) into Clinical Practice Settings: A Brief Review," *Journal of Psychoactive Drugs,* 44:4, 307–317 (September 2012), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3801194/.*

[25] Joshua Seidman and Kevin Rice, *Brief Summary of Evidence Supporting Clubhouses* (Fountain House, January 2022), *https://www.fountainhouse.org/assets/Brief-Summary-of-Evidence-for-Clubhouses_2022.pdf.*

disciplinary team consisting of mental health nurses, a social worker and psychologist seek to help manage complex needs of people in rural settings.[26]

EXPAND AND DIVERSIFY THE WORKFORCE BY ENGAGING A WIDE VARIETY OF PROVIDERS

The evidence supports engaging a wider array of providers in the behavioral health-care team, a broader set of providers than most people have access to today. Medicare covers only a set of traditional providers, such as psychiatrists, psychologists, and social workers, but not other types of licensed providers, such as marriage and family therapists or counselors. Through their flexibility, State Medicaid managed care plans often cover a range of providers that also increasingly include paraprofessionals. Paraprofessionals encompass a range of workers, from certified peer support specialists to community health workers, that play important roles across the care continuum.

Trained and accredited peer support specialists leverage their lived experience of mental health or substance use conditions to support others in recovery. There is evidence that peer support specialists can be effective in engaging people with treatment, reducing the use of emergency rooms and hospitals and reducing substance use among people with co-occurring substance use disorders.[27] Peer support, which was developed in response to the lack of access to effective care in many communities, is now increasingly part of the continuum of care. Approximately 25 percent of mental health treatment facilities and 56 percent of facilities treating substance use disorders self-reported offering peer support services in 2018.[28] As of 2018, 39 States allowed for Medicaid billing of peer support specialists.[29]

Often, peer support specialists assist with the transition from hospital to community or participate in intensive programs, providing necessary additional support as part of a care team. Increasingly though, peer support specialists are being engaged earlier and can be a critical partner and extender for integrated care models, including in collaborative care, where they help with navigating treatment and other services while building key self-management skills.[30] Clinicians appreciate peer support specialists for the additional support they lend and for keeping care grounded in the needs of the individual, ensuring that the services ultimately advance recovery.[31]

Community health workers, on the other hand, work closely with the community in more of a public health role. Research has demonstrated that for every dollar invested in a community health worker intervention, it returned $2.47.[32] In behavioral health, community health workers can educate the community about mental health and substance use issues, help people identify needs and get connected to care, and even offer some frontline interventions to reduce stress. For example, community health workers in Louisiana effectively worked with pregnant women to facilitate virtual interventions and provide social support to prevent the onset of postpartum depression.[33]

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[26] Scott J. Fitzpatrick et al., "Coordinating Mental and Physical Health Care in Rural Australia: An Integrated Model for Primary Care Settings," *International Journal of Integrated Care* vol. 18, no. 2 (2018), *https://www.ijic.org/articles/10.5334/ijic.3943/*.

[27] "Peers Supporting Recovery from Mental Health Conditions," SAMHSA, 2017, *https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf*.

[28] C. Page et al., "The Effects of State Regulations and Medicaid Plans on the Peer Support Specialist Workforce," *Health Services Research* vol. 55, issue S1 (August 2020), *https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13430*.

[29] Lynn Videka et al., *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement* (University of Michigan School of Public Health Behavioral Health Workforce Research Center, August 2019), *https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf*.

[30] Matthew Menear et al., "Strategies for engaging patients and families in collaborative care programs for depression and anxiety disorders: A systematic review," *Journal of Affective Disorders* vol. 263 (February 15, 2020), *https://www.sciencedirect.com/science/article/pii/S0165032719323110#bib0038*.

[31] Marianne Storm et al., "Peer Support in Coordination of Physical Health and Mental Health Services for People With Lived Experience of a Serious Mental Illness," *Frontiers in Psychiatry* vol. 11 (May 8, 2020), *https://www.frontiersin.org/articles/10.3389/fpsyt.2020.00365/full*.

[32] Shreya Kangovi et al., "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment," *Health Affairs* 39(2): 207–213 (February 2020), *https://pubmed.ncbi.nlm.nih.gov/32011942/*.

[33] Christopher Mundorf et al., "Reducing the Risk of Postpartum Depression in a Low-Income Community Through a Community Health Worker Intervention," *Maternal and Child Health Journal* vol. 22, 520–528 (December 29, 2017), *https://link.springer.com/article/10.1007/s10995-017-2419-4*.

Furthermore, engaging community health workers who are representative of the populations they are seeking to reach can be an important way to reduce disparities in communities where people might not feel comfortable reaching out for help. Integrated behavioral health models that include paraprofessionals illustrate the potential for improving access to care and treatment. These include:

- Primary care providers who assess patients based on intensity of symptoms and then refer them to different types of providers based on level of need. Such providers could include a therapist for moderate to high needs or, for those with milder needs, lower-intensity therapies from providers of evidence-based mindfulness, self-help strategies, and well-being workshops. This model is akin to a stepped-care approach like the United Kingdom's Improving Access to Psychological Therapies, which seeks to address patients' needs upstream by providing first-line approaches for people normally untreated or undiagnosed with a behavioral health condition.[34]
- The engagement of peer specialists as a part of clinical teams, as both the Institute for Community Living in New York City and the Lowell Community Health Center in Lowell, MA have done. These initiatives demonstrated improvements in patient engagement, supported the delivery of interventions in smoking cessation and exercise, and provided chronic disease management support.[35]
- The introduction of a new type of provider to fill workforce gaps, like general practice mental health workers, who are health professionals with a background in social support, basic psychology training, or nursing and work under supervision of a primary care provider. In the Netherlands, the integration of general practice mental health workers into primary care settings has improved patients' quality of life as well as prevented mental health conditions from developing or further intensifying.[36]

Despite the evidence on improved outcomes and cost savings, most Americans do not currently have access to the providers described here. To remedy that, policymakers could:

- Ensure that incentives, financing, and support for integrated care are inclusive of the paraprofessional workforce.
- Provide specific incentives for systems to recruit, integrate, and retain paraprofessionals, and other workforce extenders.
- Implement learning collaboratives and quality improvement initiatives around integrating a broader workforce into the continuum of care, including issues around effective supervision and delineation of roles to maximize impact.
- Consider how to improve coverage of a broader workforce, including reimbursement for peer support specialists in Medicare.

LEVERAGE TELEMEDICINE AND DIGITAL HEALTH SOLUTIONS

Now is the time to be optimistic about the potential of technology to address behavioral health needs. The pandemic caused a sudden shift: at a time when the need for support was greater than ever, people sought mental health care over the telephone and via online platforms. In addition, technology-enabled solutions have resulted in unprecedented investment in digital health tools that can help solve the provider shortage through on-demand therapy, guided mediation, chatbots and more.

Telemedicine can be an effective way to improve mental health, especially through cognitive behavioral therapy. Evidence shows that telemedicine is at least as effective as face-to-face interventions in tackling depression and anxiety, symptoms of

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[34] "Adult Improving Access to Psychological Therapies Programme," NHS, *https://www.england.nhs.uk/mental-health/adults/iapt/*.

[35] Mary Docherty et al., *How Practices Can Advance the Implementation of Integrated Care in the COVID–19 Era* (Commonwealth Fund, November 2020), *https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/practices-advance-implementation-integrated-care-covid.*

[36] Joost Wammes et al., "Netherlands," in Roosa Tikkanen et al., *International Health Care System Profiles* (Commonwealth Fund, June 2020), *https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands.*

obsessive-compulsive disorder, insomnia, and excessive alcohol consumption.[37] Telemedicine has also been shown to alleviate maternal depression symptoms.[38]

The COVID–19 pandemic, and the expanded flexibilities that were authorized around the provision of telehealth services, brought about sharp increases in the number of facilities providing telehealth treatment for both mental health and substance use services. The proportion of substance use treatment facilities offering telehealth services jumped from 28 percent in 2019 to 59 percent in 2020. For mental health facilities, the share grew from 38 percent to 69 percent over the same period.[39]

Among Medicare beneficiaries, visits to behavioral health specialists accounted for the largest increase in telehealth in 2020. Telehealth comprised a third of total visits to behavioral health specialists. Yet despite the increase in available services, Black and rural Medicare beneficiaries had lower telehealth use compared with White and urban beneficiaries, respectively. Telehealth use varied by State, with higher use in the Northeast and the West and lower use in the Midwest and the South. Urban beneficiaries had about 50-percent higher telehealth use than rural beneficiaries—1,659 visits per 1,000 urban beneficiaries versus 1,112 visits per 1,000 among rural beneficiaries. Compared with pre-pandemic levels, this represents a 140- and 20-fold increase in telehealth use for urban and rural beneficiaries, respectively.[40]

As Congress and the Biden administration weigh options for extending the telehealth flexibilities beyond the public health emergency,[41] it will be essential to understand the barriers faced by Black and rural beneficiaries in accessing telehealth and tele-mental health services, so that policies serve to ameliorate disparities rather than exacerbate them.

It is also noteworthy that the temporary continuous coverage requirement that kept Medicaid coverage intact during the health emergency helped to ensure access to medical and behavioral health services.[42] Multiple studies have found that living in a Medicaid expansion State was associated with relative reductions in poor mental health by improving access, including access to services delivered through telehealth.[43] It is critical that expansion of telehealth and other digital innovations in medicine be undertaken with universal and equitable access to care in mind.

CMS has already begun to pilot some innovative models, such as Community Health Access and Rural Transformation (CHART), that specifically provide technical assistance to rural providers to help them fully benefit from technological innovations with both financial and regulatory flexibilities. The committee could consider opportunities to provide additional support for these types of models, with a specific focus on building capacity for providers to offer telehealth for behavioral health as well as meeting the various access needs of beneficiaries so they can benefit from these innovations. This could include helping to identify spaces available to primary care providers that can be set aside for telehealth visits when patients do not have access at home or the knowledge to use the technology.

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[37] Tiago C.O. Hashiguchi, *OECD Health Working Paper No. 116: Bringing Health Care to the Patient: An Overview of the Use of Telemedicine in OECD Countries* (OECD, January 2020), *https://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2020)1&docLanguage=En.*

[38] Uthara Nair et al., "The effectiveness of telemedicine interventions to address maternal depression: A systematic review and meta-analysis," *Journal of Telemedicine and Telecare* vol. 24, issue 10 (October 22, 2018), *https://journals.sagepub.com/doi/10.1177/1357633X18794332.*

[39] Herman A. Alvarado, *Telemedicine Services in Substance Use and Mental Health Treatment Facilities* (SAMHSA, December 2021), *https://www.samhsa.gov/data/report/telemedicine-services.*

[40] Lok W. Samson et al., *Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location* (ASPE Office of Health Policy, December 2021), *https://www.aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf.*

[41] Josh LaRosa, "Avoiding the Cliff: Medicare Coverage of Telemental Health and the End of the PHE," *To the Point* (blog), Commonwealth Fund, March 23, 2022, *https://www.commonwealthfund.org/blog/2022/avoiding-cliff-medicare-coverage-telemental-health-and-end-phe.*

[42] Cindy Mann, "Stable and Continuous Coverage Provisions in Medicaid Gain Momentum Through Build Back Better Act," *To the Point* (blog), Commonwealth Fund, February 9, 2022, *https://www.commonwealthfund.org/blog/2022/stable-and-continuous-coverage-provisions-medicaid-gain-momentum-through-build-back.*

[43] John Cawley et al., "Third year of survey data shows continuing benefits of Medicaid expansions for low-income childless adults in the U.S.," *Journal of General Internal Medicine* vol. 33, 1495–1497 (June 5, 2018), *https://pubmed.ncbi.nlm.nih.gov/29943107/.*

Digital mental health is expanding, with a host of startups offering solutions that promise to fill gaps in access to care. Digital health startups offering mental health services raised $5.1 billion—$3.3 billion more than any other clinical service, including diabetes and cancer care, in 2021.[44] The vast majority of these tools target employers, health plans, or consumers directly as app-based subscription services. A few health insurers and provider systems have created "digital formularies" that seek to make digital tools more a part of the system of care. Evidence regarding these tools is highly variable; some demonstrate effectiveness in randomized, controlled trials reflecting real-world conditions, while some have never been tested.

Technology brings a clear promise for extending the existing behavioral health system. The potential benefits include on-demand access, tailored to individual needs, and well-tested interventions. Technology also increases the potential for reducing disparities for people facing the greatest barriers to obtaining access to traditional systems of care, such as rural Americans, people who lack access to transportation, or persons with disabilities. On the other hand, digital tools raise concerns: we need our behavioral health dollars spent wisely, and we don't want to champion the use of tools that are ineffective or inaccessible for beneficiaries.

There is an opportunity to build capacity at CMS to work with National Institutes of Health and the Food and Drug Administration to consider payment and coverage implications for innovative new tools as they're being developed, ensuring that our public behavioral health system stays modern and effective. CMS has already taken steps to create codes for certain technologies that are gaining more widespread use (such as remote patient monitoring codes); CMS can build on those actions with additional support to create a permanent pipeline for supporting beneficiaries' access to innovation.

Policymakers can also help CMS work with States to host a learning collaborative and to provide technical assistance on appropriate coverage of digital tools in Medicaid, as well as strategies for ensuring access for the beneficiaries most likely to benefit.[45] Currently, States often make these decisions in isolation, left to identify, evaluate, and implement digital tools without the benefit of information on models or technologies that have demonstrated success in other health systems or States.

Among the many examples of the potential to harness technological innovations to improve behavioral health, illustrative ones include:

- Utilizing telepsychiatry and sharing electronic medical records to promote and encourage provider communication and co-management of patients, like Cherokee Health Systems, a community mental health center and Federally Qualified Health Center in Tennessee does. Cherokee has embedded licensed behavioral health consultants in its primary care provider teams.[46]
- Introducing a portfolio of digital patient engagement and self-management tools, as Montefiore Medical Center in the Bronx has done. Montefiore uses a secure online application and messaging system that has allowed for long-term clinical monitoring, engagement, and follow-up with patients. Interactions with patients were conducted via HIPAA-compliant text messages, and patients were offered support, screening, condition monitoring, and prompts/recommendations around behavior modification, mindfulness exercises, and physical exercise.[47]

CONCLUSION: WE CAN BE BETTER

As I stated earlier, the problem is big and complex. However, we have tools to improve people's lives. It is certainly within our power to ensure that people's mental health and substance use needs are better met, especially youth, people with severe mental illness, residents of rural communities, and historically excluded Black,

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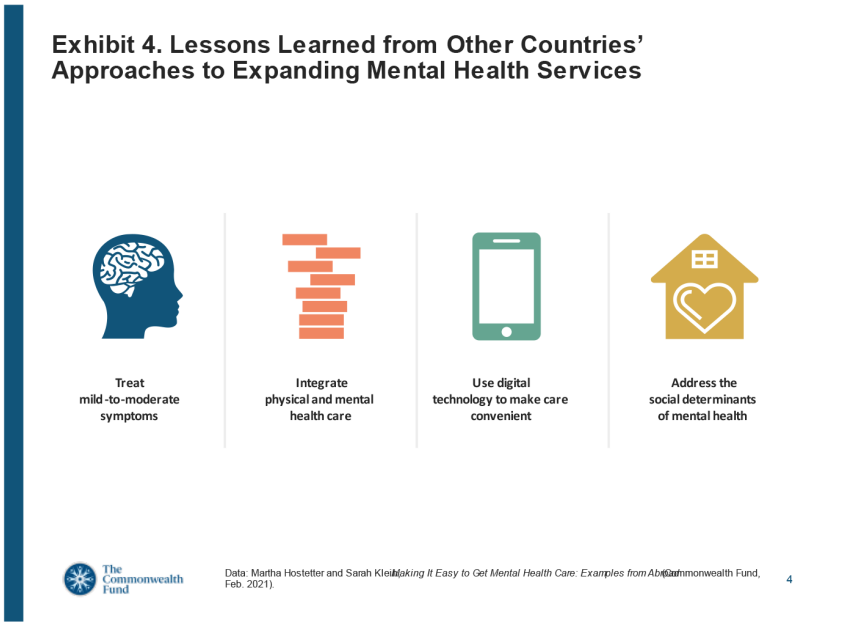
[44] Adriana Krasniansky, Bill Evans, and Megan Zweig, *2021 year-end digital health funding: Seismic shifts beneath the surface* (*Rockhealth.org,* January 2022), *https://rockhealth.com/insights/2021-year-end-digital-health-funding-seismic-shifts-beneath-the-surface/*.

[45] Andrey Ostrovsky and Morgan Simko, "Accelerating Science-Driven Reimbursement for Digital Therapeutics in State Medicaid Programs," *Health Affairs Blog,* October 30, 2020, *https://www.healthaffairs.org/do/10.1377/forefront.20201029.537211.*

[46] *Chapter 4: Integration of Behavioral and Physical Health Services in Medicaid* (MACPAC, March 2016), *https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf.*

[47] Mary Docherty et al., *How Practices Can Advance the Implementation of Integrated Care in the COVID–19 Era* (Commonwealth Fund, November 2020), *https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/practices-advance-implementation-integrated-care-covid.*

Latino, and Indigenous communities. There are myriad approaches to expanding access to services and prioritizing mental health, making care more convenient, and scaling treatment approaches to help more people.



This can all be done, and our communities will be the stronger for it. There is inspiration from abroad that we can draw upon.

For example, we can take inspiration from Italy's Trieste, which gives people grappling with mental health issues help with all aspects of their lives, ensuring their physical needs for food, clothing, and shelter are met; helping them forge connections with other community members; and supporting them in their pursuit of meaningful activities, including employment.[48]

We can be inspired by Belgium's Geel, a community that has accepted people with severe mental health needs for hundreds of years, supporting them and helping them find their own paths to better health.[49]

In the coming months, we can work to implement policy approaches that reflect our own values and commit the investments necessary to guarantee a better future for individuals, families, and communities in America. You can lead the way by advancing bipartisan policies for meeting these goals.

I believe that, as a Nation, we can do better. And by providing new opportunities to expand access to equitable, affordable care and treatment and address our behavioral health crisis, ultimately, we can be better.

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[48] Rob Waters, "A New Approach to Mental Health Care, Imported from Abroad," *Health Affairs* 39, no. 3 (March 2020): 362–66, *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00047*.

[49] Angus Chen, "For Centuries, a Small Town Has Embraced Strangers with Mental Illness," July 1, 2016 in NPR, *https://www.npr.org/sections/health-shots/2016/07/01/484083305/for-centuries-a-small-town-has-embraced-strangers-with-mental-illness.*

QUESTIONS SUBMITTED FOR THE RECORD TO REGINALD D. WILLIAMS II

QUESTIONS SUBMITTED BY HON. RON WYDEN

RURAL BEHAVIORAL HEALTH ACCESS

Question. For many years, the Finance Committee has been focused on ensuring that patients in rural areas have access to the care they need. This question is especially important for mental health services because mental health practitioners tend to be located in urban and suburban areas. As the Finance Committee considers options for improving integration of behavioral health care and primary care, it will be important to better understand whether innovative care models, such as the Collaborative Care Model, can improve access to mental health care and substance use disorder services in rural areas.

Can integrated care models work in rural areas? Do psychiatrists and behavioral health-care managers need to be located in the same physical space as the primary care doctor?

How can practices leverage telehealth to make the care teams work in rural areas?

Answer. Integrated care models can be equally effective in rural areas, and psychiatrists and behavioral health-care managers do not need to be located in the same physical space as the primary care doctor. Practices can instead leverage telehealth to make care teams effective in rural areas.

In general, the term "integration" describes the bringing together of various providers and services. Integration has been used to reference everything from consultation to collocation to a setting of shared health goals around treating the whole person without clear boundaries.[1] It is helpful to view models of care delivery as spanning a continuum of ways to integrate physical and behavioral health care (both mental health and substance use).[2] It has been projected that effective medical and behavioral health service integration that includes a focus on primary care could generate nearly $70 billion in U.S. health-care costs savings annually.[3]

For rural areas, there is strong evidence that both in-person and virtually integrated care can support rural practices across the spectrum of integration to achieve meaningful improvements in behavioral health outcomes. One study found that collaborative care with all virtual support outperformed collaborative care with in-person support for managing depression in rural a federally qualified health centers (FQHCs).[4] Thus, telemedicine can be leveraged to allow all members of the care team to be remote and make behavioral health-care accessible in rural America.

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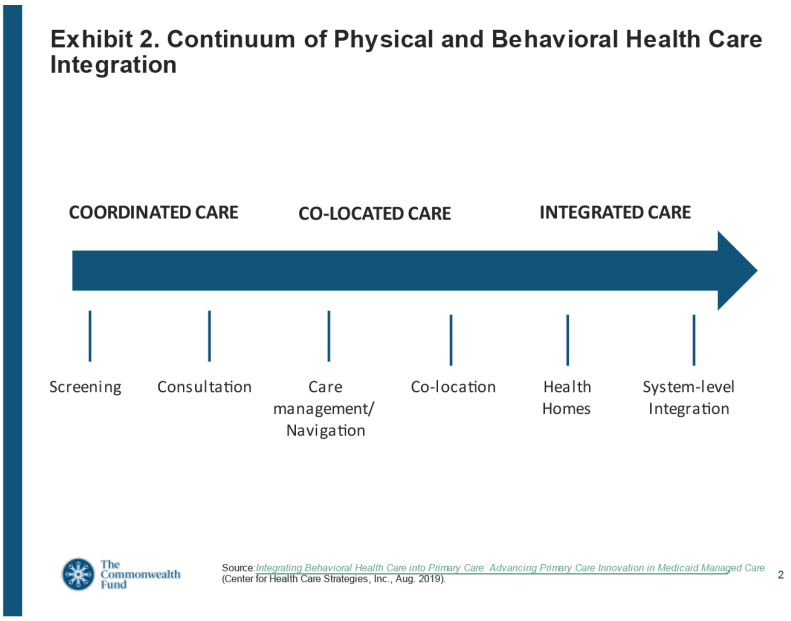
[1] *A Standard Framework for Levels of Integrated Healthcare* (SAMHSA–HRSA Center for Integrated Health Solutions, April 2013), *https://www.pcpcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf*.

[2] *Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care* (Center for Health Care Strategies, Inc., August 2019), *https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf*.

[3] "Potential economic impact of integrated medical-behavioral health care," Milliman Research Report, January 2018, *https://www.milliman.com/en/insight/potential-economic-impact-of-integrated-medical-behavioral-healthcare-updated-projections*.

[4] Fortney JC, Pyne JM, Mouden SB, Mittal D, Hudson TJ, Schroeder GW, Williams DK, Bynum CA, Mattox R, Rost KM. "Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: A pragmatic randomized comparative effectiveness trial." *American Journal of Psychiatry.* 2013 Apr;170(4):414–25.



Rural FQHCs across the U.S. are already leading important integration efforts. Southwest Montana Community Health Center in Butte, Montana links people to counseling and other community programs by deploying evidence-based models like screening, brief intervention, and referral to treatment (SBIRT). By leveraging the available resources in the community more effectively, they were able to achieve 68 percent lower illicit drug use and 39 percent lower heavy alcohol consumption six months later among individuals who had screened positive for hazardous drug and alcohol use.[5] Cherokee Health Systems in Tennessee, on the other hand, uses telepsychiatry and shared electronic medical records to enable provider communication and co-management of patients, making integration work even when behavioral health specialists are not physically on site.

CMS has already begun to pilot some innovative models, such as Community Health Access and Rural Transformation (CHART), that specifically provide technical assistance to rural providers to help them fully benefit from technological innovations with both financial and regulatory flexibilities. The committee could consider opportunities to provide additional support for these types of models, with a specific focus on building capacity for rural providers to offer virtually integrated behavioral health care. This could include helping to identify spaces available to primary care providers that can be set aside for telehealth visits when patients do not have access at home or the knowledge to use the technology.

DISPARITIES IN BEHAVIORAL HEALTH ACCESS AND OUTCOMES

Question. In the Finance Committee's hearing on youth behavioral health with the U.S. Surgeon General, Dr. Vivek Murthy sounded the alarm about the deep and pervasive racial and ethnic disparities that exist during the mental health crisis. A number of studies have found that more than half of people who need behavioral health care do not receive it, with higher rates of unmet need for racial and ethnic minority populations: 63 percent of African Americans, 65 percent of Hispanics, 80 percent of Asian and Pacific Islanders do not receive care when needed. Better inte-

[5] "Integration of Mental Health Services in Primary Care Settings," Rural Health Information Hub, 2022; Suneel M. Agerwala and Elinore F. McCance-Katz, M.D., *https://www.ruralhealthinfo.org/toolkits/substance-abuse/2/treatment/care-delivery/mental-health-integration;* "Integrating Screening, Brief Intervention, and Referral to Treatment (SBIRT) into Clinical Practice Settings: A Brief Review," *Journal of Psychoactive Drugs,* 44:4, 307–317 (September 2012), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3801194/*.

grating primary care with behavioral health may provide a critical access point for underserved populations and reduce racial and ethnic disparities.

Your testimony discusses stigma. Can you explain how the integration of mental health services into the primary care model could help with the stigma and access barriers associated with accessing mental health services?

Answer. The integration of mental health services into the primary care model could help with the stigma and access barriers associated with accessing mental health services. Studies repeatedly show that patients view primary care providers as trusted sources of information. For example, in recent history, primary care providers ranked as the preferred source of information around COVID–19 vaccination for all age groups, races, and geographical location—regardless of political party.[6] This trusted environment also offers an opportunity to combat stigma associated with discussing mental health and substance use and seeking treatment. Access in primary care also reinforces that behavioral health is part of overall health, not a separate issue that requires going to a different setting to begin a conversation around getting help. Although research is ongoing in this space, existing evidence suggests that it is likely that integrated behavioral health care does in fact reduce stigma.[7]

Reducing stigma also requires bridging the gap between providers and cultural and linguistic communities that providers may not be fully equipped to engage. In these cases, community health workers, paraprofessionals who are representative of the populations they are seeking to reach, can be an important way to reduce disparities in communities where people might not feel comfortable reaching out for help. Integrated behavioral health models that include community health workers and other paraprofessionals will be an important part of equitably reducing stigma and other barriers to care.

SUPPORTING PRIMARY CARE THROUGH BEHAVIORAL HEALTH INTEGRATION

Question. Primary care practices are often stretched thin with daily patient caseloads. These practices could likely benefit from support to help deliver behavioral health care in the primary care setting. Research suggests that the inclusion of mental health providers on primary care teams is less common in the United States, as compared to other countries—two-thirds of primary care practices in the U.S. did not include mental health providers on the team, according to survey data from The Commonwealth Fund. The same survey data suggests only about half of primary care practices report feeling "well prepared" to coordinate the care of patients with mental illness and only about 20 percent of practices feel well prepared to coordinate substance use disorder services.

Why is the integration of behavioral health services into primary care practices falling short in the United States and how can we close the gap?

Answer. The integration of behavioral health services into primary care practices falling short in the United States. Compared to other countries, the U.S. has a smaller workforce dedicated to meeting mental health needs. Countries like the Netherlands, Sweden, and Australia more frequently include mental health providers on primary care teams.[8] This compounds the comparative underinvestment in primary care teams in the U.S., which spends 5 percent to 7 percent on primary care as a share of total health-care spending, compared to 14 percent in other countries belonging to the Organisation for Economic Co-operation and Development (OECD).[9]

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[6] "American COVID–19 Vaccine Poll" (African American Research Collaborative, 2021), *https://africanamericanresearch.us/covid-poll-methodology/*.

[7] Rowan AB, Grove J, Solfelt L, Magnante A. Reducing the impacts of mental health stigma through integrated primary care: an examination of the evidence. *Journal of Clinical Psychology in Medical Settings.* 2021 Dec;28(4):679–93.

[8] Eric C. Schneider et al., *Mirror, Mirror 2021—Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, August 2021), *https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly;* and Molly FitzGerald, Munira Z. Gunja, and Roosa Tikkanen, *Primary Care in High-Income Countries: How the United States Compares* (Commonwealth Fund, March 2022), *https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/primary-care-high-income-countries-how-united-states-compares.*

[9] Yalda Jabbarpour et al., *Investing in Primary Care: A State-Level Analysis* (Patient-Centered Primary Care Collaborative, July 2019), *https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019.pdf.*

U.S. primary care providers are making strides in treating the behavioral health needs of their patients, but they are often working without necessary resources and supports. And they are working within a health-care system that does not yet fully support providing integrated care. As many as 80 percent of people with behavioral health needs present in emergency departments and primary care settings; between 60 percent and 70 percent of these individuals leave without treatment for their conditions. Primary care providers see 45 percent of people within 30 days of a suicide attempt, and data show the primary care providers have an opportunity to intervene with routine depression screening and treatment to prevent suicides. Expanding the capacity of primary care providers to meet the behavioral health needs of their patients provides an opportunity to increase access to early intervention and treatment as well as to promote social connectedness and suicide prevention.

The U.S. can start to close the gap by investing in infrastructure and incentives for primary care providers to integrate behavioral health services. Without additional support, care will remain fragmented and siloed in the U.S. This process of integration should also leverage telehealth and other modalities of virtual care to ensure more equitable access. The U.S. can also engage a wider array of providers in the behavioral health-care team. In particular, paraprofessionals can play an important role in extending the capacity and effectiveness of the care systems. Paraprofessionals encompass a range of workers, from certified peer support specialists to community health workers, that play important roles across the care continuum.

Trained and accredited peer support specialists leverage their lived experience of mental health or substance use conditions to support others in recovery. There is evidence that peer support specialists can be effective in engaging people with treatment, reducing the use of emergency rooms and hospitals and reducing substance use among people with co-occurring substance use disorders.[10] Peer support, which was developed in response to the lack of access to effective care in many communities, is now increasingly part of the continuum of care. Approximately 25 percent of mental health treatment facilities and 56 percent of facilities treating substance use disorders self-reported offering peer support services in 2018.[11] As of 2018, 39 states allowed for Medicaid billing of peer support specialists.[12]

Community health workers, on the other hand, work closely with the community in more of a public health role. Research has demonstrated that for every dollar invested in a community health worker intervention, it returned $2.47.[13] In behavioral health, community health workers can educate the community about mental health and substance use issues, help people identify needs and get connected to care, and even offer some frontline interventions to reduce stress. For example, community health workers in Louisiana effectively worked with pregnant women to facilitate virtual interventions and provide social support to prevent the onset of postpartum depression.[14]

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

HEALTH SERVICES IN SCHOOLS

Question. It is clear that COVID–19 has significantly exacerbated mental health stress on children and youth, highlighting the Nation's acute shortage of mental health services. In my State of Delaware, over 9,000 Delawareans ages 12 through 17 suffer from some sort of depression. However, according to the State, students

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[10] "Peers Supporting Recovery From Mental Health Conditions," SAMHSA, 2017, *https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf.*

[11] C. Page et al., "The Effects of State Regulations and Medicaid Plans on the Peer Support Specialist Workforce," *Health Services Research* vol. 55 issue S1 (August 2020), *https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13430.*

[12] Lynn Videka et al., *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement* (University of Michigan School of Public Health Behavioral Health Workforce Research Center, August 2019), *https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf.*

[13] Shreya Kangovi et al., "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment," *Health Affairs* 39(2): 207–213 (February 2020), *https://pubmed.ncbi.nlm.nih.gov/32011942/.*

[14] Christopher Mundorf et al., "Reducing the Risk of Postpartum Depression in a Low-Income Community Through a Community Health Worker Intervention," *Maternal and Child Health Journal* vol. 22, 520–528 (December 29, 2017), *https://link.springer.com/article/10.1007/s10995-017-2419-4.*

who have access to mental health resources within schools are 10 times more likely to seek care.

Earlier this year, the Finance Committee heard testimony from the U.S. Surgeon General who stressed that one of the most central tenets in creating accessible and equitable systems of care is to meet people where they are. For most young people, that's right there in schools. And just last week, Secretary of Health and Human Services Xavier Becerra and Secretary of Education Miguel Cardona announced a joint-department effort to expand school-based health services.

It is clear there is growing momentum to recognize the role schools already play in ensuring children have the health services and supports necessary to build resilience and thrive. We know that investing in school and community-based programs have been shown to improve mental health and emotional well-being of children at low cost and high benefit.

How can we improve coordination between primary care and mental health providers to better support our children, including through school-based services?

Answer. The Federal Government can support State Medicaid programs to improve coordination between primary care and mental health providers to better support our children, including through school-based services. State Medicaid programs have an important role both as a payer and as a leader among payers to improve access to behavioral health care for children. State Medicaid programs can ensure sufficient coverage for critical behavioral health services delivered in coordination with primary care and schools, including making sure that well-visit reimbursement allows providers to devote time to behavioral health as part of regular checkups. Medicaid can fund the information technology needed for coordination across settings, which can be a major barrier for implementing school-based care. Medicaid can also streamline billing to make integrated care feasible for small and rural schools and pediatric practices, as well as provide guidance on how to ensure compliance with State and Federal privacy laws in both health care and education as these stakeholders collaborate. As Medicaid programs take these actions, they set key conventions that allow other health insurance payers to follow suit and expand access to care for children.

Question. Do you see a role for the Federal Government beyond providing guidance and technical assistance to State programs?

Answer. The Federal Government can also support states by offering planning and/or demonstration grants that can allow Medicaid programs to take these critical actions, including convening commercial payers to promote alignment in the ways that behavioral health care is reimbursed, documented, and supported. Grants could also allow states to participate in more intensive technical assistance opportunities, such as State-to-State learning collaboratives that can allow states to share best practices. The Federal Government can also support better oversight of key Medicaid provisions, such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as it relates to behavioral health. Several states have been sued over their failure to guarantee children access to behavioral health care under EPDST. The Federal Government can assess children's access to behavioral health care in the states, identify gaps and potential litigation risks, and support states to develop improvement plans to ensure that all children get access to the behavioral health care they are promised by law. The Federal Government could even make EPSDT compliance mandatory for getting Medicaid waivers and other types of flexibility approved.

PRIMARY CARE AND MENTAL HEALTH CARE INTEGRATION IN COMBINATION WITH TELEHEALTH

Question. The pandemic has hit children's well-being hard, intensifying what was already a growing national emergency. While longer-term investments in children's health and well-being are necessary, immediate steps must be taken to better leverage existing provider capacity and telehealth to more effectively address the crisis.

Last year, I introduced the Telehealth Improvement for Kids' Essential Services, or TIKES, Act along with my colleague, Senator John Cornyn, to provide guidance and strategies to states on how to effectively integrate telehealth into their Medicaid and CHIP programs.

To that end, specific attention must be paid towards how telehealth can be used to increase access to services and lead to better behavioral health outcomes.

In your view, how can telehealth be used to better integrate behavioral health care within the primary care setting, particularly for the pediatric population?

Answer. Telehealth be used to better integrate behavioral health care within the primary care setting, particularly for the pediatric population. Evidence shows that telemedicine is at least as effective as face-to-face interventions in tackling depression and anxiety, symptoms of obsessive-compulsive disorder, insomnia, and excessive alcohol consumption.[15] Telemedicine has also been shown to alleviate maternal depression symptoms.[16] For children, models like the Child Psychiatry Access Program have demonstrated effectiveness in increasing access to mental health services in a number of states across the U.S. through virtual consultation to primary care providers.[17]

Increased use of telehealth during the pandemic increased the promise of these approaches. The proportion of substance use treatment facilities offering telehealth services jumped from 28 percent in 2019 to 59 percent in 2020. For mental health facilities, the share grew from 38 percent to 69 percent over the same period.[18] In addition, technology-enabled solutions have resulted in unprecedented investment in digital health tools that can help solve the provider shortage through on-demand therapy, guided mediation, chat-bots and more.

Congress has the opportunity to increase flexibilities around telehealth, invest in infrastructure for its effective deployment, and incentivize ongoing innovation to better integrate behavioral health care within the primary care setting, particularly for the pediatric population. Across all of these strategies, attention must be paid to the particular access challenges of rural and Black individuals in the U.S., who did not benefit from telehealth use at the same rates as other populations. Urban beneficiaries had about 50 percent higher telehealth use than rural beneficiaries—1,659 visits per 1,000 urban beneficiaries versus 1,112 visits per 1,000 among rural beneficiaries. Compared with pre-pandemic levels, this represents a 140- and 20-fold increase in telehealth use for urban and rural beneficiaries, respectively.[19] Ensuring that resources go toward small, rural, and underresourced providers to reach individuals with culturally and linguistically effective telehealth can expand equitable access in the U.S.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

MENTAL HEALTH IN THE FOSTER CARE SYSTEM

Question. In your testimony, you noted that in 2020, nearly 47 percent of young adults reported having unmet needs for mental health care, "with Black and Indigenous people and youth of color having even worse access to care . . . than White young people, teenagers, or adolescents." We also know that while youth in foster care participate in mental health services at higher rates than their peers, many still have poor mental health outcomes and that Black and Brown youth are overrepresented in the system when compared to their general population.[20]

How do we improve the quality of mental health services for youth of color in foster care to ensure they receive the services that will benefit their needs the most?

How can racial and ethnic data regarding access to mental health services for foster youth be better collected and analyzed?

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[15] Tiago C.O. Hashiguchi, *OECD Health Working Paper No. 116: Bringing Health Care to the Patient: An Overview of the Use of Telemedicine in OECD Countries* (OECD, January 2020), *https://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2020)1&docLanguage=En.*

[16] Uthara Nair et al., "The effectiveness of telemedicine interventions to address maternal depression: A systematic review and meta-analysis," *Journal of Telemedicine and Telecare* vol. 24, issue 10 (October 22, 2018), *https://journals.sagepub.com/doi/10.1177/1357633X18794332.*

[17] Stein BD, Kofner A, Vogt WB, Yu H., "A national examination of child psychiatric telephone consultation programs' impact on children's mental health-care utilization." *Journal of the American Academy of Child and Adolescent Psychiatry.* 2019 Oct;58(10):1016.

[18] Herman A. Alvarado, *Telemedicine Services in Substance Use and Mental Health Treatment Facilities* (SAMHSA, December 2021), *https://www.samhsa.gov/data/report/telemedicine-services.*

[19] Lok W. Samson et al., *Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location* (ASPE Office of Health Policy, December 2021), *https://www.aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf.*

[20] *https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf.*

What best practices, strategies, and resources exist within our current foster care system that can serve as a model for expanding access to high-quality mental health-care services for youth at large?

Answer. To advance behavioral health equity in the foster care system, policy and program design should account for disparities in race and ethnicity in resource distribution and outcomes, with a focus on achieving equity. This can be supplemented with other strategies, such as expanding the use of youth and family peer support specialists and other paraprofessionals that come from the same communities as the youth served. Paraprofessionals can provide critical additional social supports to both youth and families in ways that are culturally and linguistically effective, even when trained licensed providers are in short supply. Another strategy is to continue to build the title IV–E Prevention Services Clearinghouse to ensure that it supports culturally and linguistically effective programs for youth of color from all backgrounds served.

Continuing to improve alignment between the title IV–E Prevention Services program and Medicaid will also be critical for ensuring spread and scale of effective practices, so that youth and families of color can access effective behavioral health care.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. The promise of mental health parity has not been realized. Mental health parity laws vary between Medicare, Medicaid, and private insurance but more importantly, enforcement is inconsistent. With jurisdiction spread over multiple agencies, I believe there needs to be a coordinated, concerted effort to enforce mental health parity laws.

How can Congress improve enforcement of mental health parity laws?

What can the agencies responsible for implementation of mental health parity law—the Department of the Treasury and Department of Labor—do to improve enforcement without the need for congressional action?

What are your recommendations for Congress to address the following mental health issues: children's mental health crises; addiction and recovery; and crisis intervention, including support for law enforcement responding to mental health incidents?

Answer. Across all of these domains, critical opportunities exist in promoting flexibilities for telehealth, advancing integrating care, expanding the workforce to include paraprofessionals, and enhancing oversight of existing Medicaid benefits, with equity at the center of all of these strategies.

Recent policy changes that promoted flexible and sustainable telehealth enabled effective and accessible virtual behavioral health care for millions of Medicaid and Medicare beneficiaries, including access to high-quality cognitive behavioral therapy and even support for medication assisted treatment (MAT) for substance use. Evidence shows that telemedicine is at least as effective as face-to-face interventions in tackling depression and anxiety, symptoms of obsessive-compulsive disorder, insomnia, and excessive alcohol consumption.[21] Telemedicine has also been shown to alleviate maternal depression symptoms.[22] For children, models like the Child Psychiatry Access Program have demonstrated effectiveness in increasing access to mental health services in a number of States across the U.S. through virtual consultation to primary care providers.[23] Congress has the opportunity to increase flexibilities around telehealth, invest in infrastructure for its effective deployment, and incentivize ongoing innovation to better integrate behavioral health care within the primary care setting, particularly for the pediatric population. Across all of these strategies, attention must be paid to the particular access challenges of rural and

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[21] Tiago C.O. Hashiguchi, *OECD Health Working Paper No. 116: Bringing Health Care to the Patient: An Overview of the Use of Telemedicine in OECD Countries* (OECD, January 2020), *https://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2020)1&docLanguage=En.*

[22] Uthara Nair et al., "The effectiveness of telemedicine interventions to address maternal depression: A systematic review and meta-analysis," *Journal of Telemedicine and Telecare* vol. 24, issue 10 (October 22, 2018), *https://journals.sagepub.com/doi/10.1177/1357633X18794332.*

[23] Stein BD, Kofner A, Vogt WB, Yu H., "A national examination of child psychiatric telephone consultation programs' impact on children's mental health-care utilization." *Journal of the American Academy of Child and Adolescent Psychiatry.* 2019 Oct;58(10):1016.

Black individuals in the U.S., who did not benefit from telehealth use at the same rates as other populations. Ensuring that resources go toward small, rural, and under resourced providers to reach individuals with culturally and linguistically effective telehealth can expand equitable access in the U.S.

Behavioral health integration has been used to reference everything from consultation to colocation to a setting of shared health goals around treating the whole person without clear boundaries.[24] It is helpful to view models of care delivery as spanning a continuum of ways to integrate physical and behavioral health care (both mental health and substance use).[25] It has been projected that effective medical and behavioral health service integration that includes a focus on primary care could generate nearly $70 billion in U.S. health-care costs savings annually.[26] The committee could consider opportunities to provide additional support for these types of models, including financing and incentives for infrastructure, practice transformation, and sustainability, with a specific focus on building capacity for child-serving providers.

Paraprofessionals provide an additional opportunity to further expand the workforce and address the needs of children, those in recovery, and those in crisis. Paraprofessionals encompass a range of workers, from certified peer support specialists to community health workers, for adults, families of children with behavioral health conditions, and for children and youth themselves, that play important roles across the care continuum. Trained and accredited peer support specialists leverage their lived experience of mental health or substance use conditions to support others in recovery. There is evidence that peer support specialists can be effective in engaging people with treatment, reducing the use of emergency rooms and hospitals and reducing substance use among people with co-occurring substance use disorders.[27] Community health workers, on the other hand, work closely with the community in more of a public health role. Research has demonstrated that for every dollar invested in a community health worker intervention, it returned $2.47.[28] In behavioral health, community health workers can educate the community about mental health and substance use issues, help people identify needs and get connected to care, and even offer some frontline interventions to reduce stress. For example, community health workers in Louisiana effectively worked with pregnant women to facilitate virtual interventions and provide social support to prevent the onset of postpartum depression.[29] Furthermore, engaging community health workers who are representative of the populations they are seeking to reach can be an important way to reduce disparities in communities where people might not feel comfortable reaching out for help. Integrated behavioral health models that include paraprofessionals illustrate the potential for improving access to care and treatment.

Despite the evidence on improved outcomes and cost savings, most Americans do not currently have access to the providers described here. To remedy that, policymakers could:

- Ensure that incentives, financing, and support for integrated care are inclusive of the paraprofessional workforce.
- Provide specific incentives for systems to recruit, integrate, and retain paraprofessionals, and other workforce extenders.
- Implement learning collaboratives and quality improvement initiatives around integrating a broader workforce into the continuum of care, including

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[24] *A Standard Framework for Levels of Integrated Healthcare* (SAMHSA–HRSA Center for Integrated Health Solutions, April 2013), *https://www.pcpcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf*.

[25] *Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care* (Center for Health Care Strategies, Inc., August 2019), *https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf*.

[26] "Potential economic impact of integrated medical-behavioral health care," Milliman Research Report, January 2018, *https://www.milliman.com/en/insight/potential-economic-impact-of-integrated-medical-behavioral-healthcare-updated-projections*.

[27] "Peers Supporting Recovery From Mental Health Conditions," SAMHSA, 2017, *https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf*.

[28] Shreya Kangovi et al., "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment," *Health Affairs* 39(2): 207–213 (February 2020), *https://pubmed.ncbi.nlm.nih.gov/32011942/*.

[29] Christopher Mundorf et al., "Reducing the Risk of Postpartum Depression in a Low-Income Community Through a Community Health Worker Intervention," *Maternal and Child Health Journal* vol. 22, 520–528 (December 29, 2017), *https://link.springer.com/article/10.1007/s10995-017-2419-4*.

issues around effective supervision and delineation of roles to maximize impact.
- Consider how to improve coverage of a broader workforce, including reimbursement for peer support specialists in Medicare.

Finally, Congress can also support better oversight of key Medicaid provisions, such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for children as it relates to behavioral health. Several states have been sued over their failure to guarantee children access to behavioral health care under EPDST. The Federal Government can assess children's access to behavioral health care in the States, identify gaps and potential litigation risks, and support States to develop improvement plans to ensure that all children get access to the behavioral health care they are promised by law. The Federal Government could even make EPSDT compliance mandatory for getting Medicaid waivers and other types of flexibility approved. This could help build out a stronger continuum of care that addresses integration, recovery, and crisis systems.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

INCREASING ACCESS TO MENTAL HEALTH PROVIDERS IN MEDICARE

Question. As a doctor, I know the importance of improving access to mental health care for all Americans. This is especially important in rural parts of the country, which face some of the largest shortages in the country.

For seniors, finding a mental health provider can be particularly challenging. This is because Medicare restricts certain types of mental health providers from billing the program.

Senator Stabenow and I introduced bipartisan legislation to address this issue. S. 828, the Mental Health Access Improvement Act would allow licensed professional counselors and marriage and family therapists to bill Medicare.

This is especially important in Wyoming, where many of our community mental health centers rely on professional counselors and marriage and family therapists to provide care.

I'm sure the committee would like to hear from anyone else who wants to discuss the importance of increasing access to these professionals.

Answer. The evidence supports engaging a wider array of providers in the behavioral health-care team, a broader set of providers than most people have access to today. Medicare covers only a set of traditional providers, such as psychiatrists, psychologists, and social workers, but not other types of licensed providers, such as marriage and family therapists or counselors. Through their flexibility, State Medicaid managed care plans often cover a range of providers that also increasingly include paraprofessionals. Congress has the opportunity to support the development of a more expansive behavioral health workforce by including them within the existing financing systems. Licensed professional counselors and marriage and family therapists are one important provider to include in the Nation's behavioral health-care systems. Paraprofessionals provide an additional opportunity to further expand the workforce. Paraprofessionals encompass a range of workers, from certified peer support specialists to community health workers, that play important roles across the care continuum.

Trained and accredited peer support specialists leverage their lived experience of mental health or substance use conditions to support others in recovery. There is evidence that peer support specialists can be effective in engaging people with treatment, reducing the use of emergency rooms and hospitals and reducing substance use among people with co-occurring substance use disorders.[30] Approximately 25 percent of mental health treatment facilities and 56 percent of facilities treating

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[30] "Peers Supporting Recovery From Mental Health Conditions," SAMHSA, 2017, *https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf.*

substance use disorders self-reported offering peer support services in 2018.[31] As of 2018, 39 states allowed for Medicaid billing of peer support specialists.[32]

Often, peer support specialists assist with the transition from hospital to community or participate in intensive programs, providing necessary additional support as part of a care team. Increasingly though, peer support specialists are being engaged earlier and can be a critical partner and extender for integrated care models, including in collaborative care, where they help with navigating treatment and other services while building key self-management skills.[33] Clinicians appreciate peer support specialists for the additional support they lend and for keeping care grounded in the needs of the individual, ensuring that the services ultimately advance recovery.[34]

Community health workers, on the other hand, work closely with the community in more of a public health role. Research has demonstrated that for every dollar invested in a community health worker intervention, it returned $2.47.[35] In behavioral health, community health workers can educate the community about mental health and substance use issues, help people identify needs and get connected to care, and even offer some front-line interventions to reduce stress. For example, community health workers in Louisiana effectively worked with pregnant women to facilitate virtual interventions and provide social support to prevent the onset of postpartum depression.[36]

Furthermore, engaging community health workers who are representative of the populations they are seeking to reach can be an important way to reduce disparities in communities where people might not feel comfortable reaching out for help. Integrated behavioral health models that include paraprofessionals illustrate the potential for improving access to care and treatment.

Despite the evidence on improved outcomes and cost savings, most Americans do not currently have access to the providers described here. To remedy that, policymakers could:

- Ensure that incentives, financing, and support for integrated care are inclusive of the paraprofessional workforce.
- Provide specific incentives for systems to recruit, integrate, and retain paraprofessionals, and other workforce extenders.
- Implement learning collaboratives and quality improvement initiatives around integrating a broader workforce into the continuum of care, including issues around effective supervision and delineation of roles to maximize impact.
- Consider how to improve coverage of a broader workforce, including reimbursement for peer support specialists in Medicare.

TELEHEALTH

Question. Patients in Wyoming are using telehealth to help meet their health-care needs during the pandemic. Members of this committee support making sure telehealth becomes a permanent part of health-care delivery for those patients who want to utilize this service.

Congress, with bipartisan support, has already taken steps to extend telehealth flexibilities for five months following the expiration of the public health emergency.

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[31] C. Page et al., "The Effects of State Regulations and Medicaid Plans on the Peer Support Specialist Workforce," *Health Services Research* vol. 55 issue S1 (August 2020), *https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13430.*

[32] Lynn Videka et al., *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement* (University of Michigan School of Public Health Behavioral Health Workforce Research Center, August 2019), *https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf.*

[33] Matthew Menear et al., "Strategies for engaging patients and families in collaborative care programs for depression and anxiety disorders: A systematic review," *Journal of Affective Disorders* vol. 263 (February 15, 2020), *https://www.sciencedirect.com/science/article/pii/S0165032719323110#bib0038.*

[34] Marianne Storm et al., "Peer Support in Coordination of Physical Health and Mental Health Services for People With Lived Experience of a Serious Mental Illness," *Frontiers in Psychiatry* vol. 11 (May 8, 2020), *https://www.frontiersin.org/articles/10.3389/fpsyt.2020.00365/full.*

[35] Shreya Kangovi et al., "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment," *Health Affairs* 39(2): 207–213 (February 2020), *https://pubmed.ncbi.nlm.nih.gov/32011942/.*

[36] Christopher Mundorf et al., "Reducing the Risk of Postpartum Depression in a Low-Income Community Through a Community Health Worker Intervention," *Maternal and Child Health Journal* vol. 22, 520–528 (December 29, 2017), *https://link.springer.com/article/10.1007/s10995-017-2419-4.*

Can you discuss the importance of telehealth in terms of the delivery of mental health services?

Answer. Now is the time to be optimistic about the potential of technology to address behavioral health needs. The literature shows that telemedicine is effective for improving access to behavioral health care, especially through cognitive behavioral therapy. Evidence shows that telemedicine is at least as effective as face-to-face interventions in tackling depression and anxiety, symptoms of obsessive-compulsive disorder, insomnia, and excessive alcohol consumption.[37] Telemedicine has also been shown to alleviate maternal depression symptoms.[38]

The COVID–19 pandemic, and the expanded flexibilities that were authorized around the provision of telehealth services, brought about sharp increases in the number of facilities providing telehealth treatment for both mental health and substance use services. The proportion of substance use treatment facilities offering telehealth services jumped from 28 percent in 2019 to 59 percent in 2020. For mental health facilities, the share grew from 38 percent to 69 percent over the same period.[39] In addition, technology-enabled solutions have resulted in unprecedented investment in digital health tools that can help solve the provider shortage through on-demand therapy, guided mediation, chatbots and more.

Yet despite the increase in available services, Black and rural Medicare beneficiaries had lower telehealth use compared with White and urban beneficiaries, respectively. Telehealth use varied by State, with higher use in the Northeast and the West and lower use in the Midwest and the South. Urban beneficiaries had about 50-percent higher telehealth use than rural beneficiaries—1,659 visits per 1,000 urban beneficiaries versus 1,112 visits per 1,000 among rural beneficiaries. Compared with pre-pandemic levels, this represents a 140- and 20-fold increase in telehealth use for urban and rural beneficiaries, respectively.[40] As Congress and the Biden administration weigh options for extending the telehealth flexibilities beyond the public health emergency,[41] it will be essential to understand the barriers faced by Black and rural beneficiaries in accessing telehealth and tele-mental health services, so that policies serve to ameliorate disparities rather than exacerbate them.

It is also noteworthy that the temporary continuous coverage requirement that kept Medicaid coverage intact during the health emergency helped to ensure access to medical and behavioral health services.[42] Multiple studies have found that living in a Medicaid expansion State was associated with relative reductions in poor mental health by improving access, including access to services delivered through telehealth.[43] It is critical that expansion of telehealth and other digital innovations in medicine be undertaken with universal and equitable access to care in mind.

CMS has already begun to pilot some innovative models, such as Community Health Access and Rural Transformation (CHART), that specifically provide technical assistance to rural providers to help them fully benefit from technological innovations with both financial and regulatory flexibilities. The committee could consider opportunities to provide additional support for these types of models, including financing and incentives for infrastructure, practice transformation, and sustain-

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[37] Tiago C.O. Hashiguchi, *OECD Health Working Paper No. 116: Bringing Health Care to the Patient: An Overview of the Use of Telemedicine in OECD Countries* (OECD, January 2020), *https://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2020)1&docLanguage=En.*

[38] Uthara Nair et al., "The effectiveness of telemedicine interventions to address maternal depression: A systematic review and meta-analysis," *Journal of Telemedicine and Telecare* vol. 24, issue 10 (October 22, 2018), *https://journals.sagepub.com/doi/10.1177/1357633X18794332.*

[39] Herman A. Alvarado, *Telemedicine Services in Substance Use and Mental Health Treatment Facilities* (SAMHSA, December 2021), *https://www.samhsa.gov/data/report/telemedicine-services.*

[40] Lok W. Samson et al., *Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location* (ASPE Office of Health Policy, December 2021), *https://www.aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf.*

[41] Josh LaRosa, "Avoiding the Cliff: Medicare Coverage of Telemental Health and the End of the PHE," *To the Point* (blog), Commonwealth Fund, March 23, 2022, *https://www.commonwealthfund.org/blog/2022/avoiding-cliff-medicare-coverage-telemental-health-and-end-phe.*

[42] Cindy Mann, "Stable and Continuous Coverage Provisions in Medicaid Gain Momentum Through Build Back Better Act," *To the Point* (blog), Commonwealth Fund, February 9, 2022, *https://www.commonwealthfund.org/blog/2022/stable-and-continuous-coverage-provisions-medicaid-gain-momentum-through-build-back.*

[43] John Cawley et al., "Third year of survey data shows continuing benefits of Medicaid expansions for low-income childless adults in the U.S.," *Journal of General Internal Medicine* vol. 33, 1495–1497 (June 5, 2018), *https://pubmed.ncbi.nlm.nih.gov/29943107/.*

ability, with a specific focus on building capacity for rural providers to offer virtually integrated behavioral health care. This could include helping to identify spaces available to primary care providers that can be set aside for telehealth visits when patients do not have access at home or the knowledge to use the technology.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

The Finance Committee meets for our third hearing on mental health care this year, and we'll begin with mental health parity. For 13 years, the parity law has required equal treatment by insurance companies of mental health care and physical health care. That law was the result of the efforts of the late Senators Wellstone and Domenici, who came from families touched by mental health challenges.

The parity law was supposed to be a game-changer, but mental health patients have still spent the last 13 years all too often bogged down in insurance company foot-dragging, red tape, and piles of excuses. This committee is coming together to finally fix this on a bipartisan basis. It's not on today's docket, but I'll just say that more finally needs to be done to hold the executives of these companies accountable.

Here are four examples of what's going wrong. First, too many Americans are getting shoved by insurers into "ghost networks." When you're stuck in a ghost network, you can't get a provider to take your insurance. The insurance company's directory of providers is often wrong, even years out of date. Or insurance companies often pay so little for mental health services that patients get stuck with the entire bill. When families pay good money for insurance and wind up with a ghost network, you don't feel like you're getting parity, you feel like you're getting ripped off.

Next example: mental health patients are getting whacked by coverage limits that cut off their stays in a hospital. Health treatments ought to be driven by a professional diagnosis, not an arbitrary cap set to protect insurance company profits.

Third, insurance companies are relying on loopholes to deny coverage, requiring prior authorizations before they'll pay for care, and setting unreasonably high standards for the "medical necessity" of mental health care. Particularly for somebody experiencing a mental health crisis, these bureaucratic roadblocks to insurance coverage can be fatal. If you break your arm, you don't have to make a dozen phone calls and gather a mountain of paperwork to prove to your insurance company that you really do need to see a doctor. A mental health crisis shouldn't be any different.

Fourth, stonewalling on paying claims. I was struck during the pandemic that even leading health institutions like Oregon Health and Science University couldn't get mental health services claims paid by insurance companies. At first, they claimed it was because they couldn't hire enough staff. But after I wrote a letter calling for the GAO inquiry into this stonewalling, the floodgates reopened, and the claims got paid. It shouldn't take a United States Senator weighing in to get paid for needed mental health care.

These four barriers make a mockery of the parity that Senators Wellstone and Domenici envisioned. Tools like ParityTrack, which is run by an organization headed by former Surgeon General Dr. David Satcher and former Congressman Patrick Kennedy, are out there to hold States and Federal regulators accountable for enforcing parity law. It's going to take a lot of hard work to address these issues, but members on both sides of this committee are working to bring their best ideas forward.

The second challenge that's up for discussion is bringing mental health care and physical health care closer together. Mental health should not be fenced off from the rest of the health-care system. This lack of integration can be fatal.

People typically start with their primary care doctor, but less than half of patients who receive a referral to a mental health provider are able to get the care they need. This approach is often slow to help somebody through a crisis. As many as one in three people who have died by suicide saw their primary care doctor within a month of their death. Let's be clear: this is not a blame game that falls on primary care doctors, who often have to see dozens of patients every day. The truth is that patients need more options.

What's needed is a fresh strategy so that it's possible to get primary care and mental health care at almost the same time. Let's end the interminable delays that slow down badly needed help.

Taking care integration beyond the doctor's office is another priority. In my home State, the CAHOOTS program takes mental health care to people where they are, and mental health providers and law enforcement are both for it. It's also essential to ensure there's follow-up care once the initial crisis has been stabilized.

There's a lot of work ahead, but this committee is focused on guaranteeing that Americans can get the mental health care they need when they need it.

COMMUNICATIONS

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AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

We are pleased to see the Committee's focus on the ongoing mental health crisis in the United States. Our members strongly support your effort to increase access to quality, affordable behavioral health care. Health insurance providers are committed to providing coverage for behavioral health and substance use disorder services on par with medical and surgical care, improving behavioral health care quality and outcomes, and eliminating the stigma often associated with accessing behavioral health care.

Behavioral Health Integration

AHIP appreciates the Committee's focus on behavioral health care integration with primary care. Because the front door to health care for most individuals is their primary care provider (PCP), making that primary care practice a one stop shop for people's physical and behavioral health needs can significantly increase the identification of behavioral health needs, reduce the time to receive treatment, and improve the accessibility of behavioral health services for all consumers.

That's why health insurance providers are exploring different ways to integrate behavioral health care with primary care leveraging collaborations with PCPs, including pediatricians, as an effective way to enhance access to behavioral health and improve overall health outcomes. Integrated behavioral health care blends care for physical conditions and behavioral health, such as mental health conditions and substance use disorders, life stressors and crises, or stress-related physical symptoms that affect a patient's health and well-being.[1] Integration of behavioral health care with primary care has been identified by many stakeholders as a strategy not only to improve access and quality, but also to reduce disparities and promote equity.[2, 3] In addition, because PCPs are widely available, integrated care can substantially expand access, increasing the number and type of venues available to meet each person's needs.

Integration of physical and behavioral health can provide multiple benefits to patients, including earlier diagnosis and treatment, better care coordination, timely information sharing, improved outcomes, and improved patient and provider satisfaction. Many people with behavioral health conditions also have other chronic medical conditions. Integrating behavioral health with primary care can allow for earlier diagnosis and better coordination of care for patients with multiple complex physical and behavioral health conditions. Also, while PCPs often prescribe many, if not most, medications used to treat behavioral health conditions, they often prefer consultation with psychiatrists/clinical psychologists when prescribing for certain more serious mental health conditions and atypical psychotic drugs. Finally, PCPs are accustomed to doing measurement-based care and reporting quality metrics for other conditions. This experience can be particularly helpful as we drive toward greater

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[1] *https://www.integrationacademy.ahrq.gov/about/integrated-behavioral-health.*
[2] *https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf.*
[3] *https://www.ama-assn.org/delivering-care/public-health/behavioral-health-integration-physician-practices.*

use of measurement-based care and improved quality measurement in the area of behavioral health care.

The Center for Integrated Health Solutions, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), has developed a framework [4] for levels of integrated healthcare, on which the Center for Health Care Strategies has based its continuum [5] of behavioral health integration models. This integration continuum includes models that emphasize coordinated care through screening and consultation, models that supplement that care coordination with care management and co- location, and models that are more fully integrated at the health home or system-level. Along this continuum, there are several best practices for integrating behavioral health with primary care.

The Collaborative Care Model [6] (CoCM) is one such model designed to promote integration that many health insurance providers have implemented with their primary care partners. This model of integration includes care management support for patients receiving behavioral health treatment and psychiatric consultation. While some providers and health systems have implemented the CoCM, uptake among providers has been slow, with start-up costs, complexity, and the need for technical assistance often cited as barriers to more widespread adoption. Many health insurance providers reimburse the codes available to support CoCM and some also provide technical assistance to help providers implement this model. In addition, some health insurance providers are also partnering with technology companies that provide solutions to their provider partners to help them implement CoCM. Medicare covers services provided to beneficiaries receiving CoCM and other behavioral health integration (BHI) services.[7]

In addition to the CoCM, many health insurance providers have promoted integration and team-based care through other effective approaches, including enhanced referral, expanded case management specific to behavioral health conditions, and value-based payment arrangements. Many states have partnered with their Medicaid plans to implement behavioral health homes for enrollees with serious mental illness and chronic physical health conditions and/or functional impairments, often in combination with managed long-term services and supports (MLTSS), These programs integrate and coordinate care across a range of providers to respond to the range of an individual enrollee's care needs. These approaches rely on behavioral health and medical care managers coordinating and communicating across providers to support patients with co-morbid conditions and value-based payment incentives to encourage providers to integrate care for patients with both physical and behavioral health needs.

The range of approaches currently underway underscores the importance of flexibility and recognition that physician practices are at varying stages of readiness in their ability to deliver fully integrated physical and behavioral health care. It is important to note that all of these approaches rely on team-based care that includes PCPs using validated behavioral health screening and assessment tools to identify patients in need of services, referral/consultation arrangements and partnerships with behavioral health specialists, care management by health care professionals trained to coordinate care across behavioral and medical conditions, education and training resources to support providers, and, as discussed in more detail below, quality measurement to assess effectiveness.

Acknowledging the importance of patient-centered outcomes, AHIP recommends:

- Creating flexibilities in payment policies that allow Medicare, Medicaid, and the commercial plans the ability to innovate and test new care models;
- Additional research to further build the evidence base for effective models of integrated behavioral health care; and
- Increasing funding and/or incentives to support provider readiness for behavioral health integration with primary care, including start-up costs, care coordinators, educational resources for providers, and use of health information technology and electronic health records.

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[4] *https://www.pcpcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf.*
[5] *https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf.*
[6] *https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.*
[7] *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf.*

Commitment to Behavioral Health Parity

Health insurance providers are wholly supportive of parity between physical and behavioral health and are working diligently to achieve the goals of the Mental Health Parity and Addiction Equity Act (MHPAEA). For years, our members have supported and worked hard to comply with MHPAEA, as well as with other federal and state laws which ensure access to behavioral health care for millions of Americans.

Since MHPAEA's passage, our collective work has improved access to behavioral health and substance use disorder care for the families enrolled in the health care coverage we provide or sponsor. We have also worked diligently to address larger systemic issues that limit access to care, such as workforce shortages and the lack of integration and coordination between physical and behavioral health delivery.

Our members have expanded flexibility for, and use of, telehealth during the COVID–19 public health emergency, which has substantially improved access to treatment and laid a path for a positive way forward as the public health emergency winds down. Health plans leveraged the flexibility provided through the CARES Act to provide access to behavioral health care via telehealth pre-deductible. Ninety-five percent of plans surveyed provided this access.[8] We recognize that additional systemic improvements are needed to build on the progress made, and we are committed to working with you and your staff as you examine bipartisan solutions to address behavioral health care for all Americans.

As the Committee continues its work crafting mental health legislation, we ask that you address the need for time and appropriate regulatory guidance so that health insurance providers' have a real opportunity to demonstrate MHPAEA compliance, particularly to federal agencies. Section 203 of the transparency provisions in the Consolidated Appropriations Act of 2021 (CAA) granted the Department of Labor (DOL), CMS, and states authority to request comprehensive comparative analyses of plans' application of non-quantitative treatment limitations (NQTLs) to behavioral health and medical/surgical benefits. In January, the Departments of Health and Human Services, Labor, and Treasury released their 2022 MHPAEA Report to Congress, which included updates on their work to implement Section 203 for federally regulated plans. CMS and DOL issued a combined 171 requests for comparative analyses from plans in their respective jurisdictions. None of the initial submissions met the Departments' standards of sufficiency for review. This finding of insufficiency does not mean that the plans were not in compliance with MHPAEA, but rather that the information submitted did not include all of the information required by the Departments to proceed with the review for compliance.

AHIP appreciates efforts by DOL and CMS to issue guidance for their expectations for these submissions; however more information is needed. While guidance like DOL's Self-Compliance tool and FAQs Part 45 offer some examples of compliant and noncompliant NQTLs, that none of the submitted analyses met the Departments' threshold for sufficiency indicates that more detailed instructions and examples are necessary. Congress should require DOL and CMS to develop and provide model or sample analyses that demonstrate compliance across the different types of NQTLs. These completed analyses should include checklists and samples of documentation and data that would support the analyses and the determination of compliance. DOL and CMS should provide plans with the information necessary and a reasonable opportunity to demonstrate compliance. If provided clear guidance, health insurance providers can demonstrate compliance with the provisions of MHPAEA and the CAA and consumers can be certain that the health insurance plan they rely on is delivering care in a manner consistent with the applicable law. Working together, we can improve both behavioral and physical health for every American.

Other Policy Recommendations

Strengthening the Mental Health Workforce

Challenges in accessing behavioral healthcare are longstanding and multifaceted. Key among them is the availability and supply of behavioral health providers. Action is urgently needed to expand the number of behavioral health providers of all types—from psychiatrists and psychologist to social workers and mental health counselors.

AHIP supports legislative policies that provide incentives for individuals to enter the behavioral health field. These could include:

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[8] *https://www.ahip.org/documents/202203-CaW_TelehealthSurvey-v04.pdf.*

- Increasing funding for loan repayment programs for providers who enter the behavioral health field;
- Expanding the eligible provider types for National Health Service Corp (NHSC) scholarships to include behavioral health care professions with an additional emphasis on promoting workforce diversity;
- Increasing the number of graduate medical education (GME) slots allotted to behavioral health providers;
- Expanding the behavioral health provider types covered under Medicare, such as certified peer support specialists, licensed professional counselors, and licensed mental health counselors; and,
- Providing funding to CMS to collect provider demographic information in NPPES and requiring CMS to share that information with all health plans.

In addition to expanding the number of providers AHIP members believe that every provider should receive training and be able to deliver culturally competent care. We support training of providers and staff on cultural competency, cultural humility, unconscious bias, and anti-racism in order promote empathy, respect, and understanding among provider networks and between providers and their patients.

Moreover, AHIP members believe in promoting diverse provider networks that reflect the communities they serve so that beneficiaries can find providers that meet their needs and preferences. This includes provider and practitioner demographic diversity as well as diversity of staff and care team members.

Telehealth Is a Critical Tool to Behavioral Health

Consumers, health care providers, and health insurance providers all appreciate the value of telehealth. Patients can access telehealth from wherever they are, making it a vital tool to bridge health care gaps nationwide. Patients accept—and often prefer—digital technologies as an essential part of health care delivery including the delivery of mental health and substance use disorder (SUD) services. Those accessing behavioral health services via telehealth can do so from the privacy of their own homes and free from the stigma associated with seeking care in brick-and-mortar settings for mental health conditions. For patients in rural communities and other underserved areas with fewer practicing providers, telehealth can make behavioral health care more convenient, accessible, efficient, and sustainable. Patients who access care remotely can also avoid challenges associated with taking time off from work, arranging transportation, or finding childcare. For providers, telehealth also substantially reduces the number of no-shows assuring that the time made available for patient care is actually spent delivering services to the patients who need it.

Health insurance providers are committed to ensuring that the people they serve, regardless of where they live or their economic situation, can access high-quality, safe, and convenient care. That's why they embrace telehealth solutions that help increase access to care. The telehealth flexibilities put in place during the ongoing COVID–19 public health emergency, such as waiving originating site requirements for telehealth services under Medicare and allowing reimbursement of more video-enabled telehealth and audio-only telehealth services have proven critically important to the delivery of care throughout the pandemic.

Taken together, actions taken by Congress and the Administration, many of which were adopted across Federal programs and in commercial plans, allowed for increased access to telehealth for both patients and providers, leading to exponential growth in use especially for those in need of behavioral health services. Data shows that over 60% of telehealth use is for behavioral health care.[9]

However, legislation is required to permanently authorize key evidence-based reforms under Medicare. We encourage Congress to act to protect health insurance providers' flexibilities in creating telehealth programs and other virtual care solutions that will best serve the needs of their members and can provide convenient access to high-quality behavioral health services in an equitable manner across all populations and communities.

We encourage Congress to consider measures to permanently eliminate geographic restrictions for all telehealth services and to eliminate originating sites entirely, so that patients can access care where and when they need it. Additionally, the CARES Act permitted pre-deductible coverage of telehealth in high-deductible health plans in 2020 and 2021 allowing millions of people increased access to care. While the Consolidated Appropriations Act 2022 signed into law on March 15th extended this

[9] *https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/nov-2021-national-telehealth.pdf.*

flexibility from April through the end of the year, we support the bipartisan S. 1704, the Telehealth Expansion Act of 2021 which would provide a permanent extension of that authority.

We also ask that Congress pass the bipartisan Ensuring Parity in MA for Audio Only-Telehealth Act (S. 150/ H.R. 2166). This legislation would help ensure seniors and individuals with disabilities continue to have access to clinically appropriate audio-only telehealth which, while less preferred than video enabled care, has proven to be an effective source of care for many Medicare beneficiaries throughout the course of the COVID–19 public health emergency, particularly individuals who are unable to use or access video enabled devices. This legislation would ensure that individuals who use audio-only telehealth services are treated by Medicare in exactly the same way as individuals who receive care and treatment in person or via video-enabled telehealth, ensuring that the high value care and important supplemental benefits provided by Medicare Advantage (MA) remain available to all beneficiaries regardless of how they choose to access care.

Conclusion

Behavioral health is an essential part of a person's overall health and well-being. Health insurance providers are working everyday with consumers, providers, and communities to ensure access to behavioral health care and support. As a result, we are making progress, and more people are getting the treatment they need. But we must recognize the multi-faceted nature of the challenges facing our nation's behavioral health and acknowledge the need for all stakeholders to do much more. We need more behavioral health experts, more robust accreditation standards to ensure patients are getting good care, and continued integration of behavioral health into patients' overall health care. AHIP appreciates the Committee's increased focus on this important issue. We look forward to working with you to develop solutions to enhance mental health care access and affordability.

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Statement of Shawn Baird, President

Chairman Wyden, Ranking Member Crapo, and members of the Committee, I am the president of the American Ambulance Association and on behalf of the members of the American Ambulance Association (AAA), I greatly appreciate the opportunity to provide you with a written statement on America's Mental Health Crisis. We commend the Committee for holding this hearing and earlier hearings addressing our current mental health crisis. Ensuring that healthcare plans provide adequate coverage and that the proper care is provided is a critical piece in assuring that our healthcare delivery system meets the need of individuals with mental health issues on a par with those having other types of healthcare needs. I want to focus my comments today on the mental health needs of our first responder community. Our emergency medical services and transitional care providers need Congress to recognize the significant stress and trauma paramedics and emergency medical technicians (EMTs) have experienced as a result of this pandemic. The AAA urges Members of Congress not to forget these heroes and to expressly include **all** ground ambulance personnel in efforts to address America's Mental Health Crisis.

Emergency medical services (EMS) professionals are ready at a moment's notice to provide life-saving and life-sustaining treatment and medical transportation for conditions ranging from heart attack, stroke, and trauma to childbirth and overdose. These first responders proudly serve their communities with on-demand mobile healthcare around the clock. Ground ambulance professionals have been at the forefront of our country's response to the mental health crisis in their local communities. Often, emergency calls related to mental health services are triaged to the local ground ambulance service to address.

While paramedics and EMTs provide important emergency health care services to those individuals suffering from a mental or behavioral health crisis, these frontline workers have been struggling to access the federal assistance they need to address the mental health strain providing 24-hour care, especially during a COVID–19 pandemic, has placed on them. We need to ensure that there is equal access to

mental health funding for all EMS services, regardless of their form of corporate ownership so that all first responders can receive the help and support they need.

EMS's Enhanced Role in the Pandemic

As if traditional ambulance service responsibilities were not enough, Paramedics and Emergency Medical Technicians (EMTs) have taken on an even greater role on the very front lines of the COVID–19 pandemic. In many areas, EMS professionals lead Coronavirus vaccination, testing, and patient navigation. As part of the federal disaster response subcontract, EMS providers even deploy to pandemic hotspots and natural disasters to bolster local healthcare resources in the face of extraordinarily challenging circumstances.

EMS Response to Mental Health Patients

Paramedics and EMTs around the country respond every day to patients who have mental and behavioral health issues.

Historically, under the Medicare program, ambulance service providers and suppliers were required to transport mental and behavioral health patients to a hospital even though a psychiatric center might be the most appropriate destination at which they will be provided the best and most appropriate care. During the pandemic, the Centers for Medicare and Medicaid Services issued a waiver to allow for reimbursement under the Medicare ambulance fee schedule to alternative destinations such as psychiatric facilities. The Centers for Medicare and Medicaid Innovation is also currently piloting a program, the Emergency Triage, Treat, and Transport (ET3) Model, to evaluate the benefits of transporting patients to alternative destinations.

Mental and Behavioral Health Challenges Drive Staffing Shortages on the Front Line

Myriad studies show that first responders face much higher-than-average rates of post-traumatic stress disorder,[1] burnout,[2] and suicidal ideation.[3] These selfless professionals work in the field every day at great risk to their personal health and safety—and under extreme stress.

Ambulance services and fire departments do not keep bankers' hours. By their very nature, EMS operations do not close during pandemic lockdowns or during extreme weather emergencies. "Working from home" is not an option for Paramedics and EMTs who serve at the intersection of public health and public safety. Many communities face a greater than 25% annual turnover[4] of EMS staff because of these factors. In fact, across the nation EMS agencies face a 20% staffing shortage compounded by near 20% of employees on sick leave from COVID–19. This crisis-level staffing is unsustainable and threatens the public safety net of our cities and towns.

Sadly, to date, too few resources have been allocated to support the mental and behavioral health of our frontline healthcare workers.

Equity for All Provider Types

Due to the inherently local nature of EMS, each American community chooses the ambulance service provider model that represents the best fit for its specific population, geography, and budget. From for-profit entities to municipally funded fire departments to volunteer rescue squads, EMS professionals share the same duties and responsibilities regardless of their organizational tax structure. They face the same mental health challenges and should have equal access to available behavioral health programs and services.

Many current federal first responder grant programs and resources exclude the tens of thousands of Paramedics and EMTs employed by for-profit entities from access. These individuals respond to the same 911 calls and provide the same interfacility mobile healthcare as their governmental brethren without receiving the same behavioral health support from Federal agencies. To remedy this and ensure equitable mental healthcare access for all first responders, we recommend that:

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[1] Prevalence of PTSD and common mental disorders amongst ambulance personnel: A systematic review and meta-analysis. *Soc Psychiatry Psychiatr Epidemiol.* 2018;53(9):897–909.

[2] ALmutairi MN, El Mahalli AA. Burnout and Coping Methods among Emergency Medical Services Professionals. *J Multidiscip Healthc.* 2020;13:271–279. Published 2020 March 16. doi:10.2147/JMDH.S244303.

[3] Stanley, I.H., Hom, M.A., and Joiner, T.E. (2016). A systematic review of suicidal thoughts and behaviors among police officers, firefighters, EMTs, and paramedics. *Clinical Psychology Review,* 44, 25–44. *https://doi.org/10.1016/j.cpr.2015.12.002.*

[4] Doverspike D, Moore S. 2021 Ambulance Industry Employee Turnover Study. 3rd ed. Washington, DC: American Ambulance Association; 2021.

- During the current public health emergency and for at least two years thereafter, eligibility for first responder training and staffing grant programs administered by the U.S. Department of Health and Human Services (such as SAMHSA Rural EMS Training Grants and HHS Occupational Safety and Health Training Project Grants) should be expanded to include for-profit entities. Spending on training and services for mental health should also be included as eligible program expenses.
- Congress should authorize the establishment of a new HHS grant program (or increase funding and modify existing EMS programs such as the current ASPR healthcare readiness program) to open both public and private nonprofit and for-profit ambulance service providers to fund EMT and Paramedic recruitment and training, including employee education and peer-support programming to reduce and prevent suicide, burnout, mental health conditions and substance use disorders.

The rationale for the above requests is twofold. First, ensuring the mental health and wellness of all EMS professionals—regardless of their employer's tax status—is the *right* thing to do. Second, because private ambulance service providers offer critical assistance and vital support to overburdened local government agencies, assuring that EMTs and Paramedics on the front lines have access to the full range of mental health services will assure that we are able to provide the high-quality critical services the public expects.

Please do not hesitate to contact American Ambulance Association Senior Vice President of Government Affairs, Tristan North, at tnorth@ambulance.org or 202–486–4888 should you have any questions.

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RE: Persons with Co-Occurring Mental Illness and Substance Abuse Disorder; Persons with Co-Occurring Mental Illness and Chronic Medical Conditions; Persons with Co-Occurring Mental Health and Intellectual and Other Developmental Disabilities; Persons with Co-Occurring Behavioral Health Conditions and Disabilities

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The American Association on Health and Disability (AAHD) *(www.aahd.us)* is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.

The Lakeshore Foundation *(www.lakeshore.org)* mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

We are active in the Mental Health Liaison Group (MHLG), Consortium for Citizens with Disabilities (CCD), Disability and Aging Collaborative (DAC), and Coalition for Whole Health (CWH). We have been involved with the MHLG since 1971 and are a CCD co-founder in 1973.

We work closely with the NHMH—No Health without Mental Health—facilitated group **promoting bi-directional integration of behavioral health-general health-primary care**—NHMH, American Association on Health and Disability, Association of Medicine and Psychiatry, Clinical Social Workers Association, Lakeshore

Foundation, and Maternal Mental Health Leadership Alliance. Likewise, we work closely on integration issues with NHMH and American Psychological Association.

Data Points on Persons with Co-Occurring Conditions

Given the Committee's instructions for submissions only as Word documents and no other file type being accepted, we have not attached data point charts. The Committee's report—Mental Health Care in the U.S.: The Case for Federal Action, references similar data. The data charts listed below are available upon request. Particularly relevant data points on co-occurring conditions include:

1. Co-Occurring Serious Mental Illness (SMI) and Substance Use Disorder (SUD)—chart from December 2017 Interdepartmental Serious Mental Illness Coordinating Committee report.
2. People with Serious Mental Illness have higher rates of chronic medical illness (and shorter life spans)—charts from February 24, 2022 National Council on Mental Well-being webinars slides on integrating care.
3. Co-Occurring Mental Illness and ID/DD—from August 9, 2018 SAMHSA webinar slides on emerging best practices.
4. Co-Occurring Mental Illness and ID/DD—ID/DD only vs dual diagnosis costs—Vaya Health Managed Care Plan, North Carolina; from SAMHSA April 19, 2017 webinar on the pivotal role of Medicaid in co-occurring ID/DD and BH slides.
5. Co-Occurring Mental Illness and ID/DD—Demographic excerpts from NASDDDS–HSRI October 2019 National Core Indicators Data Brief.
6. Persons Dually Eligible for Medicare and Medicaid by Age and Chronic Conditions—February 2022 MACPAC Data Book on Persons Dually Eligible for Medicare and Medicaid.

AAHD and the Lakeshore Foundation appreciate the Senate Committee on Finance, chapter 5, pages 20–21 Mental Health Care in the U.S.: The Case for Federal Action, on integrating care for persons dually eligible for Medicare and Medicaid. We appreciated the Commonwealth Foundation addressing this population in response to hearing questions by Senators Cassidy and Casey.

There are 12.2 million individuals enrolled in both Medicare and Medicaid (dually eligible persons); 4.6 million are people with disabilities under age 65. Many dually eligible persons have complex care needs, including chronic illness, physical disabilities, behavioral health issues, and cognitive impairments; frequently these are co-occurring conditions. These persons, on average, use more services and have higher per capita costs than those beneficiaries enrolled in Medicare or Medicaid alone. Many live with major social risk factors. Although Congress created multiple authorities to integrate their care, in 2019 only about 10% of the dual-eligible population are enrolled in integrated care programs, such as the Medicare-Medicaid financial alignment initiative, PACE, dual eligible special needs plans (D–SNPs), and Medicaid Managed FFS programs. The division of coverage between Medicare and Medicaid results in fragmented care and cost shifting. A recent RAND study, commissioned by CMS, documented dually eligible persons in MA programs had much greater clinical care quality disparities (using HEDIS measures) than non-dually eligible persons.

Co-Occurring Conditions: Some Analysis and White Papers

We bring to the Committee's attention; and, available upon request are:

1. NASMHPD August 2019 assessment paper #8—Co-Occurring Mental Health and Substance Use Conditions: What Is Known; What's New.
2. NASDDDS–NADD–NASMHPD paper: Supporting Individuals with Co-Occurring Mental Health and ID/DD; May 2021.
3. NASMHPD August 2017 assessment paper #7: Co-Occurring Conditions—The Vital Role of Specialized Approaches.
4. NASMHPD August 2019 assessment paper #3: Developing a Behavioral Health Workforce Equipped To Serve Individuals with Co-Occurring Mental Health and Substance Use Disorder.
5. Administration for Community Living (ACL) funded: Mental Health and Developmental Disabilities National Training Center: a joint project of the University of Kentucky, University of Alaska, and Utah State University.

6. Administration for Community Living (ACL) paper: "Key Elements of a No Wrong Door System of Access to LTSS for All Populations and Payers." The ACL No Wrong Door web page has multiple resources, several by AARP.
7. Obesity Medicine, June 2021 article: Concurrent Mental Health Conditions and Severe Obesity.
8. CMS MMCO RIC summary, June 2020: Supporting Persons with Co-Occurring ID/DD and Behavioral Health Needs—New York Partners in Health program.
9. National Academy of Medicine, December 2021 three-day summit—Optimal Integrated Care for People with ID/DD. Specifically:
   a. Sharon Lewis, HMA, on "Rethinking Holistic Coordination."
   b. Charlene Wong, Duke University, on "Reimaging Models of Care for People with ID/DD: Integrating Cross-Sector Data."
10. HHS ASPE, September 22, 2021: "Considerations for Building Federal Data Capacity for Patient-Centered Outcomes Research Related to ID/DD."
11. The Arc: Support Needs of People with ID/DD and MH Needs and Their families.
12. The Arc: Training Needs of Professionals Serving People with ID/DD and Mental Health Needs.
13. PCORI, January 2022 Research Funding Announcement—Mental Health and Developmental Disabilities Research.
14. SAMHSA April 19, 2017 webinar slides (pivotal role of Medicaid) on addressing the needs of persons with co-occurring Mental Health and ID/DD:
   a. Slide #28: specialized training and provider networks needed.
   b. Slide #24: North Carolina Managed Care Organization serving persons with co-occurring ID/DD and Mental Illness: To serve a person with ID/DD "only"—$48,000 a year. To serve a person with co-occurring ID/DD and Mental Illness: $64,000 a year.

Persons with **"Complex Health and Social Needs."** During the past two years, several national projects, funded by seven foundations, have focused on recognizing and addressing the needs of persons with complex health and social needs. These are folks living with co-occurring conditions and frequently severe conditions. Many of their work and ideas would appropriately serve persons with co-occurring BH, disability, and chronic medical conditions.

Possible Federal Policy Initiatives Responding to the Challenges Faced by Persons with Co-Occurring Conditions

Possible policy ideas below are those of the American Association on Health and Disability and the Lakeshore Foundation and do "not" reflect the thinking or positions of leading behavioral health, disability, or developmental disabilities national organizations. Finding consensus by leading behavioral health and disability organizations on addressing the needs of persons with co-occurring conditions has been a challenge, given all the immediate issues facing these communities. During the past several months, we have been involved in discussions with some of these organizations but there is "no" agreed upon proposals. Also, some of the possible policy ideas here are proposed in papers and webinars by some of these leading national organizations (some of these resources are identified below).

We hope these ideas stimulate your thinking about how to address the needs of persons with a variety of co-occurring conditions. Most of these ideas are more appropriate for the Senate Committee on HELP, as they consider the reauthorization of SAMHSA and related programs.

1. When I worked with NAMI (National Alliance on Mental Illness): in 1999-2000, I facilitated a group of advocates that suggested that, at state discretion, states could use their SAMHSA Mental Health Block funds to serve persons with co-occurring mental illness and SUD (primary diagnosis of SUD); and, at state discretion, states could use their SAMHSA Substance Use both Prevention and Treatment Block Grant funds to serve persons with co-occurring SUD and mental illness (primary diagnosis of mental illness)—with appropriate, individualized, and effective support for each of the co-occurring conditions. Established providers and public officials opposed this idea.
   A. Repeat the state flexibility discretion and require an annual public reporting of such fund use by persons with co-conditions (both primary diagnosis and secondary diagnoses).

B. Use the same process in the SAMHSA Block Grants and the ACL disability and aging grants to states for designated categories of persons with a variety of co-occurring conditions.

2. The ACL No Wrong Door initiative largely addresses intake and eligibility processing for state and county aging and disabilities programs, and as a possible gateway to long-term services and supports (LTSS). Consideration could be given to expanding No Wrong Door tasks and encouraging state MH and SUD agencies to expand No Wrong Door approaches.
   a. National Association of Medicaid Directors, February 2021 paper—"Medicaid Forward—Behavioral Health." Paper advocates stream-line eligibility for services; and, continue to promote the integration of physical and behavioral health.
   b. Consistent with the NAMD paper—reference the needs of persons with the variety of co-occurring conditions in proposals to expand behavioral health-general health-primary care bi-directional integration.
3. Council for Quality and Leadership (CQL) 2021 paper—"Organizational Supports to Promote the Community Integration of People with Dual Diagnosis of ID/DD and Psychiatric Disabilities." Federal grant funds could support these organizational supports.
4. Consistent with: HHS ASPE, September 22, 2021: "Considerations for Building Federal Data Capacity for Patient-Centered Outcomes Research Related To ID/DD"—Federal grant funds could support public sector service program data systems to specifically address persons with co-occurring conditions.
5. Consistent with: NASMHPD August 2019 assessment paper #3: Developing a Behavioral Health Workforce Equipped To Serve Individuals with Co-Occurring Mental Health and Substance Use Disorder—Federal grant funds could support public sector service program workforce training.

Thank you for considering our ideas.

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Statement of Richard Yep, CAE, FASAE, Chief Executive Officer

INTRODUCTION

The American Counseling Association (ACA) is the world's largest professional home to more than 57,000 counseling professionals and counseling students who are members of ACA. In addition to our members, we advocate for the more than 200,000 counseling professionals in various practice settings. ACA's advocacy efforts focus on ensuring equitable, consistent, and adequate reimbursement for appropriately educated, trained, and Licensed Professional Counselors (LPCs) in all practice settings and supporting human rights and social justice issues and initiatives that reduce the challenges and barriers faced by clients, students, counselors, and communities.

The American Counseling Association (ACA) urges lawmakers to pass the Mental Health Access Improvement Act of 2021 (H.R. 432/S. 828),[1] which would add LPCs and Licensed Marriage and Family Therapists (LMFTs) to the list of Medicare-eligible mental health providers. This legislation is led by Senator Barrasso (R–WY) with Senator Stabenow (D–MI) as cosponsor, and has bipartisan support in both chambers of Congress. The Senate bill is currently pending before the Senate Finance Committee. The House bill, sponsored by Reps. Mike Thompson (D–CA) and John Katko (R–NY), was referred to the Ways and Means and the Energy and Commerce committees.

BACKGROUND

Medicare beneficiaries have fewer choices among mental health providers than do enrollees in other health plans. This can limit their access to less costly treatment, disrupt their continuity of care, and further frustrate their efforts to obtain needed

[1] Mental Health Access Improvement Act of 2021, S. 828, 117th Cong. (2021), *https://www.congress.gov/bill/117th-congress/senate-bill/828?q=%7B%22search%22%3A%5B%22s828%22%5D%7D&r=1&s=3.*

mental health care, particularly in rural and underserved areas of the country already experiencing a shortage of providers. Medicare is the primary insurance provider for approximately 60 million Americans, providing health and mental health coverage for people age 65 and older (85 percent of beneficiaries), people under 65 with disabilities (15 percent), and people with end-stage renal failure. By 2030, Medicare is expected to cover nearly 80 million people (Medicare Payment Advisory Commission, 2020).[2]

COVID–19 IMPACT

The COVID–19 pandemic has had a disparate impact on the mental health older adults, who have experienced increased social isolation, mortality risk and bereavement, financial instability, and other pandemic-related stressors. While Medicare covers mental health care, it only allows psychiatrists, psychologists, and clinical social workers to bill directly for diagnostic and therapeutic services. Yet, LPCs and LMFTs make up an estimated 40 percent of all master's level mental health professionals practicing nationwide. Their exclusion from Medicare makes it more difficult and expensive for beneficiaries to access care, compared to people who are covered by private health insurance or Medicaid.

RURAL IMPACT

In rural areas of the country, restricted access to mental health professionals is most acute for Medicare beneficiaries. More than 50 percent of counties do not have any licensed mental health providers despite higher rates of substance use disorder and suicide (Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration, Bipartisan Policy Center (BPC), 2021, p. 68).[3] BPC's report also notes that more than 60 percent of non-metropolitan counties specifically do not have a psychiatrist, and almost half do not have a psychologist. Among those mental health providers who do work in rural communities, 59 percent are counselors (including LPCs, LMFTs, and others), which suggests that counselors play a key role in providing rural mental health services outside of Medicare (Larson, et al., Supply and Distribution of the Behavioral Health Workforce in Rural America, 2016, as cited in Fullen, et al., The Impact of the Medicare Mental Health Coverage Gap on Rural Mental Health Access, 2020).[4] Without access to mental health professionals, people in rural areas often rely on general practitioners for behavioral and mental health diagnosis and treatment (Report to Congress on Medicaid and CHIP, Medicaid and CHIP Payment and Access Commission [MACPAC], 2021)[5] and, as a result, may not receive the specific treatment needed for their condition (Rural Health Information Hub, n.d.-a).[6]

PROGRAM PARITY

The exclusion of LPCs and LMFTs from Medicare also results in a lack of "program compatibility" between Medicare and Medicaid (Fullen, et al., 2020, p. 247). Licensed Professional Counselors (LPCs) whose services were covered under their state's Medicaid program may be forced to refer a client who becomes covered under Medicare to another provider (Fullen, et al., 2019). These dually eligible beneficiaries have found that their inability to produce a claim denial for counseling services under Medicare (because Medicare does not recognize claims from these providers) means Medicaid will not cover the service instead. This can occur even though Medicaid might otherwise cover the claim if it were the sole source of coverage. Further, the greater prevalence of serious mental health conditions and negative encounters with the criminal justice system involving some Medicaid beneficiaries battling serious mental illness (MACPAC, 2021) makes any disruptions to their mental health care concerning.

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[2] Medicare Payment Advisory Commission. (2020, July). A data book: Health care spending and the Medicare program, *http://www.medpac.gov/docs/default-source/data-book/july2020_databook_entirereport_sec.pdf?sfvrsn=0.*

[3] Bipartisan Policy Center. (2021). Tackling America's mental health and addiction crisis through primary care integration, *https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf.*

[4] Fullen, M.C., Brossoie, N., Dolbin-MacNab, M.L., Lawson, G., and Wiley, J.D. (2020). The impact of the Medicare mental health coverage gap on rural mental health care access. *Journal of Rural Mental Health,* 44(4), 243–251, *http://www.doi.org/10.1037/rmh0000161.*

[5] Fullen, M.C., Brossoie, N., Dolbin-MacNab, M.L., Lawson, G., and Wiley, J.D. (2020). The impact of the Medicare mental health coverage gap on rural mental health care access. *Journal of Rural Mental Health,* 44(4), 243–251, *http://www.doi.org/10.1037/rmh0000161.*

[6] Rural Health Information Hub. (n.d.-a). Barriers to mental health treatment in rural areas. *https://www.ruralhealthinfo.org/toolkits/mental-health/1/barriers;* Rural Health Information Hub. (n.d.-b). Telehealth use in rural areas, *https://www.ruralhealthinfo.org/topics/telehealth#challenge.*

COST OF CARE BARRIERS

One barrier to access to mental health care is the cost and affordability on ongoing therapy for many older adult Medicare beneficiaries, according to the PAN Foundation poll and Morning Consult (2021).[7] Furthermore, many health care providers limit their number of Medicare patients because of lower reimbursement rates compared with private insurance. Psychiatrists are the most likely of any physician specialty to opt out of Medicare (Koma, et al., 2020).[8] In 2014–2015, only 62 percent of psychiatrists accepted new patients with Medicare or private insurance, and only 36 percent accepted patients on Medicaid (Holgash and Heberlein, 2019).[9] Given that 40 percent of the mental health workforce already cannot provide services to Medicare beneficiaries, this suggests that the shortage of mental health providers is even greater than estimated. In rural areas, this shortage of providers may be especially burdensome for beneficiaries in rural areas (Fullen, et al., 2020), although primary care providers in these areas may handle some of their patients' behavioral and mental health needs, those providers report "feeling overwhelmed, ill-equipped, and underpaid" (Bipartisan Policy Center, 2021, p. 11). Thus, adding LPCs to the list of Medicare mental health providers would help to relieve this strain on primary care in rural areas, chiefly those that lack access to adequate technology (Rural Health Information Hub, n.d.-b).

THE MENTAL HEALTH IMPROVEMENT ACT OF 2021

The Mental Health Access Improvement Act of 2021 (S. 828/H.R. 432), would close the gap in mental health care coverage for Medicare beneficiaries by:

- Providing more than 140,000 LPCs the option to participate in the Medicare program, significantly alleviating current barriers and offering less costly choices to older adults and people with disabilities;
- Increasing access in rural areas underserved by currently recognized Medicare providers;
- Allowing LPCs and LMFTs to directly bill Medicare for their services, similar to social workers, psychologists, and psychiatrists; and
- Lowering the cost of care with early interventions that can improve outcomes before conditions worsen.

SUPPORTING RECOMMENDATIONS

In 2017, the Interdepartmental Serious Mental Illness Coordinating Committee recommended that Congress "remove exclusions that disallow payment to certain qualified mental health professionals, such as [MFTs] and [LPCs], within Medicare" (p. 83).[10] A 2020 Commonwealth Fund report (McGinty, 2020) [11] recommended that policy makers close the remaining gap in Medicare by allowing reimbursement for mental health services by the more than 140,000 LPCs in the United States and noted that, although LPC participation could increase Medicare costs, mental health services account for only 1% of program expenditures overall.

Most recently, in 2021, a Bipartisan Policy Center task force recommended that Congress expand the mental health provider types covered under Medicare, thereby addressing shortages in rural areas while dissolving some federal reimbursement barriers to integrated primary and mental health care. Enhanced integration of primary and behavioral health care is a cost-effective approach to federal health spending that reduces disparities and improves patient outcomes.

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[7] Morning Consult. (2021, May). Mental health concerns among seniors with chronic illnesses. PAN Foundation, *https://www.panfoundation.org/app/uploads/2021/05/PAN-Mental-Health-Analysis.pdf.*

[8] Koma, W., True, S., Biniek, J.F., Cubanski, J., Orgera, K., and Garfield, R. (2020, October 9). One in four older adults report anxiety or depression amid the COVID–19 pandemic. Kaiser Family Foundation, *https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-thecovid-19-pandemic/.*

[9] Holgash, K., and Heberlein, M. (2019, April 10). Physician acceptance of new Medicaid patients: What matters and what doesn't. Health Affairs Blog, *https://www.healthaffairs.org/do/10.1377/hblog20190401.678690/full.*

[10] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). The way forward: Federal action for a system that works for all people living with SMI and SED and their families and caregivers. Substance Abuse and Mental Health Services Administration, *https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf.*

[11] McGinty, B. (2020, July 9). Medicare's mental health coverage: How COVID–19 highlights gaps and opportunities for improvement. Commonwealth Fund, *https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities.*

CONCLUSION

The primary goal of integrated care through improved care coordination can neither exist nor be sustained if there can be no improved communication between behavioral health and primary care providers under the currently increasing mental health provider shortage. Excluding Licensed Professional Counselors from the list of covered providers under Medicare significantly limits the options beneficiaries have when choosing among mental health providers.

Congress has an opportunity to close the Medicare coverage gap and end disruption in continuity of care and the lack of access to counseling therapy for beneficiaries in support of the goal of integrating care. The Mental Health Access Improvement Act of 2021 (S. 828/H.R. 432) would significantly alleviate current barriers to care and offer less costly choices to older adults and people with disabilities by giving more than 200,000 LPCs the option to participate in the Medicare network and improve care. It would increase access in rural areas underserved by currently recognized Medicare providers and lower the cost of care with interventions that can improve both physical and mental health outcomes. Now is the time to take this crucial step toward ensuring mental health equity in America.

We thank the Committee for the opportunity to submit this statement for the record and for the Committee's continued support and interest in addressing behavioral health care parity in the United States. We look forward to working with the Committee and Senate and House sponsors to pass the important and impactful Mental Health Access Improvement Act of 2021.

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U.S. Senate
Committee on Finance

Chair Wyden and Ranking Member Crapo,

The Association for Behavioral Health and Wellness (ABHW) appreciates the Committee's support and leadership on addressing mental health (MH) and substance use disorder (SUD) issues. ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people both in the public and private sectors to treat MH, SUD, and other behaviors that impact health and wellness.

We appreciate the opportunity to submit a statement for the record supporting the Committee's efforts to identify solutions and opportunities to integrate care and implement parity in the spirit in which the Mental Health Parity and Addiction Equity Act (MHPAEA) was passed.

Promote the integration of care

As we work to recruit and train practitioners to be part of the mental health and substance use disorder workforce, patients need immediate, as well as long-term solutions. One of the most promising solutions to get patients the care that they need in an unimpeded, timely manner is the broad implementation of coordinated primary and behavioral health care models. The most promising strategy for providing prevention, early intervention, and timely treatment of mental illness and substance use disorders is the implementation of evidence-based integrated care models using a population-based approach. The Collaborative Care Model (CoCM) is a proven, measurement-based approach to providing treatment in a primary care office that is evidenced-based and already reimbursed by Medicare, with established CPT codes.

CoCM involves a primary care physician working collaboratively with a psychiatric consultant and a care manager to manage the clinical care of behavioral health patient caseloads. This model allows patients to receive behavioral health care through their primary care doctor, alleviating the need to seek care elsewhere unless behavioral health needs are more serious. CoCM demonstrably improves patient outcomes because it facilitates adjustment to treatment by using measurement-based care. Unlike other models of integrated behavioral health care so far, CoCM is supported by over 90 randomized control studies which indicate that implementing the model improves access to care and has been shown to reduce depression symptoms by fifty

percent. It is currently being implemented in many large health care systems and group practices throughout the country and is also reimbursed by several private insurers and Medicaid programs. Accordingly, we urge the Committee to include the Collaborate in an Orderly and Cohesive Manner (COCM) Act (H.R. 5218) in your MH and SUD legislative package, and explore proposals that would help expand the use and adoption of CoCM and other evidence-based integrated care models.

Incentives for Behavioral Health Providers to Obtain Electronic Health Record (EHR) Systems

ABHW also encourages the Committee to examine opportunities to increase the use of electronic health records (EHRs) by behavioral health providers. The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 provided funding for primary health care providers to adopt EHR technology. Unfortunately, most behavioral health providers were not eligible to participate in this program. To date, behavioral health providers still substantially lag behind primary care providers in adoption rates of EHR systems due to this exclusion from available funding.

In its March 2021 report to Congress, titled: *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration,*[1] the Bipartisan Policy Center (BPC) suggested Congress establish "a targeted funding structure to assist behavioral health providers with startup costs, maintenance, and training for health IT in behavioral health settings." BPC found integrating care would improve health disparities, raise the outcome of treatments, and support cost-effective care. Specifically, BPC recommended that Congress finance the Center for Medicare and Medicaid Innovation (CMMI) demonstration program authorized in Sec. 6001 of the SUPPORT Act (Pub. L. 115–271) that offers behavioral health IT incentives to psychologists and clinical social workers as well as Community Mental Health Centers, psychiatric hospitals, and residential treatment centers.

In June 2021, the Medicaid and CHIP Payment and Access Commission (MACPAC) released a report chapter titled: *Integrating Clinical Care through Greater Use of EHR for Behavioral Health.*[2] MACPAC additionally noted that behavioral health integration of EHRs would increase clinical integration and achieve cost savings, enable participation in value-based payment, and improve the quality of health reporting.

We encourage the Committee to consider the Behavioral Health Information Technologies Now (BHIT NOW) Act, recently introduced in the U.S. House of Representatives. This legislation would help propel broader certified EHR adoption among behavioral health providers and improve integrated, coordinated, and accessible care for individuals seeking MH and SUD treatment.

Expand the Certified Community Behavioral Health Clinic (CCBHC) Model

To better promote expanded access to comprehensive and evidence-based MH and SUD care, we support the nationwide expansion of the Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration program through the bipartisan Excellence in Mental Health and Addiction Treatment Act of 2021 (S. 2069/H.R. 4323). CCBHCs offer a comprehensive array of services needed to improve access, stabilize people in crisis, and provide essential treatment for those with the most serious, complex mental illnesses and substance use disorders. CCBHCs integrate additional services to ensure a community-based, holistic, and innovative approach to behavioral health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration, as well as coordination with hospitals, emergency departments, and law enforcement.

Ensuring Parity

For the last two decades, ABHW has supported mental health and addiction parity. We were an original member of the Coalition for Fairness in Mental Illness Coverage (Fairness Coalition), a coalition developed to win equitable coverage of mental health treatment. ABHW served as the Chair of the Fairness Coalition in the four years prior to the passage of MHPAEA. We were closely involved in the writing of the Senate legislation that became MHPAEA and actively participated in the negotiations of the final bill that became law.

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[1] *https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf.*

[2] *https://www.macpac.gov/publication/integrating-clinical-care-through-greater-use-of-electronic-health-records-for-behavioral-health/.*

ABHW's members provide value to their beneficiaries by designing and implementing plan benefits and limits to serve the triple aim for health care delivery by reducing the cost per member of health care, ensuring that health care services are high quality and well-coordinated, and improving population health through the efficient use of limited resources. We are fully committed to ensuring that these design and implementation strategies do not create limits on access to MH/SUD benefits that are incomparable to or more stringent than the limits on medical/surgical (M/S) benefits.

ABHW member companies have always supported MH and SUD parity and continue to strive to ensure patients receive the behavioral health services they need in a manner that complies with parity requirements. We agree with the determinations of noncompliance for blanket exclusions, and blanket pre-certification requirements for MH/SUD benefits that are cited in the recent Department of Labor's (DOL), U.S. Department of Health and Human Services' (HHS), and Department of Treasury's (collectively, "the tri-Departments") 2022 Mental Health Parity and Addiction Equity Act (MHPAEA) Report to Congress published on January 25, 2022 (Report); however, we believe that our recommendations for additional guidance are necessary to achieve full parity compliance.

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 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 discuss how plans can operationalize the regulations.

While parity has progressed in meaningful ways since its adoption 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 is a moving target through a patchwork of conflicting and changing guidance. New parity language was included in Section 203 of the Consolidated Appropriations Act of 2021 (CAA), and the DOL issued a Frequently Asked Questions (FAQs) document to help clarify the CAA provisions. While the FAQs are a step in the right direction, we believe further regulations are necessary to provide the clarity payers need to implement MHPAEA appropriately. We strongly support the flexibility built into the law. Yet, there has been a proliferation of different compliance approaches, tools, and interpretations, which leads to confusion in implementation, is costly for stakeholders, and ultimately hinders patient care. We would like to work with you and the Administration to re-invigorate efforts to clarify and improve the application of the law for the benefit of all.

We strongly support ensuring access to behavioral health services and believe that addressing the following would improve compliance.

- *Develop a core list of non-quantitative treatment limitations (NQTLs) for which documentation may be expected to be available upon request.* The final rule defines NQTLs circularly, and there is no guidance to date that explains what can constitute a "limit on the scope or duration of benefits for treatment under a plan or coverage." As such, it has not been possible to develop a 5-step analysis for all NQTLs proactively. Congress should encourage regulators to develop a focused list of NQTLs to better understand what defines this analysis.
- *Provide a clear, comprehensive example NQTL analysis that would meet the tri-Departments' standards under the requirements of the CAA for each NQTL on the focused list.* Given the new requirements mandated by the CAA to utilize the 5-step framework and that it is materially different from the guidance contained in the DOL Self Compliance Guide, comprehensive NQTL examples would significantly improve the NQTL analyses themselves and ensure efficient

use of the tri-Departments' resources. We appreciate the guidance published over the years. Still, significant ambiguity remains about the actual breadth and depth of details and supporting documentation required for each component of the CAA's five-step analyses. Model NQTL analyses would help clarify expectations, promote uniformity, and ultimately improve parity compliance. Accordingly, for each NQTL on the focused list, we believe the tri-Departments should provide at least one complete example of a compliant analysis.

Additionally, during this latest round of audits, the tri-Departments sent letters of insufficiency with a great level of detail on what is missing in the documentation for a given NQTL. Congress should urge regulators to use this as a basis for future guidance and in developing best practice examples for NQTL analyses.

- *Define a standard by which NQTL analyses are evaluated and a process by which examinations are pursued.* In FAQ 45, Q2 and Q4, the tri-Departments address the information that must be made available to regulators and the types of documents that should be prepared to submit in support of a given NQTL analysis. In practice, however, the back and forth with the regulators during examinations can be confusing due to the lack of a defined process for NQTL documentation requests. ABHW is willing to work with the regulators to determine the most efficient process to avoid confusion and better implement MHPAEA and asks Congress to support these efforts.
- *Proactively promote uniformity between state and federal requirements.* It is also critical to note that some state parity policies and compliance approaches differ significantly from federal policies and enforcement even when based upon federal parity standards, creating confusion in understanding how to achieve and demonstrate compliance at the state level even if federal requirements are clarified. In fact, there are discrepancies in how NQTLs are interpreted not only between a federal and state level and across states but within states as well. As such, we urge Congress to stress to the tri-Departments to proactively coordinate with state regulators to help ease the issues surrounding parity compliance.

ABHW recently sent a detailed letter to the tri-Departments outlining our specific guidance requests, which can be viewed here.

We look forward to working with you to ensure that individuals seeking MH and SUD treatment have improved integrated, coordinated, and accessible care. Please reach out to Maeghan Gilmore, gilmore@abhw.org, or 202–503–6999 with any questions or concerns.

Sincerely,

Pamela Greenberg, MPP
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Statement of Brad Bauer, Senior Vice President

Bamboo Health thanks Chairman Ron Wyden, Ranking Member Mike Crapo, and members of the Senate Finance Committee ("the Committee") for holding this important hearing about behavioral health care, the third in a series of hearings on this topic. Bamboo Health provides trusted technology solutions to federal and state governments, payers, health systems, clinicians, pharmacies, and health information exchanges working to improve public health. Through our offerings, we are implementing the solutions to identify patients in need of help and connect them to medical and behavioral health services to improve their well-being. Through this work, we are committed to integrating behavioral and physical health to improve whole-person care.

Bamboo Health appreciates the complexity of developing policies that best serve patients with mental health and substance use disorders and is pleased that the Committee is exploring how to better integrate behavioral health care into the delivery system. Each of our solutions, highlighted below, plays a key role in coordinating patient care, and patients will benefit should these or similar solutions be more widely adopted. We have a nationwide network connecting hospitals, pharmacies,

and payers with over 1 billion patient encounters per year across 50 states, 1 million clinicians, over 11,000 facilities, over 25,000 pharmacies, 52 PDMPs networked, and work with over 130 different EMRs.

Through the PatientPing platform, providers can better coordinate care, thereby improving outcomes and reducing health care costs; it also allows providers to leverage admission, discharge, and transfer data in a timely manner. Additionally, our OpenBeds product facilitates decision support, rapid digital referrals, and collaboration among behavioral health providers by identifying, unifying, and tracking all behavioral health treatment and support resources in a trusted network. Insert a sentence on the adoption of both products. In conjunction, Bamboo Health's Crisis Management System expedites access to assessment and treatment for those in behavioral health crisis, tracks their journey from call to treatment, and coordinates all stakeholders within one system. Where these solutions have been adopted, they demonstrate the value of integrating these care coordination systems and behavioral health information into electronic health records and clinical workflows.

This Committee is demonstrating its commitment to improving behavioral health care through its thorough consideration of the issue beginning with the request for information on mental health and substance use disorders released last fall and this series of hearings on the topic. Bamboo Health also recognizes the Biden administration's commitment to addressing this topic through the actions it has taken and the recommended investments in the president's Fiscal Year 2023 budget proposal. However, any programs and investments must support an expeditious referral to treatment to improve outcomes; otherwise, patients may opt to discontinue their treatment falling out of the referral and health care systems. Providers generally do not have insight into available beds and service providers for mental health and substance use disorder referrals and coordinated care, resulting in major barriers to appropriate and timely care. Without integrating this information into their clinical workflow, a patient's care team cannot communicate and appropriately coordinate a patient's care.

The coordination challenges are not limited to providers' ability to find available facilities and providers to refer patients for mental health services but also applies to coordination and the handoff between primary care and mental health providers. Primary care providers serve as an entry point for patients to the mental health care system, and they need to be empowered to make the connections necessary to support their patients. Integrating mental health information into electronic medical records and other workflows is vital to ensuring primary care providers, who may be a patient's first contact when seeking mental health care, can make timely and appropriate referrals and coordinate care. As the Committee considers this issue, it should be addressed in a manner that does not place additional administrative burden on primary care providers who already have many requirements that must be met in a single visit. Bamboo Health is committed to supporting primary and behavioral health care integration and coordination as we believe it is a critical component of improving patient outcomes.

To meaningfully improve mental health care and outcomes, the federal government must take the steps, including making the financial investment, to integrate mental health information in an actionable manner. While most providers utilize electronic medical records, supporting interoperable systems that integrate mental health data and facilitate warm handoffs will require Congress and the administration to explore additional incentives since these additional tools come with an additional cost. Financial incentives have helped increase the adoption of electronic medical records; however, adoption is still limited for behavioral health both in hospitals and office-based practices. Mental health providers were ineligible for the federal financial incentives provided by the Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) that supported electronic medical record adoption in other sectors of the health care system. Without this support, mental health providers were not able to make the investment required because of the narrow margins associated with this care.[1] The Committee will have to support meaningful solutions to improve adoption to achieve true integration and care coordination.

Besides financial support, Bamboo Health urges the Committee to carefully consider how to balance policies that encourage integration and care coordination and the unique privacy concerns related to mental health data. Privacy concerns have lim-

[1] *https://www.macpac.gov/wp-content/uploads/2021/09/Behavioral-health-IT-adoption-and-care-integration.pdf.*

ited the exchange of this data to date. In many instances, state privacy laws are more stringent than federal laws further limiting care coordination and integration. This Committee and the administration must carefully consider how to protect this data while still allowing the exchanges necessary to coordinate care. A first step to accomplishing this may be working with and encouraging states to adopt more unified guidelines in this area. The country's experience during the COVID–19 pandemic, particularly as Americans have quickly adopted with virtual care, has demonstrated why a responsible solution must be adopted as quickly as possible.

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On behalf of the nation's more than 220 children's hospitals and the children and families we serve, thank you for holding this hearing, "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration." As you consider policy options to ensure mental health parity and access to the full continuum of services, we urge you to recognize the tailored and dedicated mental health support and care that children, adolescents and young people need and to advance meaningful and transformational solutions.

The statistics illustrate an alarming picture for our children. Prior to the pandemic, almost half of children with mental health disorders did not receive care they needed.[1] Although the trends in pediatric mental health were worrying before the COVID–19 emergency, demand over the past two years for all levels of crisis care for children and teens has risen significantly. According to a recent study in *JAMA Pediatrics,* there was an alarming increase in children diagnosed with anxiety (27%) and depression (24%) between 2016 and 2020.[2] In 2021, children's hospitals reported emergency department visits for self-injury and suicidal ideation and behavior in children ages 5–18 at a 44% higher rate than during 2019.[3] There was also a more than 50% increase in suspected suicide attempt emergency department visits among girls ages 12–17 in early 2021, as compared to the same period in 2019.

Demand for care is outstripping supply, leaving far too many children waiting for needed mental and behavioral health care and "boarding" in emergency departments until an appropriate placement becomes available. This is not limited to one state or one community—children in states across the country face similar challenges accessing the necessary mental health care to address their needs.[4] Fifty percent of all mental illness begins before age 14[5] and, on average, 11 years pass after the first symptoms appear before treatments begins.[6]

Investments in the full spectrum of pediatric mental health services are critical in making immediate strides to address the crisis end of the continuum, which is overstretched right now, and prevent emergencies in the future. While the COVID–19 pandemic has certainly contributed to the crisis in child and adolescent mental health, we know that this problem and its root causes, which includes inadequate and restrictive insurance practices and a lack of a youth-specific mental health care across the full continuum of service needs, predate the pandemic. The challenges and limitations of the current mental health care system are affecting all children, but the pandemic has exacerbated and highlighted existing disparities for children of color in mental health outcomes and access to high-quality mental health care

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[1] Daniel G. Whitney and Mark D. Peterson, "US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children," *JAMA Pediatrics* 173, no. 4 (2019): 389–391, doi:10.1001/jamapediatrics.2018.5399, *https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377.*

[2] Lebrun-Harris L.A., Ghandour R.M., Kogan M.D., Warren M.D., Five-Year Trends in US Children's Health and Well-being, 2016–2020. *JAMA Pediatr.* Published online March 14, 2022. doi:10.1001/jamapediatrics.2022.0056.

[3] Children's Hospital Association (CHA), analysis of CHA PHIS database, n=38 children's hospitals.

[4] *Ibid.*

[5] Substance Abuse and Mental Health Services Administration (SAMHSA), *Adolescent Mental Health Service Use and Reasons for Using Services in Specialty, Educational, and General Medicaid Settings,* March 5, 2016, *https://www.samhsa.gov/data/sites/default/files/report_1973/ShortReport-1973.html.*

[6] National Alliance on Mental Illness, "Mental Health Screening," accessed on November 10, 2021, *https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Screening.*

services. In 2019, the Congressional Black Caucus found that the rate of death by suicide was growing at a faster rate among Black children and adolescents, and that Black children were more than twice as likely to die by suicide before age 13, than their white peers.[7] Studies of Latino communities have found higher reported rates of depression symptoms and thoughts of suicide among Latino youth, but comparatively lower rates of mental health care utilization. The needs of children from racial and ethnic minority communities and the added barriers they frequently face in accessing needed services must be addressed in any and all approaches to strengthen mental health parity enforcement and strengthen care models.

The national state of children's mental, emotional and behavioral health is so dire that we joined the American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry in declaring a national emergency[8] in child and adolescent mental health last fall. On the same day that we declared a national emergency, we launched the Sound the Alarm for Kids initiative[9] to raise the visibility of the children's mental health crisis and build momentum for action. Significant investments are needed now to better support and sustain the full continuum of care needed for children's mental health. These investments will significantly impact our children and our country for the better as we avoid more serious and costly outcomes later—such as suicidal ideation and death by suicide. The emergency for our children is broadly recognized—now we need to work together on immediate action.

We applaud the committee for your attention to strengthening the Mental Health Parity and Addiction Equity Act (MHPAEA) and enhancing care integration through expanded implementation of effective models of integrated behavioral health care. We strongly encourage the committee to put forward tailored and dedicated policies and support for children and youth to better address their emotional, mental and behavioral health needs. The current mental health system for children has been under-resourced for years and now requires significant attention.

Strong enforcement of the MHPAEA is critical to the ability of children and youth to access needed mental health services without unnecessary delays due to plan limits or other requirements that are not applied to medical/surgical plans. As we note above, far too many children with mental health needs do not receive the care that they need, with children commonly waiting years to receive treatment after symptoms first appear. Problematic payer practices, including inadequate provider networks and strict utilization controls, among others, further limit children's access.

In addition, greater investments are urgently needed to develop and enhance community-based systems of care, including resources and technical assistance to support the implementation of integrated care models, care coordination services and other collaborative partnerships so children have access to the right care, in the right setting, at the right time. Children experience better outcomes when their mental and behavioral health needs are identified earlier on, and they are connected to the care they need to manage their mental and emotional health. Unfortunately, in many communities there are gaps within the continuum of care for children and adolescents and a lack of coordination between existing providers and systems. At the core of a strong pediatric mental health care delivery system is a strong, interconnected network of pediatric mental health providers and supportive services that are available to deliver high-quality, developmentally appropriate care. Integrated care is an effective method of meeting families where they are to facilitate preventive interventions, early identification and treatment.

We appreciate the Finance Committee's attention to the need to bolster compliance with the MHPAEA and to advance care integration models that can help address mental health concerns early and comprehensively. As you work to develop legislative solutions, we ask you to consider the following policy priorities that will result in improved access to appropriate mental health services for children and youth, from promotion and prevention through needed treatments.

Recommendations to address mental health parity

- **Congress should give the Department of Labor (DOL) and states the tools they need to enforce parity requirements.** The DOL annual report

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[7] Congressional Black Caucus, *Ring the Alarm: The Crisis of Black Youth Suicide in America,* December 17, 2019, *https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf.*

[8] *https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/.*

[9] *https://www.soundthealarmforkids.org/.*

on private health plan compliance with the MHPAEA[10] clearly shows that health plans miss the mark on parity. The recent GAO report, Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts,[11] similarly documented plan practices that restrict access to needed care. Though that report focuses on adults, the 43% of the nation's children who have private insurance coverage are also impacted. The violations cited in these reports mean needless delays in care or no access to care at all, particularly due to payers' non-quantitative treatment limits, not otherwise seen in medical and surgical benefits.

- **Congress should prioritize actions that address current inadequacies and inequities in reimbursement rates and policies.** Rates of reimbursement have historically been lower for mental health services in Medicaid and CHIP, as well as in private insurance. Low reimbursement rates contribute to difficulty in both recruitment and retention into mental health fields and lead to fewer providers participating in Medicaid, CHIP and commercial health plans—a significant barrier to care for children. Since the Medicaid program is the single largest payer of pediatric mental health services, we recommend increasing Medicaid reimbursement rates for pediatric mental and behavioral health services to Medicare levels or increasing the federal medical assistance percentage for pediatric mental and behavioral health services to 100%. We also encourage Congress to place a priority on the examination of commercial payment policies as part of any initiatives to strengthen MHPAEA enforcement and compliance.

  In addition, more oversight of payment procedures is needed to ensure that children, particularly those in mental health crisis, are not waiting for care due to payment and other unnecessary insurance delays that are wholly unrelated to their mental health needs. Children's hospitals often face numerous challenges navigating health plan payment policies for mental health services that are more complicated and restrictive than those imposed on medical/surgical benefits. In particular, the administrative burden associated with medical management policies, such as prior authorizations, claims processes and approvals for care transitions, often do not exist to the same extent for coverage of treatment for physical health conditions. These additional requirements are time-consuming for providers to navigate and can lead to delays in care for children and slower claims processing.

- **Congress should direct CMS to review how the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is implemented to ensure that children have access to the mental health services to which they are entitled.** CMS has determined that EPSDT fulfills the mental health parity requirements under the MHPAEA and requires states and Medicaid managed care plans to analyze limits placed on mental health benefits under Medicaid and CHIP. However, as the Medicaid and CHIP Payment and Access Commission has noted, the MHPAEA has not had a substantial impact on improving access to behavioral health services for the 39% of all children covered by Medicaid. Children's hospitals have noted significant gaps in access for children, particularly to the intermediate level of care—including intensive outpatient services and day programs—which can prevent hospitalizations and help transition children back to their homes and community after a hospitalization.

- **Congress should ensure that pediatric mental health network adequacy standards are sufficient to ensure that all children and youth have appropriate access to needed mental health services.** Robust pediatric network adequacy standards and assessments are a key aspect of ensuring compliance with the MHPAEA by public and private payers. Those standards should include specific requirements that health plans demonstrate they contract with an appropriate number of trained mental health professionals with expertise in child and adolescent mental and behavioral health. Currently, it is not unusual for health plans to have many fewer providers at all levels of care in their mental health networks than they do in their medical/surgical networks. In addition to quantitative metrics to measure network adequacy, standards related to mental health services should prohibit the imposition of more restrictive limitations and exclusions on facility types and clinically recognized levels of care,

[10] *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.*
[11] *https://www.gao.gov/products/gao-22-104597.*

such as residential treatment programs, or the establishment of more stringent payment policies and procedures than those that are applied to medical/surgical benefits. Furthermore, network adequacy reviews must include assessments of claims processing policies and payment rates. Reimbursement delays due to overly burdensome utilization reviews and slow and complicated claims processing, combined with historically low reimbursement rates, are contributing factors to mental health providers not participating in private and public plans' provider networks.

- **Congress should expand MHPAEA to all children and adolescents enrolled in Medicaid fee-for-service.** By specifically requiring in statute that parity protections apply across all Medicaid payment and delivery models, Congress can help ensure that all children and youth in need of mental health services are afforded the same parity protections regardless of the state they live in. At a minimum, Congress could direct CMS to provide guidance to states on how to ensure consistent application on what is required under EPSDT to meet MHPAEA requirements, so children have timely access to the full range of mental health services without unnecessary administrative delays or arbitrary service restrictions. Even though children enrolled in Medicaid fee-for-service programs are guaranteed needed mental health services under the EPSDT benefit, state implementation has been inconsistent. Over the years, families have had to sue to receive necessary behavioral health care services, particularly recommended intensive home and community-based services to correct or ameliorate their child's disorders. Consistent application of what is required under EPSDT, regardless of Medicaid payment structure, will help ensure that children have access to the full range of mental health services, including intensive outpatient services, partial hospitalization and other stepdown levels of care that bridge inpatient care and home and community.

Recommendations to facilitate care integration and improve coordination

- **Congress must support legislative reforms and investments which improve access and quality across the full continuum of pediatric mental health services.** To address the crisis in child and adolescent mental health now and into the future, Congress must support innovative methods of enhancing service delivery to children with both public and private coverage, scale up community-based prevention and treatment services, ensure adequate capacity to provide care to children with more intensive needs and invest in the pediatric mental health workforce. We support enactment of legislation that has been introduced in the House, H.R. 4944, Helping Kids Cope Act,[12] and H.R. 7236, Strengthen Kids' Mental Health Now Act.[13] Both bipartisan bills would create unique programs within the Health Resources and Services Administration to fund projects to improve the availability of mental health services and supports for children based on communities' particular needs and improve recruitment, retention, training and diversity within pediatric mental health professions.
- **Congress should explore and advance payment models for all payers that incentivize and include mechanisms to reimburse for care coordination services, community partnership and consultative services.** While there are well-established, evidence-based practices in providing coordinated and integrated care to facilitate access for children, reimbursement is a significant challenge to increasing preventive care, standing up care coordination services, implementing integrated care models and facilitating partnerships between schools and community-based mental health professionals. Reimbursement policies that support integrated care across a variety of settings, including through telehealth and consultation services, can improve identification of mental and behavioral health needs in children and streamline connections to care. For example, schools can play a critical role in primary prevention and early identification, especially through school-based health centers and partnerships between schools and local providers, including children's hospitals. We support S. 3864/H.R. 7076, Supporting Children's Mental Health Care Access Act,[14] which will reauthorize the Pediatric Mental Health Care Access Grant, an important and effective program that supports care integration and early intervention in primary care through behavioral health teleconsultation. Critically, S.

[12] *https://www.congress.gov/bill/117th-congress/house-bill/4944?s=1&r=2.*
[13] *https://www.congress.gov/bill/117th-congress/house-bill/7236.*
[14] *https://www.congress.gov/bill/117th-congress/senate-bill/3864.*

3864/H.R. 7076 [15] would also extend these programs into schools and emergency departments to serve more children across settings.

There is also a critical need to fund care coordination services that can identify and mitigate gaps within the continuum of care that often lead to children waiting for treatment they need to overcome mental health challenges. Care coordinators, in particular, provide crucial support by conducting follow-up with patients discharged from inpatient care or crisis stabilization. Professional peer support and family peer support specialists can also be critical members of a care team, supporting children and their caregivers with helpful insights, often from lived experience and strong community connections. Too often, this work is not reimbursable despite its value to the care relationships that benefit children and families.

- **Congress should work to address payment policies that hinder access to mental health services.** Pediatricians and other primary care providers can play a critical role in early identification and intervention for children experiencing mental health symptoms and conditions. With proper training and support, some children's mental health needs can be well managed by primary care, especially when providers have access to mental health consultation services. However, public and private payers routinely exclude payment for mental health services provided by a primary care provider, putting unnecessary burden on providers prepared to conduct screenings and assessments that are convenient and beneficial to their patients. Additionally, same-day billing limitations persists in some state Medicaid plans, and children's hospitals have reported that they can prevent effective implementation of integrated care and cause delays in a patient's connection to care.

Children's hospitals are eager to partner with you to advance policies that can make measurable improvements in children's lives. Please call on us and our members as you develop these important policy improvements to stem the tide of the national emergency for children's mental health. Children need your help now.

COMPASS PATHWAYS
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Dear Chairman Wyden and Ranking Member Crapo:

COMPASS Pathways appreciates the opportunity to provide feedback on the current state of mental health care in the United States and how Congress can help to address existing barriers to care. In November, COMPASS Pathways submitted comments to the Finance Committee in response to the Committee's request for information on mental health policy solutions. We continue to believe that a comprehensive approach to mental and behavioral health care is necessary and appreciate the opportunity to provide a statement for the record to the Committee as you work to ensure behavioral health parity and integration. COMPASS Pathways (Nasdaq: CMPS) is a mental health company dedicated to accelerating patient access to evidence-based innovation in mental health.

COMPASS' focus is on improving the lives of those who are suffering with mental health challenges and who are not helped by current treatments. A vital part of this focus is creating equitable patient access through collaboration, partnership across industries, and advocacy for policies that support mental health care professionals, patients, caregivers, and communities. An important aspect of bolstering equitable patient access is ensuring parity between mental/behavioral health care and physical health care benefits. As the Finance Committee continues to address mental and behavioral health, we urge the Finance Committee to take a comprehensive approach to ensuring mental and behavioral health services are covered in parity with physical health services. COMPASS has identified the following policy solutions to help ensure parity:

- Improve enforcement and oversight of parity laws currently on the books.
- Improve payment policies that contribute to better parity.
- Expand telehealth to ensure parity.

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[15] *https://www.congress.gov/bill/117th-congress/senate-bill/3864.*

Below, we examine each of these themes in further detail, providing specific policy solutions that will ensure greater parity between mental/behavioral health care and physical health care.

Improving Enforcement and Oversight

In 2008 the Mental Health Parity and Addiction Act was enacted, requiring insurance coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for medical conditions. Since its inception, plans have struggled to fully comply with such parity requirements. The federal government as well as state governments, tasked with enforcing such parity laws, have also struggled to enforce them.

Currently, the Department of Labor (DOL) is unable to enforce the MHPA directly against insurance companies that offer the plans. This leaves DOL with no front-end enforcement mechanism to ensure there is compliance with existing mental health and substance-use parity requirements. To remedy this, Congress should provide this front-end authority to DOL. The House of Representatives is currently considering legislation that would do this. H.R. 1364, Parity Enforcement Act of 2021 would provide DOL the authority to enforce the parity requirements for group health plans directly, not relying upon employers to reimburse their workers after there are parity violations. The Finance Committee should work directly with the HELP Committee to consider similar legislation that would provide DOL this front-end authority.

Congress can also bolster state enforcement of the current laws by providing grants to states directly that support's their oversight of health insurance plan compliance with mental health parity requirements. S. 1962, sponsored by Senator Chris Murphy and currently being considered by the Senate HELP Committee would authorize $25 million in grants to states to support their oversight of health insurance plan compliance with such mental health parity requirements. Though, not within Senate Finance's jurisdiction, the Finance Committee should commit to working closely with Sen. Murphy and the HELP committee to ensure passage of this legislation or similar legislation. Additionally, Congress should work to collect better qualitative and quantitative data from on shortfalls in compliance with parity laws.

Payment Policies to Contribute to Better Mental Health Parity in Practice

Generally, claims payment delays occur in all sectors of the medical field and reimbursement for mental health services tend to be lower than others. The lack of sufficient payment rates for mental health, and the undervaluing of mental health services has disincentivized providers to accept insurance or participate in federal programs. A transactional relationship between payers and providers makes billing and reimbursement a priority over the outcomes for the patient and the patient experience. Behavioral health providers do not want to be required to prioritize adequate compensation for their services over caring for those in need. Further a lack of innovation in this space, especially regarding updated coding practices for the valuation of the mental health practitioner's time and the type of treatment covered, undermines the relationship between behavioral health care providers and payers.

The Finance Committee should consider the following policies to improve payment practices in a way that benefits the patient and encourage innovation:

- Support for more enforcement of mental health parity laws.
- Support for the generation of real-world evidence to reflect the value of physician work and coverage of mental health treatments.
- Creating a standard set of quality metrics and measurable outcomes agreed upon by payers to improve willingness to pay for innovative mental health care services.

Telehealth Parity

Over the last 2 years, we've seen the vast expansion of telehealth services across the health care system, most notably the mental health care space. As Congress continues to weigh further telehealth expansion as a means to expand access to mental health services, payment parity must be a top consideration. Current payment policies act as a barrier to ensuring access to mental health services. As you know many mental health providers do not work within the Medicare and Medicaid programs due to lack of payment incentives. The same principle applies to services offered via telehealth. Regardless of whether telehealth is expanded permanently, if payment parity does not follow, providers will continue to withhold their services from federal health programs. That is why it is imperative that in any expansion of telehealth, Congress include policies that require the Medicare program to ensure payment parity.

COMPASS is working to transform the patient experience of mental health care, creating a world of mental well-being. In doing so, active collaboration, innovation, research, and integration across systems is a priority; the Finance Committee's commitment to identifying the challenges and creating lasting solutions for patients in need of care is encouraging and the opportunity to provide a statement for the record is appreciated. COMPASS looks forward to working with the Committee toward enactment of innovative policy solutions. If you have any questions, please contact Steve Levine at steven.levine@compasspathways.com.

Sincerely,

George Goldsmith
Co-founder, CEO, and Chairman of the Board

STATEMENT SUBMITTED BY JOHN D. CURTIS

U.S. Senate
Committee on Finance

Behavioral Health Care When Americans Need It:
Ensuring Parity and Care Integration

One way to ensure parity would be for Medicare beneficiaries to have access to the same counselors that Medicaid reimburses. Another would be for these providers to be paid the same. And another would be for that reimbursement rate to be little more than 85%.

ERISA INDUSTRY COMMITTEE
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Chairman Wyden, Ranking Member Crapo, and Members of the Committee, thank you for the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration," providing specific recommendations to improve mental and behavioral health access and quality.

ERIC is a national nonprofit organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans and to lawfully operate under ERISA's protection from a patchwork of different and conflicting state and local laws, in addition to federal law.

Americans engage with an ERIC member company many times a day, such as when they drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage or snack, use cosmetics, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, or go shopping.

ERIC member companies voluntarily offer comprehensive health benefits to millions of active and retired workers and their families across the country. Our members offer great health benefits to attract and retain employees, be competitive for human capital, and improve health and provide peace of mind. On average, large employers pay around 75 percent of health care costs on behalf of 181 million beneficiaries.

Employers like ERIC member companies roll up their sleeves to improve how physical, mental, behavioral health care is delivered in communities across the country. They do this by developing value-driven and coordinated care programs, implementing employee wellness programs, providing transparency tools, and adopting a myriad of other innovations that improve quality and value to drive down costs. These efforts often use networks to guide our employees and their family members to providers that offer high-value care.

ERIC member companies understand the shortage of mental and behavioral health providers and offered policy solutions [1] to address the crisis and long wait times. This included the following policy recommendations that will help ensure that Americans are better able to access the mental and behavioral health services they need, when and where they need them, without excess financial burden:

- Allow mental health providers to practice across state lines to improve access to care.
- Expand telehealth benefits for all employees to improve access to providers.
- Incentivize more practitioners to enter the mental health field by increasing education funding and tuition reimbursement.
- Require provider transparency around the ability to accept new patients, reducing patient uncertainty and frustration.
- Integrate multiple health care disciplines through collaboration to provide patients with higher quality care.
- Ensure patients and plan sponsors have access to meaningful provider quality and safety information.
- Modernize health care account rules to increase flexibility for employees and improve access to mental and behavioral health.
- Reduce regulatory barriers to encourage employer innovation.
- Apply lessons learned from COVID–19 to advance health equity and better prepare for the future.
- Encourage the transition to value-based payments to better manage the costs of mental and behavioral health.

Our policy recommendations require a collaborative approach from Congress, employers, and providers, but many providers eschew insurance networks [2] since they can make more money without a prohibition on balance billing (due to lack of competition). Others move to a cash-only model that greatly reduces their administrative burdens, but obviously is a significant hardship for patients. We urge the Committee to develop legislation that will:

- Require that mental health facilities accept private insurance.
- Increase telehealth access for employers' workforces and address unnecessary state and federal government barriers such as licensure and specific technology requirements.
- Integrate multiple health care disciplines through collaboration to provide patients with higher quality care.

We also request that Congress steer clear of policies that establish counterproductive mandates that are likely to increase costs without improving access or care. We specifically request that the Committee refrain from advancing policies that use civil monetary penalties (CMPs) for mental health parity violations in favor of clear-cut policies that promote access and affordability of care.

Avoid Mandating a One-Sided Network Adequacy Requirement

Some have proposed that the way to provide more access to providers is to mandate a network adequacy requirement on health plans. We oppose this approach in favor of policies that allow more providers to reach patients in need such as through telehealth and cross-border licensing. ERISA plans do not profit from denying care to beneficiaries, and they do not seek to limit access to needed care. In fact, to do so would be completely counterproductive. Employers strive to ensure that beneficiaries have access to the type and volume of care they need, when they need it, as they want their employees and families healthy physically and mentally. This is why we have continually worked to improve access and quality in all aspects of the health care system.

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[1] *https://www.eric.org/wp-content/uploads/2021/07/ERIC-Mental-Health-Task-Force-Report-2021.pdf.*

[2] Bishop, Tara F et al. "Acceptance of insurance by psychiatrists and the implications for access to mental health care." *JAMA psychiatry* vol. 71,2 (2014): 176–81. doi:10.1001/jamapsychiatry.2013.2862, *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3967759/*.

As mentioned before, many mental and behavioral health providers choose not to participate in any insurance network. This could be for a variety of reasons—perhaps they prefer to accept out-of-network rates and balance bill patients. Perhaps they choose to take cash only. Or perhaps they simply recognize that due to provider shortages, they wield such market power that agreeing to anything other than the price they want, is unnecessary. In a 2017 Milliman report, 17.2 percent of behavioral health office visits were to an out-of-network provider showing that more patients are paying higher costs to get the care they need.[3] Regardless, many mental and behavioral health providers are charging high rates as payment in full, and as such, do not participate in networks. Enabling more providers to practice such as across state lines will give patients more affordable choices.

Simply requiring insurers to include these providers in-network will necessarily lead to price increases for patients. If providers know an insurer has to bring them in-network, they have an incentive to demand prices higher than what the market would otherwise bear, thus leading to higher costs for all insured beneficiaries due to premium increases. This approach hits patients in self-insured plans especially hard. After all, with half the workforce in high-deductible health plans, and a significant portion of other beneficiaries whose cost-sharing is based on the cost of care, these price increases will serve to increase out-of-pocket costs for those who need the care most.

Any effort to implement a requirement that insurance networks include more mental and behavioral health providers must be a fair, two-sided requirement: it must be paired with a requirement that providers themselves participate in networks and show their willingness to be a part of the solution for mental and behavioral health care access and affordability. If not, Congress must take action by requiring that providers go in-network in at least a few plans. If Congress does this, it will show lawmakers are addressing the patient needs and should encourage good faith negotiations between providers and health plans. If providers are going to demand that a mandate be placed on health plans, providers should be prepared to also participate in this mandate, for the benefit of their patients, not providers' pockets.

Telehealth Innovation Can Improve Behavioral Health Care Access

ERIC's member companies are pioneers in offering robust telehealth benefits. Telehealth enables individuals to obtain the care they need, when and where they need it, affordably and conveniently. Telehealth visits are generally less expensive than in-person visits and significantly less expensive than urgent care or emergency room visits. Telehealth visits allow individuals who may not have a primary care provider and are experiencing medical symptoms an affordable option of care rather than an emergency room visit. Access to telehealth benefits saves individuals significant money and time, and reduces the cost to the plan which ultimately lowers health plan premiums.

As in most health insurance and value-driven plan design, self-insured employers have been the early adopters and drivers of telehealth expansion. Some employers also have value-based care and worksite health centers that have utilized clinic-based and specialty telehealth services during the pandemic, with the services rising to 78 percent in 2021 compared to 21 percent in 2018.[4] ERIC's member companies continued to lead the way in rolling out telehealth improvements—held back only by various federal and state government barriers. This includes provider licensing, unnecessary barriers, such as banning store and forward communications, or implementing specific technology requirements, and offering telehealth to certain sectors of the employer's workforce. These impediments to provider licensing seriously impact telehealth coverage offered to employees from state to state.

We encourage Congress to pass the following pieces of legislation to permanently increase telehealth care for individuals:

- *Telehealth Expansion Act (S. 1704).* The legislation would allow for individuals enrolled in a high-deductible health plan to have access to telehealth benefits

[3] Melek, Steve, Davenport, Stoddard, and Gray, T.J., "Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement." Milliman. November 19, 2019, *https://www.milliman.com//media/milliman/importedfiles/ektron/addiction andmentalhealthvsphysicalhealthwideningdi_sparitiesinnet_workuseandproviderreimbursement.ashx.*

[4] Mercer, National Association for Worksite Health Centers, Worksite Health Centers 2021 Survey Report, *https://www.mercer.us/content/dam/mercer/attachments/north-america/us/us-2021-worksite-health-centerssurvey-report.pdf.*

at a low cost or free of charge before their deductible is met and continue to maintain Health Savings Account eligibility.

- *Telehealth Benefit Expansion for Workers Act.* This bill would allow employers to offer standalone telehealth benefits to millions of individuals who are not enrolled on their full medical plan, such as part-time workers, interns, seasonal workers, persons on a waiting period, and more by removing barriers currently presented under current law, such as the Affordable Care Act.
- A permanent solution to interstate licensure that could be addressed by either:
  - National reciprocity for medical provider licenses;
  - A new national license specifically for telehealth;
  - One comprehensive interstate compact with financial incentives for states; or
  - Update and pass the TELE–MED Act and TREAT Act.

Telehealth is currently regulated only at the state level. As a result, individuals in national, ERISA governed self-insured health plans, face many barriers to care and other limitations, which vary state by state. This kind of regulation may be appropriate for individuals enrolled in (and providers contracting with) fully-insured plans, which are regulated at the state level. However, it creates uneven care for workers, families, and retirees who get their health insurance through self-insured health plans, which are regulated at the federal level. This unfairness is exactly what ERISA preemption was intended to prevent.

Congress could fix this inequity by creating a new national standard for telehealth benefits offered under an ERISA governed self-insured health plan. Such a standard should consider the following tenets (which are the key areas in which state laws currently conflict and disadvantage telehealth patients):

- Specifically allow telehealth to establish a patient-provider relationship.
- Apply the same standard of care to in-person visits and telehealth visits.
- Do not require reimbursement for telehealth visits to be at the same rate as reimbursement for in-person visits.
- Encourage interstate practice among providers.
- Coordinate between the patient's telemedicine provider and primary care provider is encouraged.
- Simply define "telehealth" and "telemedicine" and apply the terms to broadly include all types of care that use technology to connect a provider in one location and a patient in a different location.
- Do not require or encourage patients to travel to specific "originating sites" to access telehealth services.
- Apply the same informed consent requirements to in-person visits and telehealth visits.
- Allow prescribing via telemedicine.

Congress can develop a set of rules that protect patients while maximizing flexibility and care, rather than some of the current protectionist rules that serve to block patients from care onthe state level. These simple, streamlined set of rules will provide clarity to providers and maximize access for patients.

Improving Care Integration for All Patients

As the access to psychologists and psychiatrists, in particular, has proven a challenge to plan beneficiaries, many have utilized other health care providers, such as those in primary care, to take care of their mental and behavioral needs. Congress can facilitate the transition of some mental and behavioral health services to non-traditional providers, such as to:

- Pursue efforts to ease a transition for coordinated care between interdisciplinary teams.
- Direct CMS to pursue new opportunities for mental and behavioral health to be included in accountable care organization (ACO) type arrangements.
- Eliminate regulatory barriers to creating capitated models that include mental and behavioral health professionals and condition some portion of public pro-

gram reimbursement on participation in these types of models for mental health professionals and facilities.

- Create incentives for states to broaden "scope of practice" laws that currently hinder the ability of various medical providers (a prime example being nurse practitioners) from meeting unmet mental and behavioral health needs.
- Mandate fully interoperable electronic medical records (EMRs), and redesign the Meaningful Use program to ensure that every provider or facility participating in CMS programs transitions to a fully interoperable system so that a patient's entire interdisciplinary care team can access and contribute to the same EMR.
- Explore how coverage rules may be applied or expanded in order to encourage and facilitate behavioral health options such as attending group meetings or therapy sessions.

While not every provider can address all health care matters, ensuring that medical teams have proper systems and relationships is crucial in making sure that patients receive the best care.

Do Not Implement Civil Monetary Penalties (CMPs) for Mental Health Parity (MHP) Violations

One oft-repeated idea to improve access to mental health providers and treatments for beneficiaries of employer-sponsored health insurance has been to implement a monetary penalty regime to punish insurance companies and employers who are found to have fallen short of parity requirement.

We are deeply troubled by the Department of Labor's (DOL) recommendation encouraging Congress to authorize the agency to assess civil monetary penalties for parity violations, as mentioned in their 2022 Mental Health Parity and Addiction Equity Act (MHPAEA) Report. Penalties are not the answer. Rather, what is needed is clearcut, comprehensive guidance that helps employers support their workforce and mental health providers that support patients over their bottom line.

It is our understanding that problems in the large-group market among self-insured plans are primarily a result of non-quantitative treatment limitations (NQTLs), a requirement that was never contemplated in the original MHP legislation, but instead developed by the federal agencies.

Employers looking for a firm understanding of what is allowed, and what is not, have to resort to third-party publications, consultants, and outside vendors. In the large-group market, employers who are found to have parity violations inevitably have relied on outside counsel.

Large employers have continually made available the newly required comparative analyses upon request from DOL. However, despite extensive good faith efforts to comply, our member companies have reported that upon submitting analyses, DOL staff sent back dozens of questions and requests for substantially more documentation without explanation of what changes employers can make to comply with parity rules.

As such, penalizing employers for these violations are unlikely to prevent them in the future. Rather than implementing CMPs, if the goal is to reduce MHP violations through NQTLs, Congress should consider mandating that DOL provide much clearer, simpler guidance, that includes examples of what is actually allowed—rather than just citing various impermissible plan design elements.

Conclusion

Thank you for this opportunity to share our views with the Committee. The ERISA Industry Committee and our member companies are committed to working with Congress to meaningfully improve access to quality behavioral health care for our employees, their families, and retirees. We look forward to working with the Committee to enact legislation to meet the behavioral health needs of Americans.

HEALTHCARE LEADERSHIP COUNCIL

April 11, 2022

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

RE: March 30th "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration" Hearing

Dear Chair Wyden and Ranking Member Crapo:

The Healthcare Leadership Council (HLC) thanks you for holding a hearing on, "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration."

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, homecare 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 December 2021 report by the Government Accountability Office (GAO) found that over 43% of adults have reported struggling with anxiety or depression since the beginning of the pandemic.[1] The impact of COVID–19 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 individuals and communities. HLC also supports your work to examine how to improve mental health services, particularly by ensuring parity and care integration. We offer the following proposals as you deliberate on these areas of care:

Ensuring Parity

Ensuring parity for patients struggling with behavioral health challenges is an important step in providing necessary care. We thank Congress and federal agencies for their work to reduce disparities in care delivery. As you examine additional steps to ensure better parity for patients, we encourage you to examine how regulatory guidance can be better leveraged to provide clarity to stakeholders. Recent changes in the "Consolidated Appropriations Act, 2021," impose significant new compliance requirements on ensuring parity. Additionally, regulatory oversight for this area spans across several federal agencies including the Departments of Health and Human Services, Labor, and the Treasury. HLC encourages further action to provide more guidance on how to comply with new regulations and ensure that these actions educate rather than unnecessarily penalize impacted entities and achieve the desired goal.

Care Integration

Integrating mental health treatment within primary care visits has been shown to have benefits for patient health outcomes. By treating mental health challenges separately from other medical conditions, patients miss out on the benefits of care coordination. For example, separating care creates logistical challenges related to seeking care from different providers. Notably, 67% of patients do not typically receive treatment from their primary care providers (PCPs) for mental health challenges, while 80% of those patients visit a PCP at least once a year.[2] Studies have found that integrating these appointments leads to a 16% reduction in the use of

[1] "Behavioral Health and COVID–19: Higher-Risk Populations and Related Federal Relief Funding," Government Accountability Office (December 10, 2021), *https://www.gao.gov/assets/gao-22-104437.pdf.*

[2] Alexander Kieu, "Now More Than Ever, Mental Health Care Needs Family Medicine," American Association of Family Physicians (May 2021), *https://www.aafp.org/fpm/2021/0500/oa1.html.*

separate behavioral health services that can be handled by a PCP.[3] Additionally, patients suffering from depression saw an average of $3,300 in decreased costs over a 2-year period when mental healthcare was integrated into primary care visits.[4] Combining primary care and mental healthcare has proven successful with certain patients and should be encouraged when appropriate.

Successful integration of behavioral health services within primary care also requires robust collection of patient information. HLC supports efforts to improve health information interoperability among providers, particularly social determinants of health (SDOH) data capture and sharing. This data should include standardized information on race, ethnicity, and language and be tracked throughout all federal programs. Despite the numerous initiatives to address SDOH in patient care, providers still struggle to incorporate SDOH into care delivery because this information is oftentimes not part of the patient's electronic health record. It is critical that providers are able to uniformly assess and identify potential social risk factors among all patients. Standardization of this data is vital to providers' success in moving toward greater health equity, as it will foster the development and sharing of best practices within clinical settings, health systems, and delivery designs.

We encourage the Committee to examine ways to further strengthen information sharing among providers so that they can make informed decisions about patient care. However, any proposals should ensure that patient information receives robust privacy and security protections. Special focus should be given to health information not governed by the HIPAA regulatory framework to build patient trust in information sharing.

HLC appreciates your work on improving mental health outcomes for patients and looks forward to working with you on future solutions. Please contact Tina Grande at 202–449–3433 or tgrande@hlc.org with any questions.

Sincerely,

Mary R. Grealy
President

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AND

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The HR Policy Association (Association) and the American Health Policy Institute (Institute) appreciate the Committee holding this important hearing on behavioral and mental health care issues.

The Association is the leading organization representing chief human resource officers of 400 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 Institute, a part of the 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.

Congress should enact the following policy recommendations to improve access to behavioral and mental health care services.

More Guidance Will Achieve Mental Health Parity, Not Civil Monetary Penalties

HR Policy strongly opposes enacting civil monetary penalties for mental health parity violations before the Department of Labor (DOL) publishes and implements its parity rulemaking and the additional guidance that is required by the Consolidated Appropriations Act of 2021 (CAA).

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[3] "Benefits of Integration of Behavioral Health," Primary Care Collaborative, *https://www.pcpcc.org/content/benefits-integration-behavioral-health.*
[4] *Id.*

Congress recognized that employers needed substantially more guidance to implement the complicated mental health parity requirements for non-quantitative treatment limitations (NQTLs) when it enacted the CAA. Specifically, Congress required DOL to publish a "compliance program guidance document" that provides "illustrative, de-identified examples" of previous findings of compliance and noncompliance, including:

- Examples illustrating requirements for information disclosures and non-quantitative treatment limitations; and
- Descriptions of the violations uncovered during the course of such investigations.[1]

Importantly, the CAA requires the examples to "provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits."[2]

Congress also required DOL to publish "additional guidance" that "shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers . . . may use for disclosing information to ensure compliance" with their parity requirements.[3] Specifically, "[s]uch guidance shall include information that is comparative in nature with respect to—

> (I) non-quantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;
>
> (II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and
>
> (III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits."[4]

Regarding non-quantitative treatment limitations, the CAA also requires DOL to publish guidance that provides clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers may use regarding the development and application of non-quantitative treatment limitations to ensure compliance with their parity requirements, "including—

> (i) examples of methods of determining appropriate types of non-quantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including non-quantitative treatment limitations pertaining to—
>
> (I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;
>
> (II) limitations with respect to prescription drug formulary design; and
>
> (III) use of fail-first or step therapy protocols;
>
> (ii) examples of methods of determining—
>
> (I) network admission standards (such as credentialing); and
>
> (II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;
>
> (iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of non-quantitative treatment limitations;
>
> (iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;
>
> (v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

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[1] 29 U.S.C. 1185a(a)(6)(B)(i).
[2] 29 U.S.C. 1185a(a)(6)(B)(ii).
[3] 29 U.S.C. 1185a(a)(7)(B)(i).
[4] 29 U.S.C. 1185a(a)(7)(B)(ii).

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance. . . .''[5]

Under the CAA, DOL is supposed to publish this guidance 18 months after the CAA was enacted (July 2022) and is required to provide at least a 60-day public comment period before issuing any final guidance. DOL is also required to update this guidance every 2 years. According to DOL's latest regulatory agenda, the Department is currently scheduled to publish a proposed mental health parity rule that incorporates examples and modifications to account for the CAA in July 2022.

The need for this guidance before imposing any civil monetary penalties is abundantly clear from DOL's 2022 MHPAEA Report to Congress *(https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf).* The report shows none of the 134 self-funded employer plans' NQTL comparative analyses "contained sufficient information" despite the nine sets of FAQs, draft and final Disclosure Templates, and several enforcement fact-sheets DOL has published. When not one employer plan has a sufficient comparative analysis, it is not because none of them want to comply. It is because they do not know how to comply.

Moreover, imposing civil monetary penalties on plan sponsors will not solve the serious problem of provider shortages. According to HHS, 129.[6] million Americans live in areas designated as Mental Health Professional Shortage Areas,6 and 6,559 additional behavioral health providers[7] are needed to fill these provider gaps.[8] Addressing this long-term problem will require significant investments by the federal government.

Employers have innovated and invested in significant new behavioral health benefits during the COVID pandemic. Addressing the current mental health care crisis and achieving mental health parity compliance will require significant efforts in partnership between employers, providers, government, patient groups and other stakeholders. We believe that enacting punitive legislative provisions like civil monetary penalties at this point will poison these efforts and serve only to hurt patients.

To achieve mental health parity compliance, Congress should:

- Encourage DOL to publish the guidance required by the CAA and additional de-identified examples of comparative parity analyses that are compliant under a final determination letter; and
- Focus on fostering partnerships between employers, providers, and carriers rather than punitive legislative provisions which further push stakeholders into their respective corners.

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[5] 29 U.S.C. 1185a(a)(7)(C).

[6] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health and Human Services, "Designated Health Professional Shortage Areas Statistics," September 30, 2021, available at: *https://data.hrsa.gov/Default/GenerateHPSAQuarterly Report.*

[7] Behavioral health providers are health care practitioners or social and human services providers who offer services for the purpose of treating mental disorders including: psychiatrists, clinical social workers, psychologists, counselors, credentialed substance use specialists, peer support providers, and psychiatric nurse providers.

[8] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health and Human Services, "Designated Health Professional Shortage Areas Statistics," September 30, 2021

Expand the Collaborative Care Model (CoCM)

To increase access to behavioral health services the Association urges Congress to enact the bipartisan Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) to promote the uptake of the collaborative care model by providing grant funding to remove the barriers that primary care practices face when trying to implement the model. The collaborative care model increases access by creating a care team comprised of a primary care provider, a psychiatric consultant and care manager working together in a coordinated fashion. Over 90 randomized controlled trials have demonstrated collaborative care models are more effective and cost efficient than usual care.[9]

Behavioral health conditions often initially appear in a primary care setting and primary care clinicians provide mental health and substance use care to most people with behavioral disorders, as well as prescribe the majority of psychotropic medications. An integrative model that joins behavioral health and primary care would significantly improve behavioral health services, reduce the burden of other illness, lower medical costs, and reduce disparities in the identification and effectiveness of treatment for behavioral health issues.

The stigma surrounding mental health and substance use disorders results in patients not seeking treatment and even when they do, it can be difficult to find a provider in a timely manner. The collaborative care model provides a strong building block to address these problems by ensuring that patients can receive expeditious behavioral health treatment within the office of their primary care physician. Importantly, the team members also use measurement-based care to ensure that patients are progressing, and when they are not, treatment is adjusted.

In addition to increasing access, the collaborative care model has tremendous cost savings potential. For example, cost/benefit analysis demonstrates that this model has a 12:1 benefit to cost ratio for the treatment of depression in adults.[10] Furthermore, the model greatly increases the number of patients being treated for mental health and substance use disorders when compared to traditional 1:1 treatment. Lastly but no less important, the model has been shown to increase physician and patient satisfaction and reduce stress among primary care physicians.

Despite its strong evidence base and availability of reimbursement, uptake of the collaborative care model by primary care physicians and practices remains low due to the up-front costs associated with implementing the model. Additionally, many primary care physicians and practices may be interested in adopting the model but are unsure of next steps. The Collaborate in an Orderly and Cohesive Manner Act addresses both potential roadblocks by providing grants to primary care practices to cover start-up costs and by establishing technical assistance centers to provide support as practices implement the model. Moreover, the bill promotes research to identify additional evidence-based models of integrated care.

Remove Barriers to Providing and Expanding Telebehavioral Health

To help improve access to behavioral health care when Americans need it Congress should eliminate restrictions that impede an employer's ability to provide employees with telehealth services. During the COVID pandemic, telehealth became the preferred way for patients to see providers and liberalized telehealth rules resulted in an exponential growth in the use of telehealth, particularly telebehavioral health.[11] It allowed access to needed care while meeting patients' needs of convenience and safety as the virus spread.

A survey of HR Policy members showed that 79 percent of respondents offered mental health virtual care and telebehavioral health services to their employees to address access challenges.[12] Telebehavioral health has the potential to overcome patient stigma and improve access and efficiency of care for behavioral health services. Since the public health emergency, there has been a significant increase in patients

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[9] Jürgen Unützer, et al., The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center, May 2013, available at: *https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.*

[10] Washington State Institute for Public Policy Benefit-Cost Results for Adult Mental Health. Retrieved from: *https://www.wsipp.wa.gov/BenefitCost?topicId=8.*

[11] Bestsennyy, O., Gilbert, G., Harris, A., and Rost, J. (2021). Telehealth: A quarter-trillion-dollar-post-COVID–19 reality? McKinsey and Company. *https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.*

[12] HR Policy Association, CHRO Survey 2021.

keeping their behavioral health appointments. When patients keep their first appointment, they are more likely to keep subsequent appointments and patients satisfied with their treatment are more likely to continue with their course of therapy. Research also suggests that telebehavioral health results in better medication compliance, fewer visits to the emergency department, fewer patient admissions to inpatient units, and fewer subsequent readmissions.[13]

Despite the positive impact of expanded telebehavioral health, state and federal barriers continue to limit employers' ability to innovate in the telehealth space. While many positive steps were taken to increase flexibility around telehealth offerings during the public health emergency, several permanent changes are needed so employers can expand the scope of their telehealth offerings. Our recommendations for changes to expand access to affordable coverage and care through telehealth are below.

Pass the Primary and Virtual Care Affordability Act (H.R. 5541): Under the CARES Act, employees with a high-deductible health plan (HDHP) were able to access first-dollar coverage of telehealth visits through December 31, 2021. Its expiration left many employees without the ability to seek care through telehealth without first meeting their deductible. While an extension was included in the Omnibus package, it was only extended through the end of 2022. For behavioral health services, permanent change is especially important as provider shortages, in conjunction with limited in-network providers, makes it difficult for patients to find affordable in-network providers.

Allow telehealth services to be treated as an excepted benefit. Currently, stand-alone telehealth programs are considered excepted benefits and can only be provided to full-time employees enrolled in the employer health plan. Part-time, seasonal, and full-time employees that declined the employer medical plan cannot access these telehealth programs because it violates coverage rules under the ACA employer mandate. This was removed temporarily during the COVID–19 pandemic, but a permanent solution would allow employers to expand access to telehealth services to more employees, specifically younger workers and economically disadvantaged workers.

Allow providers in good standing with a valid license in at least one state provide telehealth services to patients in other states. While states should remain able to determine licensure requirements around prescribing ability or scope of practice, a state should not be able to prohibit a provider that is deemed qualified in another state from operating according to their licensure. Telehealth increases patients' ability to get adequate care from a qualified provider in another state. Additionally, cumbersome and expensive credentialing and licensing processes disincentivize many providers from obtaining licenses in multiple states. Congress should encourage states to join interstate medical licensure compacts to expedite the process for providers that want to practice in multiple states and expand the accessibility of providers for patients in need.

Enact the Telemental Health Care Access Act (S. 2061, H.R. 4058). This legislation will ensure Medicare beneficiaries can access telemental health services post-pandemic without satisfying the unnecessary and restrictive in-person requirement that was passed into law at the end of 2020 that requires physicians to see their patients in-person at least six months prior to their telemental visit before a Medicare will reimburse for the telehealth visit. Congress should also ensure similar restrictions are not imposed on employer plans and individual coverage.

Enact the Telehealth Response for E-prescribing Addiction Therapy Services Act or TREATS Act (S. 340, H.R. 1647). This legislation would allow certain controlled substances specifically schedules III and IV to be prescribed via telehealth without an in-person requirement. It also allows telehealth services to be provided via audio-only technology, if a physician has already conducted a video or in-person visit.

Enable ERISA plans to offer a uniform set of telehealth benefits. Congress passed the Employee Retirement Income Security Act (ERISA) to enable employers to provide uniform health care benefits to their employees. While health care reforms should offer states greater flexibility regarding their individual and small group health insurance markets, creating a uniform set to telehealth rules will en-

[13] Hilty, D.M., Ferrer, D.C., Parish, M.B., Johnston, B., Callahan, E.J. and Yellowlees, P.M. (2013). The effectiveness of telemental health: A 2013 review. *https://www.liebertpub.com/doi/10.1089/tmj.2013.0075.*

able multi-state employers to create and expand valuable telehealth benefits for their plan participants.

Expand the Use of Measurement-Based Care

It is estimated that only 18% and 11% of psychiatrists and psychologists, respectively, use assessment tools regularly.[14] When such tools are used in initial assessments, earlier diagnosis is more likely and can prevent conditions from becoming more severe. Outcomes improve 20–60% when such tools are used over the course of treatment because the provider has additional evidence on the effectiveness of the course of treatment.[15] Measurement-based care provides an objective tool for providers, mitigating inherent biases and resulting disparities in treatment. Measurement-based care is also a critical component of the collaborative care model above.

Policy Recommendations

- Establish incentives with carriers (*e.g.,* star ratings) and providers (*e.g.,* pay for performance) to increase the use of appropriate measurement tools when providing care.
- Allocate funds to support a change effort to educate and implement measurement-based care across the country. A portion of such funds should be allocated to virtual programs such as telebehavioral interventions and digital behavioral apps to facilitate behavioral health integration models to add measurement-based care for small and rural practices in addition to larger practices.
- Instruct the CMS Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program to mandate that certified electronic health record (EHR) vendors must include screening and symptom follow up tools using standardized measures (PHQ–9, *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/*, GAD–7, *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410326*) for major mental health and substance use disorders, including depression, suicide, anxiety, PTSD, mania, addiction, and psychotic disorders at no cost to providers. Supports for documentation, billing, panel management, and tracking measure scores over time should also be included.
- Increase incentives for using existing CPT Codes such as GO444, 96127, 96160, 96161, 96130, 96139.
- Include measurement-based care as a standard of care regardless of the modality.

The HR Policy Association and the American Health Policy Institute 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.

Sincerely,

D. Mark Wilson
President and CEO,
American Health Policy Institute
Vice President, Health and Employment Policy
HR Policy Association

Margaret Faso
Director, Health Care Research and Policy
HR Policy Association
American Health Policy Institute

MICHAEL J. FOX FOUNDATION FOR PARKINSON'S RESEARCH

April 11, 2022

The Honorable Ron Wyden
Chairman

The Honorable Mike Crapo
Ranking Member

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U.S. Senate
Committee on Finance
Dirksen Senate Office Building, SD–211
Washington, DC 20510

U.S. Senate
Committee on Finance
Dirksen Senate Office Building, S–239
Washington, DC 20510

RE: Senate Finance Committee hearing titled "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration" hosted March 30, 2022

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of The Michael J. Fox Foundation for Parkinson's Research (MJFF), I write to express my appreciation to you and the members of the committee for hosting a hearing on "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration." Access to behavioral health care is essential for people with Parkinson's disease (PD) because the disease makes them prone to adverse mental health conditions. We urge the committee to pass legislation to expand the behavioral health workforce and remove barriers to accessing behavioral health services via telehealth so people with Parkinson's can access behavioral health care when and where they need it.

PD is a chronic, progressive neurological disorder affecting over one million people in the United States. Currently, there is no treatment to slow, stop, or reverse the progression of the disease, nor is there a cure. PD is the fastest growing neurological disease in the world and is the second most common condition after Alzheimer's disease. Currently, PD costs Americans at least $52 billion each year—roughly half of which is through Medicare in caring for people living with PD. By 2037—just 15 years from now—that cost will balloon to around $80 billion when more than 1.6 million Americans are projected to be living with PD.

PD is often characterized by motor (movement-related) symptoms like tremor, stiffness, and walking problems, but the disease also has non-motor symptoms, including anxiety, depression, and dementia, among others. There is an interplay between Parkinson's motor and non-motor symptoms, and access to behavioral health services is vital to ensuring people with Parkinson's can manage their symptoms and lead healthy lives. To ensure people with Parkinson's can access these services, MJFF urges the committee to support two key pieces of legislation: the Telemental Health Care Access Act of 2021 (S. 2061) and the Mental Health Access Improvement Act of 2021 (S. 828).

The Telemental Health Care Access Act of 2021

In the Consolidated Appropriations Act of 2021, Congress included a requirement that prevents Medicare from covering telemental health services for beneficiaries that have not seen their provider in person in the 6 months prior to their telehealth visit once the COVID–19 public health emergency expires. This in-person requirement for telemental health services is the first and only instance of a federal statute expressly mandating an in-person exam as a condition for Medicare coverage of a telehealth-based service.

MJFF urges the committee to pass the Telemental Health Care Access Act of 2021, led by Senators Cassidy (R–LA), Smith (D–MN), Cardin (D–MD), and Thune (R–SD), to remove the arbitrary and unnecessary in-person requirement for telemental health services. This will allow Medicare beneficiaries to maintain access to needed mental health services without having to make an in-person visit with their provider. Additionally, as expert witness Dr. Anna Ratzliff testified during the committee hearing, this is a parity issue and the decision to meet in person or via telehealth should be between the provider and their patient.

Nearly 90 percent of people with Parkinson's rely on Medicare for their health care coverage, and they are prone to mental health conditions because of how the disease impacts the brain. In-person requirements create barriers to patients seeking care, especially for mental health services and patients with disabilities. By passing the Telemental Health Care Access Act of 2021, Congress would allow people with Parkinson's to maintain access to telemental health services without being required to make unnecessary and burdensome trips to see their providers in person.

The Mental Health Access Improvement Act of 2021

About one in four Medicare beneficiaries live with a mental illness, but a majority (71 percent) of seniors have never been screened for a mental health condition. Lack of access to mental health providers contributes to this problem. Poor mental health can lead to worse health outcomes and greater use of health care services, as well

as more expensive interventions for non-mental health conditions, for older and disabled adults on Medicare, including those living with Parkinson's.

MJFF urges the committee to pass the Mental Health Access Improvement Act of 2021, led by Senators Barrasso (R–WY) and Stabenow (D–MI), to close the gap in federal law that excludes licensed professional mental health counselors (LPCs) and licensed professional marriage and family therapists (LMFTs) from participating in the Medicare program. LPCs and LMFTs participate in virtually all other health plans, including Tricare, the Veterans Administration, Medicaid, and most Medicare Advantage, commercial, and employer plans. The Mental Health Access Improvement of 2021 would expand access to mental health services for people with Parkinson's by allowing 225,000 additional licensed and highly qualified mental health professionals to participate in the Medicare program.

Once again, thank you for hosting this important hearing and allowing MJFF the opportunity to recommend policy solutions that will help people with Parkinson's access mental health services when and where they need them. Please contact Mason Zeagler at mzeagler@michaeljfox.org should you have any questions or require further information.

Sincerely,

Ted Thompson, JD
Senior Vice President
Public Policy

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I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer and utilize health plans of all types. The health insurance agents and brokers that NAHU represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers select health plans that are best for them. These plans include coverage for mental and behavioral health benefits as is required by law. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees [1] and 84 percent of people shopping for individual exchange plans found brokers helpful—the highest rating for any group assisting consumers.[2]

Access to mental health services is a crucial component of health care. National discussion has addressed mental health care for years, but often focuses more on physical health. The COVID–19 pandemic has reminded us of the importance of adequate mental health care and exposed a mental health crisis: About 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from 1 in 10 adults who reported these symptoms from January to June 2019.[3] For these reasons it is more vital than ever that consumers can access and afford behavioral health services. These recommendations were put together with the help of NAHU's Mental Health Task Force, a legislative working group comprised of NAHU members with an advanced understanding of mental and behavioral health services and how they are provided and used in health plans.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) created standards for the financial requirements and treatment limitations that a group health plan or group health plan issuer may impose on mental health and substance

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[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013, *https://www.kff.org/wp-content/uploads/2012/09/8465-employer-health-benefits-2013.pdf.*

[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014, *https://hrms.urban.org/briefs/obtaining-information-on-marketplace.html.*

[3] Kaiser Family Foundation. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID–19 Pandemic. 27 September 2021, *https://www.kff.org/other/state-indicator/adults-reporting-symptoms-of-anxiety-or-depressive-disorder-during-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

use disorder (MHSUD) benefits. MHPAEA established those financial requirements (such as copayments, coinsurance) and treatment limitations (such as limits on the number of outpatient visits, or prior authorization requirements) cannot be more restrictive than those that apply to medical and surgical benefits. Regarding financial requirements or quantitative treatment limitations (such as the number of inpatient days covered), a plan cannot impose a requirement or limitation on MHSUD benefits that is more restrictive than what is imposed on two-thirds of the medical and surgical benefits in the same classification

Most recently, the Consolidated Appropriations Act of 2021 mandated that employers offering medical, surgical, and mental health and substance use disorder coverage provide comparative analyses and relevant supporting documentation demonstrating compliance with mental health parity requirements to the Department of Labor upon request. Both fully insured and self-funded ERISA plan sponsors are required to comply with the quantitative treatment limits imposed by the Mental Health Parity Act. Complying with the new CAA mandates and in particular the non-quantitative treatment limits (NQTL) reporting is challenging for many employers, who, because of their size, must rely on their intermediaries such as third-party administrators to monitor and comply with network adequacy requirements for access to mental and behavioral health care. Smaller plans with fewer compliance resources particularly struggle with the complexity of the MHPAEA rules, but the complexity concerns in this area extend to plans of all sizes. In the event of a Department of Labor request, these employers often will need to work with legal counsel to identify treatment limitations and contact multiple providers to request information necessary to complete comparative analyses. This makes compliance particularly difficult for employers who already face other compliance requirements relating to the plans they sponsor for employees. To assist employers in this regard, NAHU recommends that reporting requirements for ERISA plan sponsors be lessened by reducing the number of notices, as well as allowing disclosures to be made electronically.

Earlier this year, the Department of Labor, Department of Health and Human Services, and Department of the Treasury released the first Annual Report to Congress on the Mental Health Parity and Addiction Equity Act. Out of the 216 NQTL analyses reviewed by DOL and 21 NQTL analyses reviewed by CMS, none were found to meet regulators' expectations.[4] The Report noted that most of the initial findings of noncompliance were due to incomplete comparative analyses, which did not provide the information, analyses, and supporting documentation the Departments anticipated. These findings underscore the difficulties and complexities that employers are facing as they try to meet MHPAEA and CAA obligations, with employers struggling to determine what is necessary to satisfy these requirements.

NAHU also recommends that Congress look at easing certain regulatory burdens to allow employers to create new and innovative mental health benefits for their employees. Employers want their employees to experience the best possible physical and mental health. These healthy employees make the best workers and increase productivity in the workplace. Because each workforce, workplace and community are different and offer different challenges and opportunities, the lack of flexibility in meeting mental health parity requirements can make it difficult and cumbersome for employers to develop comprehensive mental health benefit programs, as there is concern that they could come in conflict with one of the many regulations in this area. NAHU recommends that employers be given greater flexibility to create new mental health benefit programs outside of the current benefits structure. While these benefits programs would still be subject to the ACA, MHPAEA, and other relevant statutes, the establishment of new stand-alone mental health benefit programs separate from group health plans would be of immense value for Americans seeking MHSUD services and could even be expanded to offer access to mental health care to employees who aren't eligible for the employer's health plan(s).

Another way in which Congress can improve Americans' access to mental and behavioral health services is by addressing the shortage of MHSUD providers. While attempts have been made to make improvements in this area, there is still a significant amount of ground to cover. 119 million Americans live in areas designated as "Mental Health Professional Shortage Areas."[5] Often it is difficult for patient to lo-

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[4] *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.*

[5] Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). 30 September 2020, *https://www.kff.org/other/state-indicator/mental-health-care-*

cate a provider that accepts insurance at all, much less participates in their insurer's network. If a provider does participate, that participation may not be consistent resulting in provider directory inadequacy. A survey of privately insured patients found that 53 percent of those that used provider directories found inaccuracies in their insurer's provider directory, often leading them to receive care from out-of-network providers.[6] Additionally, recent American Academy of Pediatrics data shows that there are, on average, just 9.75 child psychiatrists per 100,000 children, and child psychiatrists are disproportionately located in larger urban centers; more than two-thirds of U.S. counties don't have even a single child psychiatrist.[7] According to the Health Resources and Services Administration, an additional 6,586 providers would be needed to bridge the gap for consumers living in these shortage areas.[8]

The workforce shortage is not only an issue in the mental and behavioral health sphere. The United States could see an estimated shortage of between 37,800 and 124,000 physicians by 2034, including a shortfall of between 17,800 and 48,000 primary care physicians.[9] Prior to the COVID–19 pandemic, physician shortages were already evident, with 35 percent of voters in 2019 saying they had trouble finding a doctor in the previous two or three years. This was a 10-point jump from when the question was asked in 2015.[10] To enhance Americans' access to mental and behavioral health care, strengthening both the mental health and primary care workforce must be a top priority. NAHU supports workforce development and training programs that aim to increase the amount of MHSUD and primary care professionals.

Strengthening the workforce of both mental health and primary care providers is vital, as a further source of inefficiency impeding Americans' access to mental and behavioral health is the lack of communication between behavioral health and primary care providers. Approximately two-thirds of primary care physicians are unable to connect their patients to outpatient mental health services.[11] Since mental and behavioral health is often not integrated with primary care, this leaves patients with undiagnosed or poorly managed mental and behavioral health conditions, even though mental and behavioral health conditions often initially appear in a primary care setting. Currently, primary care clinicians provide mental health and substance use care to many people with mental and behavioral disorders and prescribe the majority of psychotropic medications. NAHU believes that a collaborative care model that incorporates behavioral health and primary care could significantly decrease the weight of other illness, lessen the demand for mental and behavioral health services, and thereby lower medical costs and reduce disparities in identification and the effectiveness of treatment for behavioral health issues. Collaborative care models such as Direct Primary Care arrangements and employer-run Accountable Care Organizations would also assist in improving collaboration between primary care and behavioral health providers.

State licensure requirements and cross-state-border restrictions also remain some of the largest, most complex barriers within the mental health space as well as the telemedicine space broadly. Due to the COVID–19 pandemic CMS, along with a handful of states, decided to relax regulations around telehealth and state-licensure requirements, temporarily waiving requirements for licensure in the state where the patient was located. This added flexibility was of great benefit to patients across the country, particularly MHSUD consumers. For these reasons, NAHU recommends that Congress look at ways to facilitate reciprocity of state-provided licenses and

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health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[6] Busch, Susan, et al. Incorrect Provider Directories Associated with Out-of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs.* June 2020, *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.*

[7] McBain, Ryan, et al. Growth and Distribution of Child Psychiatrists in the United States: 2007–2016. American Academy of Pediatrics, *https://publications.aap.org/pediatrics/article/144/6/e20191576/77002/Growth-and-Distribution-of-Child-Psychiatrists-in?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000.*

[8] Health Resources and Services Administration. Shortage Areas, *https://data.hrsa.gov/topics/health-workforce/shortage-areas.*

[9] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Association of American Medical Colleges. June 2021, *https://www.aamc.org/media/54681/download?attachment.*

[10] *Ibid.*

[11] Cunningham, Peter. Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care. *Health Affairs.* 2009, *https://www.healthaffairs.org/doi/10.1377/hlthaff.28.3.w490.*

other ways to ease cross-state-border restrictions on tele-behavioral health and telehealth generally.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595–0639 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
CEO

NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH
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Re: Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration

Domestic and sexual violence and other lifetime trauma can have significant mental health and substance use-related consequences for survivors. On behalf of the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH), one of four national Special Issue Resource Centers funded by the U.S. Department of Health and Human Services' Family Violence Prevention and Services Program, we thank you for your focus on behavioral health care. Safe use of telehealth can provide domestic violence (DV) survivors access to much needed behavioral health services. We are grateful for the opportunity to share NCDVTMH's insight which is guided by the experiences of DV survivors, up-to-date research, and by an intersectional analysis of how systems impact the lives of survivors and their families.

DV is common. According to the Centers for Disease Control and Prevention, about 1 in 5 women, 1 in 10 men, and 26%–61% of LTBTQ individuals (43.8% of lesbian women; 61.1% of bisexual women; 26.0% of gay men; 37.3% of bisexual men; 25%–54% of trans individuals) have experienced violence and/or stalking by an intimate partner. DV has serious mental health consequences. Abuse by an intimate partner significantly increases a person's risk for developing a range of mental health conditions, including depression, anxiety, PSTD, eating disorders, chronic pain, insomnia, substance use disorders, psychotic episodes, and suicide attempts. There are high rates of DV among people accessing mental health and substance use disorder treatment. Across studies, lifetime DV prevalence rates average 30% for outpatient settings, 33% for inpatient settings, and 60% for psychiatric emergency settings. Individual inpatient studies report significantly higher rates (*e.g.,* 70% of women admitted for a first psychotic episode and 90% of women admitted for suicidal ideation). Among women accessing substance use disorder treatment, 47%–90% reported experiencing DV in their lifetimes and 31%–67% in the past year. Furthermore, abuse targeting a partner's mental health or substance use are common forms of DV. These forms of abuse—referred to as mental health and substance use coercion—occur with disturbing frequency. Preventing a partner from accessing services, attempting to control providers' perceptions, and trying to obtain information about a partner's treatment to use against them, particularly in relation to child custody not only jeopardizes the well-being of DV survivors and their children, but also compromises the effectiveness of mental health and substance use disorder treatment.

Telehealth services are critical to ensuring that people who experience DV have access to needed mental health and substance use care. At the same time, DV survivors report consistent challenges to accessing care due to interference by abusive partners (*e.g.,* monitoring or listening-in to sessions, trying to prevent or disrupt participation, threatening the treatment provider). Behaviors such as tracking access to technology, monitoring phone and Internet usage, attempting to access electronic health records, impersonation, and location surveillance are common. Given the widespread adoption of telehealth services and efforts to support expanded access, it is crucial that telehealth services are both widely accessible and safe. Providing options and flexible access to services while maximizing safety, privacy and confidentiality are critical. Policies should allow for a wide range of telehealth modalities so that patients' evolving personal circumstances and/or lack of access to technology, internet, or sufficient broadband infrastructure are not limiting factors for safer access to services and do not exacerbate existing disparities.

Unauthorized access to personal health information places people who experience DV at substantial risk. It is crucial that providers mitigate the risk of the misuse of personal health information by employing technology and process safeguards that offer the strongest possible privacy protections for shielding sensitive information. HIPAA protections do not necessarily include enhanced security features that are critical for people at risk from disclosure of personal information. Therefore, mental health and substance use disorder treatment providers serving survivors of DV should be incentivized to use technology platforms that offer enhanced privacy protections (*e.g.,* protective segmentation and restricted provider/patient-only access to personal information, increased levels of encryption, advanced authentication tools with flags for when breaches occur, zero-knowledge encryption, as well as liability for unauthorized access). These protections are necessary in order to shield DV survivors from unauthorized disclosure and minimize the avenues through which access to personal information can occur. Given that DV is highly prevalent and treatment providers are often unaware that a patient is experiencing DV, a universal precaution approach is recommended.

NCDVTMH urges Congress to use this opportunity to ensure that where behavioral health and telehealth policy overlap that attention is paid to the importance of both increasing access to services and protecting patient safety. If both of these concerns are not addressed, DV survivors are put at greater risk when attempting to receive crucial services. We stand ready to be of assistance. Please feel free to contact Carole Warshaw, MD, Director of the National Center on Domestic Violence, Trauma, and Mental Health at cwarshaw@ncdvtmh.org should you have additional questions.

Enclosure:
Telehealth Recommendations to Support Survivors of Domestic Violence

Telehealth Recommendations to Support Survivors of Domestic Violence

Why Should Telehealth Policy Consider the Needs of Domestic Violence Survivors?

- *Domestic violence is common.* According to the Centers for Disease Control and Prevention, about 1 in 5 women, 1 in 10 men, and 26%–61% of LTBTQ individuals (43.8% of lesbian women; 61.1% of bisexual women; 26.0% of gay men; 37.3% of bisexual men; 25%–54% of trans individuals) have experienced violence and/or stalking by an intimate partner.
- *Domestic violence impacts health, mental health, and substance use disorder treatment systems.* In addition to the physical health impacts, over 50% of survivors of domestic violence have experienced depression, PTSD, substance use, and suicidality. Research over the past 35 years has consistently demonstrated that people receiving services in mental health and substance use disorder treatment settings also experience high rates of domestic violence.
- *Abuse targeted toward a partner's mental health or substance use is common.* Preventing a partner from accessing treatment, attempting to control providers' perceptions, and trying to obtain information about a partner's treatment to use against them—particularly in relation to child custody—are common forms of domestic violence.
- *Technological abuse is part of domestic violence.* Domestic violence survivors commonly experience tech abuse from abusive partners (*e.g.,* tracking access to technology, monitoring phone and internet usage, or location surveillance).

Key Policy Principles and Priorities

The National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) considers telehealth a valuable care delivery method for improving access to safe and timely services for survivors of domestic violence (DV) who need health, mental health, and substance use care. At the same time, given the safety risks survivors face, telehealth legislation should consider DV survivors as a special population with unique needs. Here are some specific principles and priorities to consider:

Flexibility Is Necessary to Provide Safer Access to More Comprehensive Services

Accessing services from home when an abusive partner is present poses safety, security, and privacy risks to DV survivors and to other household members. At the same time, abusive partners often interfere with DV survivors' ability to access in-person services. Providing options and flexible access to services while maximizing safety, privacy and confidentiality are critical. Policies should allow for a wide range of telehealth modalities so that patients' evolving personal circumstances and/or

lack of access to technology, internet, or sufficient broadband infrastructure are not limiting factors for safer access to services and do not exacerbate existing disparities.

- **Extend access of audio-only communications to all survivors of DV accessing mental health or substance use disorder-related telehealth services.** Many individuals in need of services are not yet established patients; therefore, limiting access to audio-only telehealth services to established patients only or requiring an in-person visit before accessing care via telehealth, could present insurmountable and life-threatening service barriers for survivors of DV. Additionally, the flexibility to extend the 6-month check-in to 12 months should not be limited to only existing patients.
- **DV survivor safety requires additional originating site flexibility.** While originating site restrictions have been largely removed for mental health and substance use disorder treatment, it is imperative that survivors are able to access necessary health, mental health and substance use care from any location in which they feel safe. This includes allowing established patients to receive care from their trusted providers—even if that location is not a "short distance" from their home.
- **Prohibit utilization management tools for mental health or substance use-related services.** Limiting the frequency of visits or restricting sites of service imposes unnecessary barriers to care and reduces the likelihood that DV survivors will be able to safely access needed services. Both of these obstacles place them at greater risk from abusive partners.
- Because survivors of domestic violence are at increased risk for experiencing a range of mental health and substance use-related conditions, **policies should ensure parity of access to all necessary services.**
  - Invest in culturally competent resources and translation/interpretation services to support availability of telehealth services for all, including people with disabilities, people with limited English proficiency, and people who are Deaf or hard of hearing.
  - Guarantee that services are available in-person, via telehealth, or a combination of both.

Ensure Telehealth Policy Addresses Safety, Privacy, and Confidentiality Needs of Survivors of DV

DV survivors report consistent challenges to accessing care due to interference by abusive partners (*e.g.,* monitoring or listening-in on sessions, tracking phone or internet usage, trying to prevent or disrupt participation, threatening the treatment provider, attempting to access electronic health records).[1] These tactics—known as mental health and substance use coercion—are part of a broader pattern of abuse and control designed to undermine a partner's sanity, trap them into using substances, control their ability to engage in treatment, sabotage their recovery, and use information about their mental health or substance use condition to discredit them with friends, family, service providers, and the courts. Threats related to child custody and retaliation for seeking help are additional tactics of control. Protecting the safety and well-being of DV survivors is a critical concern for Telehealth policy.

In order to minimize the risk of retaliation for disclosing abuse and to prevent the misuse of personal health information, telehealth policies should:

- **Grant survivors additional protections to shield sensitive information and engage in DV-specific informed consent** that addresses DV safety, privacy, confidentiality concerns; centers survivors' individual safety needs; and includes strategies to mitigate risks associated with disclosure of personal health information.
- **Maintain strict privacy and confidentiality protections** in all efforts to connect survivors to clinical and non-clinical services and supports.

Require Technology and Process Safeguards to Protect Survivor Safety

Unauthorized access to personal information places a survivor of DV at substantial risk. It is imperative that policies expanding access to telehealth require sensible and potentially life-saving safeguards.

- **Establish stricter privacy standards for telehealth technology platforms.** While HIPAA compliant telehealth platforms offer important privacy

[1] NCDVTMH, "Substance Use Coercion as a Barrier to Safety, Recovery, and Economic Stability: Implications for Policy, Research, and Practice," *http://www.nationalcenterdvtraumamh.org/publications-products/su-coercion-reports/*.

protections, HIPAA protections do not necessarily include enhanced security features that are critical for people at risk from disclosure of personal information. Therefore, healthcare, mental health and substance use disorder treatment providers serving survivors of DV should be required to use secure technology platforms that offer enhanced privacy protection (*e.g.,* protective segmentation and restricted provider/patient-only access to personal information, increased levels of encryption, advanced authentication tools with flags for when breaches occur, as well as liability for unauthorized access) in order to shield victims from unauthorized disclosure and minimize the avenues through which access to personal information can occur. Given that DV is highly prevalent and healthcare providers are often unaware that a patient is experiencing DV, a universal precaution approach is strongly advised.

- **Prohibit third-party vendors from accessing patient information.** Restrictions should include barring third-party vendors from being able to access, retain, data mine, or monetize personal information contained within the database they sell or support. To reduce access to sensitive information by anyone aside from the provider and patient, additional protections such as zero-knowledge encryption must be offered to providers by third-party vendors.
- **Require providers to receive training on safe use of telehealth,** including strategies to optimize safety, privacy, and access (*e.g.,* timing, location, headphones, code words, safety plans) and strategies to address potential technology monitoring concerns (*e.g.,* ensuring digital communications do not leave an online trail, enabling and rechecking privacy settings, using password protected devices and WiFi and/or obtaining secure devices for patients to use during telehealth encounters).
- **Require the incorporation of DV-specific safety, privacy, and confidentiality concerns into informed consent processes.**
- **Authorize a study to identify best practices for both providers and DV survivors to minimize privacy risks when using telehealth.**

If you have any questions, please contact Carole Warshaw, M.D., Director of the National Center on Domestic Violence, Trauma, and Mental Health, at cwarshaw@ncdvtmh.org.

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April 5, 2022

The Honorable Ron Wyden
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The Honorable Mike Crapo
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Dear Chairman Wyden and Ranking Member Crapo:

We write to share concerns regarding your March 30, 2022 hearing: "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration." The Partnership for Employer-Sponsored Coverage (P4ESC) is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and the over 181 million American workers and their families who rely on employer-sponsored coverage every day. We are committed to ensuring that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

We are concerned that this hearing—like so many others concerning access to mental health care—is wrongly and punitively focused on employers and other payers for health care and mental health care benefits. The bigger barriers to access to care come from acute shortages of mental health care providers and mental health care providers, many who refuse to enter our networks so that employees can access care. Telemedicine has been one positive exception to the shortages during the pandemic; it is our hope that telemedicine access to mental health care services can be made permanent.

Employers work tirelessly to provide quality mental health and substance use disorder coverage for our employees and their families. Employers have innovated and invested in significant new programs during the COVID pandemic. Addressing the current mental health care crisis will require significant efforts in partnership between employers, providers, government, patient groups and other stakeholders. We believe that punitive legislative provisions like civil monetary penalties will poison these efforts and serve only to hurt patients.

Employers and mental health care providers worked together to build the compromise that became the Mental Health Parity and Addiction Equity Act of 2008. Employers and providers worked closely with the late former Senators Edward Kennedy (D–MA) and Pete Domenici (R–NM) to build compromise language that balanced financial parity in coverage with health plan and insurer's retained ability to medically manage that coverage. It is this latter element—particularly as regards noneconomic factors, such as network adequacy, formulary design, and step therapy—that is at issue now.

Civil monetary penalty enforcement proposes to impose network adequacy requirements by penalizing employers based on the raw number of mental health or substance use disorder providers in network. Yet, employer networks consistently report that these providers refuse to bargain in good faith and decline to participate in our networks at reasonable rates. Provider shortages—inside as well as outside networks—are rampant. According to HHS, 129.6 million Americans live in areas designated as Mental Health Professional Shortage Areas.[1] There are 6,559 additional BHC providers[2] needed to fill these provider gaps.[3] Provider shortages, in conjunction with limited in-network providers, make it difficult for patients to find affordable in-network providers.

Additionally, employers and other issuers have repeatedly and earnestly urged the DOL's Employee Benefits Security Administration to provide adequate guidance regarding the applicable mental health parity standards.µ As evidenced by the DOL's recent 2022 MHPAEA Report to Congress in which NO plans were without findings under agency review—we believe the agency has failed to provide sufficient implementing guidance for any plan to truly comply.µ While we believe employers and other payers wish to comply, there is and will continue to be no way to do so without additional rulemaking guidance and time to come into compliance.

We implore you to call on the agency to work in partnership with all the stakeholders and provide additional guidance. Without this guidance we will continue to see the intent of MHPAEA inadvertently frustrated by well-intentioned employers and other payers who are trying to do their best in the absence of adequate agency implementation. We are concerned and wary of the defeating cycle of attempting to comply, but perpetually being found lacking because the rules are not adequate or clear.

We believe the call for civil monetary penalties is premature. Civil monetary penalties, at this point, will add unnecessary tension and fear into what we think should be a partnership to breathe life into the MHPAEA requirements in a fulsome and sustainable way. Penalties distract from and compound the absence of guidance and may make a confusing situation into chaos. Plans and payers are doing their best to build a house without adequate blueprints and calling for civil monetary penalties is like the designer standing on the sidewalk, yelling "you're doing it wrong," and then charging for design changes after the fact. It's not fair, efficient, or good for the system as a whole.

Imposing penalties on plan sponsors cannot solve provider shortages. The federal government should not put its thumb on the scale in private negotiations between providers and employers. In keeping with the spirit of the mental health parity law, employers should be treated on par with providers.

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[1] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health and Human Services, "Designated Health Professional Shortage Areas Statistics," September 30, 2021, available at: *https://data.hrsa.gov/Default/GenerateHPSAQuarterly Report.*

[2] Behavioral health providers are health care practitioners or social and human services providers who offer services for the purpose of treating mental disorders including: psychiatrists, clinical social workers, psychologists, counselors, credentialed substance use specialists, peer support providers, and psychiatric nurse providers.

[3] Bureau of Health Workforce Health Resources and Services Administration, U.S. Department of Health and Human Services, "Designated Health Professional Shortage Areas Statistics," September 30, 2021.

We would welcome the opportunity to discuss these issues with you or your respective staff. If such a meeting would be of interest to you, please have your staff contact P4ESC's Executive Director Neil Trautwein at eneiltrautwein@gmail.com.

Sincerely,

Partnership for Employee-Sponsored Coverage (P4ESC)

SMARTER HEALTH CARE COALITION
900 16th Street, NW, Suite 400
Washington, DC 20006

Statement of Andrew MacPherson, Ray Quintero, and Katy Spangler, Co-Directors

Chairman Wyden, Ranking Member Crapo, and Members of the Senate Finance Committee, it is our pleasure on behalf of the Smarter Health Care Coalition ("the Coalition"), to submit this testimony to provide input on the behavioral health care needs of the nation and how Congress can ensure that they are appropriately addressed through policy changes. The Coalition represents a broad-based, diverse group of health care stakeholders, including consumer groups, employers, health plans, life science companies, provider organizations, and academic centers. **We urge Congress to include the Chronic Disease Management Act of 2021** [1] **in the upcoming mental health package to improve access to critical mental and behavioral health prescription drugs and services.**

A key area of focus for the Coalition is ensuring patients have access to high-value health care services. Based on research conducted over several decades, many employers and health plans have changed their plan designs to remove cost-sharing for high-value drugs and services that treat populations with chronic conditions, who recent studies have suggested are more likely to also suffer from behavioral health disorders such as depression.[2] Regulatory and legislative barriers, however, have continued to inhibit some of these value-based plan designs. Specifically, Health Savings Account (HSA)-eligible plans have limited ability to offer services and medications to manage chronic conditions on a pre-deductible basis.

Guidance issued in 2019 by the Internal Revenue Service,[3] Notice 2019–45, was a helpful step in granting more flexibility to employers and health plans to offer certain chronic disease prevention pre-deductible, but more work remains. **The Chronic Disease Management Act of 2021 builds on and expands the flexibility included in Notice 2019–45 by granting health plans and employers more flexibility to vary their benefit designs and offer high-value care pre-deductible.** The rapid expansion of plans with high deductibles, in conjunction with the global COVID–19 pandemic, makes enacting this policy even more timely and important.

The COVID–19 pandemic has claimed more than 900,000 lives in the United States, and its stressors have exacerbated the behavioral health crisis, affecting thousands.[4] More than 42% of people surveyed by the US Census Bureau in December 2020 reported symptoms of anxiety or depression, an increase from 11% the previous year.[5] Notably, this crisis disproportionately affects certain populations, such as those that have historically been underserved within the health care system. Nearly half of all Black, Hispanic, Asian, Native American and LGBTQ+ individuals say they have personally experienced increased mental health challenges over the past 12 months, but few received treatment, according to a poll by the National Council for Mental Wellbeing.[6] For those who have tried to seek treatment, many are faced with challenges related to inaccessibility and unaffordability.

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[1] *https://www.congress.gov/bill/117th-congress/house-bill/3563/text?r=15&s=1#:~:text=Introduced%20in%20House%20(05%2F28%2F2021)&text=To%20amend%20the%20Internal%20Revenue,to%20satisfying%20their%20plan%20deductible.*

[2] *http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm.*

[3] *https://www.irs.gov/pub/irs-drop/n-19-45.pdf.*

[4] *https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.*

[5] *https://www.nature.com/articles/d41586-021-00175-z.*

[6] *https://www.thenationalcouncil.org/wp-content/uploads/2021/07/National-Council-Minority-Mental-Health-PPT-Analysis-July-2021-.pdf?daf=375ateTbd56.*

In 2013 mental disorders topped the list of most costly conditions, with spending at $201 billion.[7] Despite over 90% of general health care services being billed through insurance plans, an estimated 45% of psychiatrists do not accept any form of insurance and a much larger portion accept only a very limited set of plans.[8] The statistics illustrate the need for additional flexibility allowing employers and health plans to offer mental and behavioral health drugs and services pre-deductible for Health Savings Account-eligible plans.

Survey results from various publications have shown an overwhelming positive response to Notice 2019–45 in the form of employers and health plans making changes to their plan designs to cover more high-value services pre-deductible. The 2021 AHIP and Smarter Health Care Coalition survey found that 75% of health insurance plans responding covered additional services pre-deductible in their fully insured products and 80% of plans covered additional services pre-deductible in their self-insured products.[9] The 2021 Employee Benefit Research Institute (EBRI) survey of employers found three in four employers (76%) say that they have added pre-deductible coverage as a result of IRS Notice 2019–45.[10] These results highlight how much interest exists among health plans and employers to make it easier for their enrollees and employees with chronic conditions to access high-value health care that will prevent exacerbation of their conditions, especially those related to mental and behavioral health, including depression, anxiety, opioid use disorder, and many other conditions.

The Coalition greatly appreciates your leadership to improve access to health care services for Americans with mental health and substance use disorders. Given the overwhelming, positive response to Notice 2019–45, the very high number of employers and health plans who modified their benefits to make it easier for patients with chronic disease to afford care, as well as the nation's growing mental and behavioral health needs tied to COVID–19, we urge Congress to include the Chronic Disease Management Act of 2021 in the upcoming mental health package as one small step to improve access to critical mental and behavioral health drugs and services.

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April 7, 2022

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

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

Dear Chairman Wyden and Ranking Member Crapo:

SHRM (the Society for Human Resource Management) thanks you for your interest in expanding access to mental health services and holding the hearing titled "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration" on March 30. As the voice of all things work, workers and the workplace, SHRM is committed to preserving and improving critical employer-sponsored benefits like health care. However, we have concerns with proposals that have the potential to increase costs for both workers and employers rather than improving network adequacy and access to mental health providers.

The Mental Health Parity and Addiction Equity Act already requires that financial and treatment limitations applied to mental health and substance use disorder benefits and services are no more restrictive than for medical or surgical benefits and services. We believe there are better policies to expand access to mental health ben-

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[7] *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1659.*
[8] *https://jamanetwork.com/journals/jamapsychiatry/article-abstract/1785174.*
[9] *https://www.ahip.org/wp-content/uploads/202109-AHIP_HDHP-Survey-v03.pdf.*
[10] *https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_542_hsaemployersur-14oct21.pdf?sfvrsn=73563b2f_2.*

efits without imposing arbitrary and punitive fines. The committee should explore network adequacy, the talent pipeline for mental health providers and the ability of telehealth services to increase access to care.

SHRM appreciates that Congress recently restored the ability of employers to offer health plans that provide pre-deductible telehealth services for workers with high-deductible health plans and health savings accounts (HDHP–HSAs). This policy expires on December 31, 2022, and a permanent extension would provide both workers and employers the necessary certainty regarding the availability of these benefits. SHRM research shows that 43 percent of our members increased the telemedicine services available to employees during the COVID–19 pandemic and that health care is the employer-provided benefit that employers believe is the most important to their workforce.

SHRM and our members stand ready to be a resource for the Senate Committee on Finance in your work to expand access to mental health services. Please contact us any time we can be of assistance to the committee.

Sincerely,

Emily M. Dickens
Chief of Staff, Head of Government Affairs, and Corporate Secretary