The United States Senate Committee on Finance
"Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions"
June 15, 2021

Chairman Wyden, Ranking Member Crapo and members of the Committee:

My name is Dr. Benjamin F. Miller, and I am the Chief Strategy Officer for Well Being Trust, a national foundation started in 2016 through a gift by the Providence Health System that is focused on advancing the mental, social, and spiritual health of the nation.

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

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

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

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

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[1] https://www.dodig.mil/reports.html/Article/2309785/evaluation-of-access-to-mental-health-care-in-the-department-of-defense-dodig-2/
[2] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect10pe2018.htm
[3] https://www.gao.gov/products/gao-21-437r
[4] https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/

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

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

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

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

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

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

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

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

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

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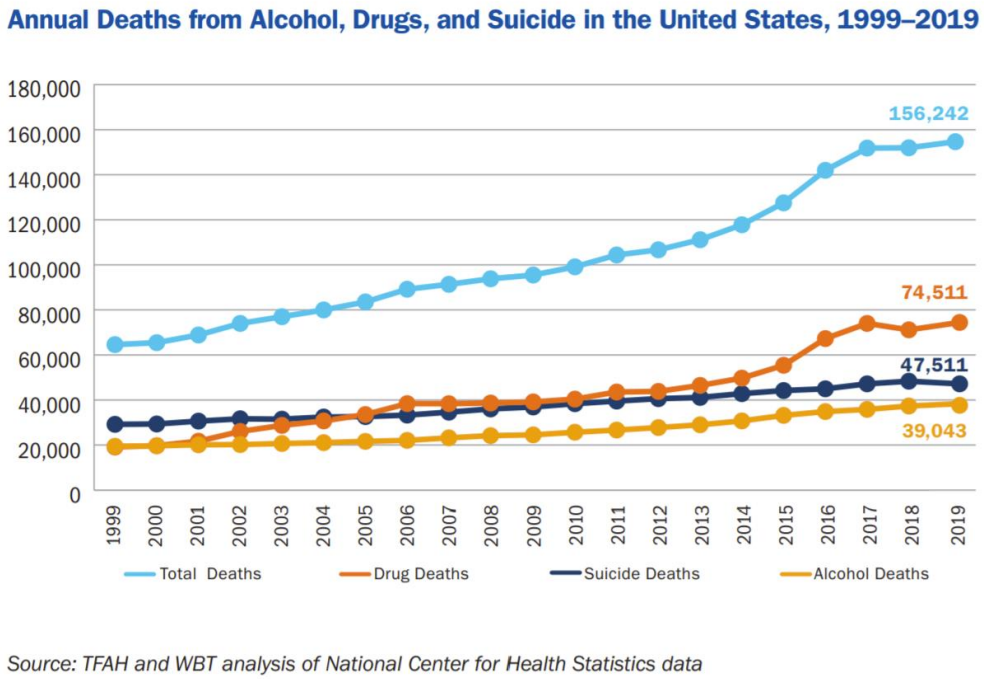
[5] https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC-MC-FINAL-Slide-deck-on-Mental-Health-Analysis-Poll.pdf

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

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

Context

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



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

A few things to note:

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

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

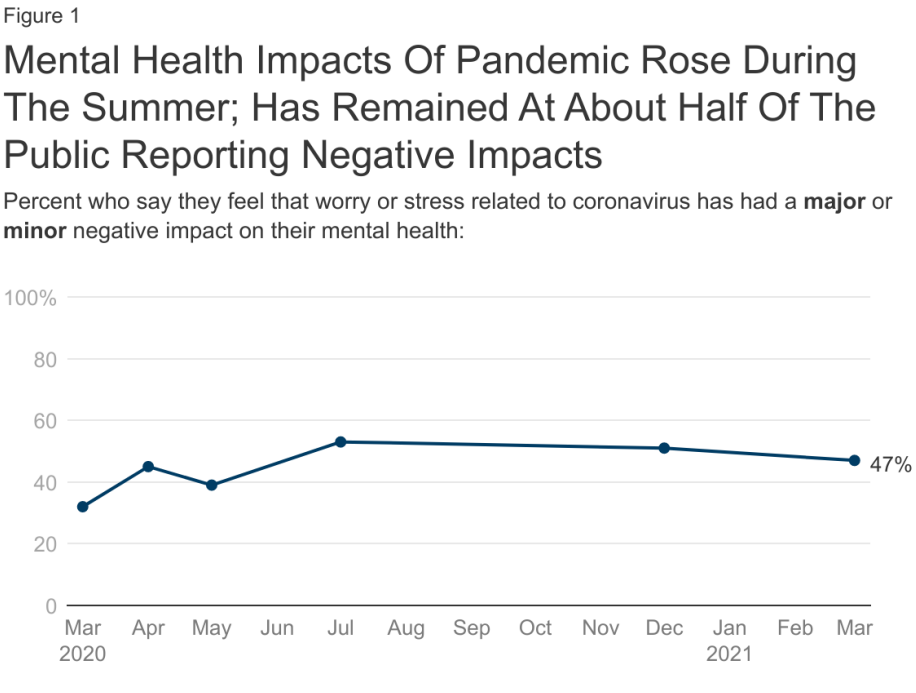
Finally, it's important to see these data points for what they are – a macro trend line going in the wrong direction. While the calculations are ongoing, the projections informed by the CDC data and others

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

suggest that our problems are only getting worse and are overwhelming communities. We must stop trying to see substance us disorder and mental, physical and behavioral health as separate issues – they are all interconnected. Assessing and addressing all is essential to achieve the outcomes and well-being we want for individuals and society as a whole. But in order for us to do this, and do this well, we need a system that can take care of all aspects of our health and not just the pieces. In fact, COVID-19 has given our nation an opportunity to see mental health for what it is – a foundation to our overall health and well-being.

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

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



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

Perhaps most concerning is the impact that COVID-19 has had on our kids and younger adults. Thirty one percent of 18–29-year-olds report stress has had a major impact on their mental health. Schools are

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

overwhelmed by the mental health needs of students but must make difficult decisions on where to invest their limited resources.

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

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

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

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

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

1. Reimagine care delivery

Mental health is local. We need to consider all the places that people show up with need and be prepared with a mental health response. From community settings like schools, and workplaces to

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

health delivery settings like primary care, one of the best ways we can begin to enhance access and more proactively address mental health needs is to integrate mental health.

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

Primary Care

Care for those seeking mental health services is fragmented in many of today's local systems, leaving even the most connected of people waiting for help. The issues that contribute to the problems in our current care delivery systems include: 1) unnecessary care limitations restricting where and how a person can get access to care; 2) referrals being the dominant intervention for mental health in most health care settings; and 3) care approaches remain fragmented with team-based interventions remaining an aspirational goal in most settings. Integrating mental health into primary care addresses all three of these issues head on.

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

Additional integration recommendations include:

- **Creating a definition for mental health and primary care integration.** The definition should allow for local adaptation and flexibility in how practices implement an integrated model of care. There are operational definitions that have been created, which may prove useful in this process.[20] The evidence for integration is that patients like it, clinicians like it, it saves money from total costs, the costs are currently borne by practices and are unsustainable.[21,22] The National Academies' report on Implementing High Quality Primary Care published last month with support from four federal health agencies, points to mental health integration in primary are as the team-based intervention most supported by evidence.

- **Fixing the financing of integrated mental health in primary care because practices typically bear the cost, one size will not fit all, and flexible financing options will allow for practices to**

[19] https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R02.pdf

[20] https://integrationacademy.ahrq.gov/products/lexicon

[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5698230/

[22] https://jamanetwork.com/journals/jama/fullarticle/2545685

create a model of care that works best for their community. I have offered an example below from Colorado.

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

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

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

They key? They have embraced a new model of care that pays for mental health differently in primary care settings. This model begins to take us away from traditional fee for service codes and embraces the power of what can happen when we push for flexibility in our financing that supports the concept of a team working in concert to improve health. A recent report from the National Academies reinforces this by recommending paying for primary care teams to care for people, not doctors to deliver services.[23] A forceful charge to move away from volume-driven payment mechanisms that may reinforce a siloed approach to mental health.

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

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

[23] https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care
[24] https://www.ohsu.edu/sites/default/files/2021-05/McConnell%20et%20al.%20Financial%20Integration%20of%20Behavioral%20Health%20in%20Medicaid.pdf

- **Assuring that our mental health workforce is trained and prepared to work in integrated settings.**

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

  To this end, the federal government could consider:

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

- **Providing technical assistance to primary care practices looking to integrate mental health.**

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

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

Schools

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

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

[25] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8118489/
[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6827672/

promoting the mental wellbeing of the students and addressing the needs of those with mental health conditions.

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

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

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

Congress can provide three major lanes of support to comprehensive school mental health programs:

- Providing funding via appropriations, grants, initiatives;
- setting up sustainable funding mechanisms and incentives ex: increasing the Medicaid federal Medicaid matching rate for school-based health services and working with schools to support their ability to bill Medicaid; and,
- Scaling up technical assistance centers and programs to provide ongoing support for implementation at the district and school levels.

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

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

2. Reconsider the Design and Capabilities of our Workforce

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

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

- 33% of those seeking care wait more than a week to access a mental health clinician;
- 50% drive more than one-hour round trip to mental health treatment locations;

- 50% of counties in the US have no psychiatrist;
- And only 16% of active psychologists are from minority populations despite comprising 40% of the US population[27]; and
- Only 10% of practicing psychiatrists are from underrepresented minorities.[28]

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

First, we can map out mental health utilization and gaps to better determine where services are needed and for whom.[29] We should look at where people are showing up for care and who is available to help. Without this important foundational step, we run the risk of widening disparities or putting money into places or programs people are not using.

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

Current workforce

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

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

- Increase funding for Medicare residency slots. Without this, it's nearly impossible to increase the number of clinicians like psychiatrists. Of note, parity implementation and enforcement may also help here considering that some clinicians eligible to bill for services may be under-reimbursed making it less desirable to fill a residency slot.

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[27] American Psychological Association. *Demographics of the U.S. psychology workforce: Findings from the American Community Survey.* Washington, D.C.2015.
[28] Wyse R, Hwang W-T, Ahmed AA, Richards E, Deville C. Diversity by Race, Ethnicity, and Sex within the US Psychiatry Physician Workforce. *Acad Psychiatry.* 2020;44(5):523-530.
[29] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00073-0/fulltext
[30] https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12229
[31] https://thinkbiggerdogood.org/enhancing-the-capacity-of-the-mental-health-and-addiction-workforce-a-framework/

- Make permanent 1135 waiver allowing Medicaid providers in another state to provide Medicaid services (though, state licensing laws still apply).
- Promote telehealth and other digital service options to expand the service reach of our existing medical professionals.
- Incentivize providers to take additional Continuing Medical Education (CME) classes on current mental health best practices.[1]
- Focus existing federally funded quality improvement organizations on mental health integration across diverse primary care practices and for serving diverse populations, and finance additional learning collaboratives as necessary.

Future workforce

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

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

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

- Develop non-medical multi-discipline community workforces to help address service requests that do not require a medical license to satisfy. Offering up payment mechanisms like Medicare to support critical services like peer support specialists would go a long way in strengthening this approach.
- Promote the use of innovative technologies like automated testing and screening platforms to reduce the requirements on medical professionals.
- Develop innovating payment methods and coverage designs like global payments to promote additional testing services from non-medical and technology platforms to better identify and improve access to the right care at the right time.

Community workforce

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

We must also recognize that there are never going to be enough clinicians to meet service demands. Even as we reform Medicare and Medicaid to help primary care better integrate mental health, we will still run into the issue of finding time to undergo trainings and recruit mental health professionals to join their practice in the short term. And in truth, many mental health needs people have are not going to be solved solely at a clinical level, e.g. housing, employment, etc. Of course we will need people to be able

[32] https://pubmed.ncbi.nlm.nih.gov/29914185/

to diagnose and prescribe, but we also need many more people to be able to teach important skills for navigating recovery or building a sense of community that supports people in times of crisis. Ideally, these skills would be spread out across many people and can mutually reinforce one another.

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

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

3. Modernize federal programming and operations strategies

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

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

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

Policymakers should consider reforms to key federal financing authorities as a means of promoting greater local control over how resources are programmed. At the same time, policymakers can improve how the federal government plans for and allocates funds to communities to help maximize on these critical investments and better justify new expenditures that might be required in the future.

Policymakers should consider:

- **Establishing a national strategy for how the federal government can establish "smart" or collaborative financing strategies to improve the efficiency of federal spending, leverage new uses of existing funds, and create better budgetary certainty for local communities.** The 21st Century Cures Act, which became law, contained provisions intended to establish such a strategy. Policymakers might consider steps already taken by the agency in response to the act to establish such a national strategy more quickly.

  In 2016, there was a Community Solutions Task Force that had a focus on solving major challenges facing communities.[33] Congress could use this as a model for mental health and ensure that in each policy it works on it specifically enables cross-agency and community-level collaboration.

- **Repositioning the Family First Prevention Services Act (FFPSA) and Community Mental Health Services Block Grant (CMHSBG) to act as lead funding authorities for the various acts with overall responsibility for managing and verifying performance aspects related to federal funds and other resource allocations meant to support the provision of mental health services within local communities.**

- **Requiring the federal government to regularly update the Committees of Jurisdiction in the House and Senate on the goals of the reformed financing process including progress against those goals.**

  While the resources provided for by the federal government are substantial, overly prescriptive federal requirements and lack of collaboration amongst the various federal authorities in charge of overseeing these resource allocations impede the ability of communities to use these resources effectively.

  As example, the Community Mental Health Services Block Grant (CMHSBG) requires communities seeking funding to "ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs." While community mental health centers play an important role, such requirements on local system performance unnecessarily tie the hands of officials struggling to manage growing service needs - especially in areas where solutions would otherwise exist except for federal regulation.

- **Reviewing the federal requirements under existing community mental health federal funding streams and considering easing requirements that unnecessarily impede care.**

- **Including program sustainability measures with new sources of funding or other resources meant to support the operation and modernization activities of local systems.**

  Modern federal laws like 988 promote modern programming strategies such as program sustainability best practices combined with local autonomy measures to ensure that local officials have sufficient freedom to establish successful and predictable local systems for individuals in need. The ability of local systems to improve their own systems operations

[33] https://obamawhitehouse.archives.gov/the-press-office/2016/11/16/fact-sheet-establishing-council-community-solutions-align-federal

through use of information sharing that leads to evidence development and best-practice adoption can help pave the way for continuous system improvement. Such a "system of learning" can provide federal policymakers and local officials greater ability to collaborate and plan for program modernization today and in the future.

- **Developing information-sharing and best practice development processes to provide local communities and federal policymakers insights into the need for and design of future reforms.**

While the above areas are the three priorities I have chosen to focus on for today – reimagine care delivery, reconsider the design and capabilities of our workforce, and modernize federal programming and operations strategies – outlined below are several other notable issues this committee should consider.

Other Issues & Recommendations to Consider

Mental health parity and health insurance coverage

- The Finance Committee could take aggressive steps to ensure parity enforcement in Medicaid managed care and expansion populations, which is critical to both mental health equity and racial equity. There could now be an opportunity to engage consumers in setting key indicators of access and track progress with intensive oversight from CMS/CCIIO.
- The Finance Committee could ensure parity be applied to Medicare and Medicare Advantage. This will require eliminating discrimination against MH/SUD that is baked into Title XVIII of the Social Security Act, and ensuring the full continuum of services are covered, including all intermediately levels of care.[34]
- The Finance Committee could require Medicaid and Medicare Advantage plans to follow Generally Accepted Standards of Care and use level of care criteria from non-profit clinical specialty associations as outlined in the federal case *Wit v. United Behavioral Health*.

988 and crisis response

- The Finance Committee could make the CAHOOTS enhanced match permanent and extend it to a comprehensive range of crisis services to create a continuum beyond response.
- The Finance Committee could make sure Medicare and commercial insurance plans cover crisis services and look to Medicaid crisis benefits as a model.

[34] https://www.realclearpolicy.com/articles/2020/12/30/medicare_must_cover_mental_health_654797.html