Bipartisan Policy Center

VIA ELECTRONIC SUBMISSION

November 15, 2021

Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

RE: In Letter to Behavioral Health Care Stakeholders, Finance Leaders Seek Input to Aid Bipartisan Policy Development

Dear Senate Finance Committee Staff:
In response to the request for input by Chairman Wyden and Ranking Member Crapo on areas relating to behavioral health care, the Bipartisan Policy Center would like to highlight BPC federal policy recommendations, including those in our March, 2021 report, *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*. The report presents a clear, pragmatic pathway to the integration of behavioral health and primary care, which enhances access to care for both pediatric and adult care, improves treatment outcomes, reduces health disparities, and can be cost effective.

Even before the COVID-19 pandemic, the unmet need for mental health and substance use services was alarming.[1,2] Indeed, less than half of adults with mental health conditions received services in 2019, and the percentage was even lower in Black and Latino communities.[3,4,5] As for substance use, nearly 90% of people with a substance use disorder did not receive treatment. These treatment gaps are in part because our behavioral health care system does not have the capacity to serve everyone who needs treatment and most primary care providers lack the training, financial resources, guidance, and staff to deliver integrated physical and behavioral health care services.

The situation worsened during the pandemic; symptoms of anxiety and depression among adults nearly quadrupled,[6] drug overdose deaths outpaced all previous records for a 12-month period,[7] and 25% of young adults seriously considered suicide over the period of a single month in 2020.[8]

Recognizing the strong connection between physical and behavioral health, BPC in 2020 convened the Behavioral Health Integration Task Force, co-chaired by former **Rep. Patrick J. Kennedy**; former **Sen. John E. Sununu**; **Sheila P. Burke**, fellow, BPC and chair, Government Affairs and Public Policy, Baker Donelson Berman & Berkowitz; and **Richard G. Frank**, Margaret T. Morris Professor of Health Economics, Harvard University.

The task force recommendations would make integration possible in both existing and new value-based payment structures. They would also improve the ability of primary care clinicians to handle some behavioral health needs of their patients by providing enhanced payments, training, and technical assistance, and improving access to behavioral health providers for consultation and referral. The recommendations would also address workforce shortages by permanently breaking down barriers to the use of telehealth services.

BPC contracted with Health Management Associates (HMA) to assess key task force recommendations and found that important proposals would both increase access to care and reduce federal spending.

The overall net cost of the report recommendations to the federal government is $2.2 billion over 10 years. That includes $6.9 billion in new federal spending and $4.7 billion in savings. The recommendations would benefit an estimated 1 million Americans.[9]

BPC appreciates the opportunity to provide comments in response to Chairman Wyden and Ranking Member Crapo's request for input from stakeholders. These comments reflect expertise and input from our health care leaders and a broad range of stakeholders. They do not represent official positions of BPC's founders or board of directors.

Executive Summary

Section 1: Strengthening Workforce (For greater detail, see page 6)

- **Create pathways to behavioral health and primary care Integration.** Integration would optimize the existing, inadequate workforce. It would improve screening for mental health and substance use conditions in primary care, treatment delivery for mild-to-moderate behavioral health issues through primary care, care coordination for patients who need more substantial services, and connection to behavioral health specialists when appropriate.
- **Expand the National Health Service Corps scholarship and loan repayment programs to include behavioral health professionals.** Also, expand employer eligibility to include a wider variety of behavioral health service sites, such as crisis intervention call centers, mobile response teams, and stabilization centers.
- **Use grants to improve workforce diversity.** Grants would support medical school partnerships with local organizations to create a pipeline for students at institutions with successful records of supporting diverse populations.
- **Establish tax credits to improve retention in rural and underserved areas.** A 5-year annual federal tax credit should be offered to physicians and advanced practice clinicians in rural and other health professional shortage areas. Loan repayment programs have helped with recruitment, but many providers don't remain in underserved areas without ongoing incentives.
- **Reimburse social workers for chronic care management services in Medicare.** Licensed social workers perform integral duties associated with quality chronic care management, including case management and administrative services, but are currently unable to bill for these services. HMA estimates that this recommendation would cost the federal government $113 million over 10 years.[10]
- **Consider covering Peer Support Specialists and other provider types under Medicare.**
- **Expand the health care workforce through interstate licensure portability.** Eliminate federal in-state licensure requirement for practitioners licensed in another state or expand the HHS secretary's authority to waive the requirement outside of a declared emergency. In addition, incentivize state participation in voluntary professional licensure compacts and adoption of a mutual recognition model with a single license for member states.

Section 2: Increasing Integration, Coordination, and Access to Care (For greater detail, see page 13)

- **Establish core, minimum standards essential for integration**. Define a core set of service elements, quality and performance measures, and health plan network performance standards that apply across payment and health systems.
- **Drive integration in new and existing value-based payment models.** Congress should provide financial incentives and require accountability to build integrated care into Medicaid MCOs, Medicare ACOs, and MA plans. Also, Congress should create a capitated, risk-adjusted payment model for primary care providers who treat mild to moderate behavioral health services.
- **Remove barriers to the Collaborative Care Model (CoCM) in traditional Medicare and Medicaid.**
    - For Medicare, increase the baseline value of the service and compensate for initial start-up costs. Congress should direct CMS to re-evaluate the codes to ensure adequate payment. Another option is to enact a one-time increase in payment codes by 75% in the first year of the policy for all practices using collaborative care, 50% in the second year, and 25% in subsequent years.
    - For Medicaid, Congress should direct HHS to provide detailed guidance to states on implementing the CoCM.
- **Create an 1115 waiver opportunity encouraging states to move provider practices toward integration through a value-based payment approach with incentives for providers that meet benchmarks for integration.** Congress should also consider a grant to states to support capacity building for behavioral health integration, particularly to help small independent.
- **Require states to describe in their managed care quality strategy how they will advance behavioral health integration.**
- **Reinstate the time and distance-to-provider standards for Medicaid network adequacy and require two additional quantitative measures.** These could include patient wait times, percent of providers accepting new patients, and ratio of patients to providers filing claims. HMA estimates that this recommendation would save the federal government $105 million over 10 years. This recommendation is estimated to add 800 to 900 additional behavioral health providers to Medicaid MCO networks, improving access for an estimated 500,000 to 800,000 enrollees.[11]
- **Increase the use of health information technology among behavioral health providers.** Create targeted funding to support adoption of ONC-certified electronic health records (CEHRT) among behavioral health providers and require vendors to include clinical decision support tools for behavioral health screening and common behavioral health terminology in CEHRT.
- **Direct an independent third-party to evaluate mobile health product effectiveness in real-world settings**.
- **Future rounds of the CCBHC demonstration should include a separate integration bonus payment available to CCBHCs and FQHCs that partner to meet escalating clinical outcome measures that reflect integration of behavioral health and primary care.** Also, require CCBHCs to report data by disadvantaged populations to identify disparities.

- **Require FQHCs to align with core integrated care measures and ensure accountability, particularly with respect to health disparities.**
- **Require greater coordination between CMS, HRSA, and SAMHSA to advance integration.**

Section 3: Ensuring Parity (For greater detail, see page 24)

- **Require Claims Transparency.** Labor and Health secretaries should require plans to publicly report comparative mental health and substance use disorder claims data versus medical claims.
- **Apply the 2008 parity law requirements to Medicare fee for service, Medicare Advantage, Medicaid fee for service, and alternate payment and delivery models.**
- **Improve network performance standards.**
    - Include time and distance standards
    - Consider telehealth, while considering relevant accessibility issues and patient choice
    - Are reported specifically for behavioral health providers
    - Include a uniform set of quantitative performance measures
    - Are transparent and publicly reported
    - Define adequate diversity and cultural competence

Section 4: Expanding Telehealth (For greater detail, see page 28)

- **Evidence demonstrates that the quality of tele-behavioral health services is generally equivalent to in-person care, and that telehealth could be particularly cost effective for individuals with high clinical needs (and less so as a triage tool and for low-acuity conditions).**
- **Cover Audio-Only Services with Guardrails.** Coverage for audio-only services has the potential to extend access to populations with technology-related barriers, but there is some concern it could lead to a two-tiered system in which disadvantaged beneficiaries receive audio-only care, while others receive video services. Of course, the exclusion of audio-only services also results in a two-tiered system in which some people have access to video services while other, disadvantaged populations, lack telehealth access altogether. To avoid exacerbating inequities, guardrail options include:
    - For providers in fee-for-service, limit audio-only services to established patients, unless a practitioner who has an established relationship with a patient attests to the need for audio-only services.
    - Lower reimbursement rate for audio-only services.
    - Require patient consent to bill for audio-only services. The decision to deliver audio-only services should be driven by the patient, not the provider.
- **Studies comparing in-person and video behavioral health services to audio-only services revealed evidence of little difference between modes in terms of therapeutic alliance** (cooperative relationship between patient and behavioral health provider), patient openness, empathy, attentiveness, or participation.
- **Paying at parity may encourage more providers to adopt telehealth, but then it is less likely telehealth will lead to lower overall spending.**
- **Consider building on current telehealth flexibilities for behavioral health care.** Options include:
    - Aligning face-to-face visit requirements for tele-behavioral health services when home is the originating site across all patient populations regardless of diagnosis or if the patient

lives in a rural area.
    - Extending tele-primary care services on a permanent basis with additional guardrails. Many mild-to-moderate behavioral health issues can and already are being addressed through primary care. Guardrails for this additional extension of tele-primary care services could include adding caps on visits delivered via telehealth, limiting flexibility to only FQHC or RHC providers, and/or imposing face-to-face or existing relationship requirements.
- **Structure payments differently for fee-for-service and APMs.** Options include:
    - Cap the number of visits allowed via telehealth with a given fee-for-service provider
    - Reimburse telehealth at the facility rate (or other rate discounted from in-person services)
    - Differ payments for Medicare telehealth providers who are accredited or credentialed

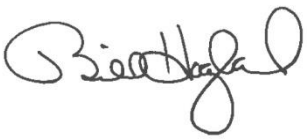
Section 5: Improving Access for Children and Young People (For greater detail, see page 36)

- **Update network performance standards across payers.** HHS should hold health plans accountable for time and distance standards and develop core network performance metrics for HHS regulated plans. These metrics should include a defined set of quantifiable measures, such as wait times, new patient acceptance, and failure to submit a behavioral health claim during the past six months.
- **Encourage behavioral health integration.** Integration in pediatrics would reduce the need for additional behavioral health specialists by making the most of the current workforce.
- **Medicaid MCOs, through which many children receive care, already has well-defined quality metrics, delivery standards, and payment methodologies through which integration can be applied, enforced, and incentivized.** Specifically, Congress should:

    - Direct HHS to provide early guidance and technical assistance to states and MCOs to help them prepare for upcoming FY 2024 congressionally mandated reporting requirements on Medicaid core measurement sets. The mandatory core set of behavioral health measures should include measures of behavioral health integration.
    - Direct HHS to review quality measurement initiatives, and through consultation with experts and stakeholders, identify key measures that highlight outcome disparities and encourage integration for populations with behavioral health conditions.
    - Direct HHS to require states to describe in their managed care quality strategy how the state will advance behavioral health integration.
    - Direct HHS to reinstate the time and distance-to-provider standards for Medicaid network adequacy and require two additional quantitative measures. Quantitative measures that HHS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period.
    - Encourage states to integrate behavioral health in Medicaid by supporting capacity building through a new grant program or 1115 waivers.
    - Direct HHS to include measures of behavioral health integration in the Medicaid MCO quality rating system and recommend that states set a minimum rating for performance measures.

- Ensure mental health and addiction parity in Medicaid and Medicare by expanding 2008 parity act provisions to all Medicaid fee-for-service and alternate payment and delivery models, Medicare fee-for-service, and Medicare Advantage.

Sincerely,



G. William Hoagland
Senior Vice President
gwhoagland@bipartisanpolicy.org
(202) 204-2420

Marilyn Serafini
Director, Health Project
mserafini@bipartisanpolicy.org
240-401-3514

Full Explanation of Recommendations

Section 1: Strengthening Workforce

The integration of primary and behavioral health care is critical to addressing the unmet need for mental health and substance use disorder services, partly by making better use of the existing workforce. Approximately 60%-80% of all primary care visits include a behavioral health component, yet many primary clinicians report feeling overwhelmed and ill-equipped to meet their patients' behavioral health needs. BPC's task force recommendations on integration would provide primary care providers with the necessary incentives and supports – along with accountability – to handle more mild-to-moderate behavioral health services. Importantly, the recommendations would improve primary care access to behavioral health specialist consultations, which would consume less specialist time than would referrals. Training initiatives and technical assistance for integration can help bridge the gap, ensure patients have access to culturally responsive care, and, together with reforms to federal reimbursement and workforce growth programs, help make integration possible.

- **What policies would encourage greater behavioral health care provider participation in these federal programs?**

  Behavioral health care professions are currently excluded from National Health Service Corps scholarships and should be added to the list of eligible provider types. In addition, employer eligibility criteria could be expanded to include a wider variety of behavioral health service sites, such as crisis intervention call centers, mobile response teams, and stabilization centers. In addition to financial incentives, increasing the size of the behavioral health workforce across provider types is critical to increasing participation in federal programs. Expanding funding for programs that improve the affordability of health care education, such as NHSC scholarship and Loan Repayment Programs (LRP), can reduce financial barriers for aspiring health care providers and increase both the primary care and behavioral health workforce. The NHSC Federal LRP provides loan repayment assistance to primary care clinicians in exchange for service in underserved areas, and includes licensed

behavioral health clinicians such as child and adolescent psychologists, licensed clinical social workers, and nurse practitioners in behavioral health specialties.

- **What barriers, particularly with respect to the physician and non-physician workforce, prevent patients from accessing needed behavioral health care services?**

  Many factors prevent patients from accessing needed services, including insurance coverage, the cost of care, limited availability of providers, and social factors, such as stigma, language barriers, and lack of cultural understanding by providers. These challenges, combined with the national rise in behavioral health conditions, increasing demand for services, and ongoing workforce shortages, make the integration of primary and behavioral health care critical to expanding access for those in need. Integration would improve screening for mental health and substance use conditions through primary care providers, treatment delivery for mild-to-moderate behavioral health issues, care coordination for patients who need more substantial services, and connection to behavioral health specialists when appropriate. However, additional training, technical assistance, financial resources, and staff are needed to support providers and practices in the transition to more integrated care models and to adequately prepare providers meet the needs of diverse populations. In particular, Congress should pass legislation to increase the behavioral health provider types covered under Medicare and require CMS to adopt measures that would facilitate behavioral health provider placement in integrated care settings. One provider type that should be considered for coverage under Medicare is peer support specialists. Peer support staff use their lived experience and training to help patients navigate care systems and sustain recovery. CMS should also consider reforms to allow licensed social workers to bill Medicare for chronic care management services. These reimbursement reforms can help accelerate the uptake of integrated care models and expand the availability of services for those in need by utilizing non-physician providers.

- **What policies would most effectively increase diversity in the behavioral health care workforce?**

  To expand and diversify the workforce, BPC recommends increasing financial support for programs that recruit diverse students into primary care and behavioral health professions and improve access to and affordability of health care education. These efforts should seek to improve representation across a variety of measures, including race, ethnicity, language proficiency, and geography, and ensure rural populations are included to ensure representation and participation in the behavioral health workforce. Options for consideration include grant funding to support partnerships between medical schools and local organizations to create a pipeline for the recruitment of students from underserved or underrepresented populations and internship programs that enhance recruitment of students from institutions with successful records of supporting diverse populations. In addition, increased funding for programs that improve the affordability of health care education, such as the National Health Service Corps Scholarship and Loan Repayment Programs (LRP) can be utilized to reduce financial barriers for aspiring health care providers. Increasing funding for LRPs and expanding scholarship eligibility would also improve the debt-to-income ratio of behavioral health providers, incentivize service in Health Professional Shortage Areas, and help health plans meet network adequacy standards by increasing the pipeline of available providers. Scholarship programs can play a particularly significant role in recruitment as students are able to take these financial incentives into consideration when weighing the costs and benefits of behavioral health career paths before enrollment. In addition, stakeholders report that

increased efforts are needed to educated students from underrepresented communities about career opportunities in behavioral health care, facilitate pathways to enrollment in educational programs, and support diverse students who are already in the field. Finally, current health care education training programs should be evaluated to consider financial and educational barriers to achieving a diverse workforce. This assessment should include funding mechanisms for graduate medical education and the effect of these investments on the supply and demographics of various types of providers, which can perpetuate disparities in access to and quality of care.

- **What federal policies would best incentivize behavioral health care providers to train and practice in rural and other underserved areas?**

  A combination of federal programs could have a synergistic effect on both recruitment and retention of providers in rural and other HPSA areas. While loan repayment programs, such as the National Health Service Corps, have been successful at recruiting clinicians, ongoing incentives are needed to retain providers in rural and underserved areas and decrease the risk relocation to non-HPSAs once financial incentives are no longer available. Housing is an important need in rural areas, for example. Therefore, federal initiatives should consider living conditions that may prevent providers from practicing in rural areas, such as housing shortages. With all of this in mind, BPC recommends establishing a federal tax credit for providers practicing in rural areas to augment the efforts of other federally-administered HRSA programs. A 5-year annual federal tax credit should be offered to physicians and advanced practice clinicians choosing to work in rural HPSAs. Under this model, federal dollars would only be spent if providers practice in rural HPSAs. The federal tax credit, for example $10,000, $15,000, and $20,000, should be tiered based on provider type. To ensure a consistently targeted benefit for underserved rural areas, the rural HPSA designation should be updated every five years. Some states have already successfully instituted such tax incentives. For example, Oregon established a Rural Practitioner Tax Credit in 1989, which offers an average of $8.5 million annually in tax credits for providers practicing in rural areas of the state. The $3,000, $4,000, or $5,000 annual tax credit is tiered – with those working farthest from an urban center receiving the maximum amount. New Mexico offers a $3,000 or $5,000 tax credit that prioritizes certain provider types. A 2016 review of relevant workforce programs in Oregon demonstrated that while the NHSC LRP was successful at attracting providers to the area, it had minimal effect on retention. Conversely, the Rural Practitioner Tax Credit increased the likelihood that a provider would stay in the area, but was not a significant tool for recruitment.

- **Are there payment or other system deficiencies that contribute to a lack of access to care coordination or communication between behavioral health professionals and other providers in the health care system?**

  Behavioral health integration depends on the use of health IT to provide the secure transfer of information to and from primary care settings. The exclusion of behavioral health providers from HITECH has led many to use EHRs without the functionality necessary for sufficient integration and interoperability. Ultimately, behavioral health providers have been slow to embrace them, which has created significant barriers to integration and interoperability.

  Congress should direct the secretary to create a targeted funding structure to assist behavioral health providers with startup costs, maintenance, and training for health information technology

(IT) in behavioral health settings to support health IT adoption and utilization by behavioral health clinicians. In 2018, Congress authorized CMMI to offer incentives to behavioral health providers for health IT use under Sec. 6001 of the SUPPORT Act.[12] The bipartisan CARA 2.0 Act further authorized additional funding for Section 6001.[13] Nevertheless, CMMI has not yet developed a pilot to implement the provision. Demonstration participants should be required to integrate behavioral health and primary care services and meet ONC certification and interoperability standards, including the universal Fast Healthcare Interoperability Resource API standards that enable data-sharing between all platforms. Grants should also support the use of lower cost, cloud-based EHRs and direct API sharing tools.

The secretary should require inclusion of common behavioral health terminology in EHRs and direct CMS or SAMHSA to provide crosswalks for the International Statistical Classification of Diseases and Related Health Problems and the Diagnostic and Statistical Manual of Mental Disorders sources to improve EHR performance for behavioral health providers. Currently, EHRs are not optimized for rapid documentation of behavioral health history, nor do they support access to relevant history across settings. Inclusion of universal behavioral health and social determinants of health terminology in coding standards is necessary to simplify documentation.

The Office of the National Coordinator for Health Information Technology (ONC) should require Certified EHR Technology (CEHRT) to include clinical decision support tools to simplify behavioral health screening in primary care settings. These tools should also provide screening reminders, offer recommendations for next steps based on screening scores, and track follow-up. Most CMS and CMMI payment models require the use of CEHRT, but behavioral health guidelines have not been sufficiently represented. **The secretary of HHS should add clinical decision support functionality to the EHR certification standards and require its inclusion in basic platforms at no additional charge to the consumer.**

Currently, CMS does not include licensed master-level social workers in the list of Medicare-covered providers approved to bill for chronic care management services. These professionals often perform integral duties associated with quality chronic care management, including case management and administrative services. However, their inability to bill for chronic care management services makes insufficient use of their skills in integrated care settings. To mitigate licensed social workers underutilization in integrated care settings, CMS should allow these professionals to bill Medicare for chronic care management services. While these licensed providers do not perform clinical services, they can be an asset to an integrated care team. Licensed nonclinical social workers are appropriately trained to deliver chronic care management services. Including nonclinical social workers as a Medicare-covered provider could help optimize the currently available workforce and create flexibility in the integrated care staffing model. Some experts argue this change could also allow licensed clinical social workers on integrated care teams to dedicate more of their clinical training to psychotherapy services. Allowing licensed social workers to bill Medicare for chronic care management services would require $113 million in direct federal spending over 10 years, according to HMA's analysis.[14]

One provider type that should be considered for coverage under Medicare are peer support specialists. Peer support staff are certified and trained at the state level and can be an asset to integrated care teams. These professionals use their lived experience and training to help patients

navigate care systems and sustain recovery, especially in patients with severe mental health conditions or substance use disorders. Evidence suggests that peer support services benefit staff as well, helping them to feel a greater sense of connectedness to the behavioral health care system. Recognizing these benefits among others, some payers already cover peer support services. As of 2019, 37 states cover peer support services through Medicaid. CMS has also clarified that the service can be covered under Medicare Advantage as a part of non-opioid pain management.

Peer support staff have proven to be a valuable tool for providers in improving patient-provider relationships and promoting shared decision making with respect to medications and treatment plans. In addition, adding peer support staff offers an opportunity to diversify the workforce to better reflect communities served by the primary care practices. Additional providers who should be considered for Medicare reimbursement include licensed marriage and family therapists and mental health counselors and licensed mental health counselors. To further facilitate integration, CMS should adopt measures that would facilitate provider placement in integrated care settings.

- **Which characteristics of proven programs have most effectively encouraged individuals to pursue education and careers in behavioral health care?**

Programs that improve access to and affordability of education are integral to efforts to expand the behavioral health care workforce. Increased funding for programs such as the National Health Service Corps (NHSC) Scholarship and Loan Repayment Programs (LRP) can be utilized to reduce financial barriers for aspiring health care providers, however, behavioral health care professions are currently excluded from NHSC scholarships and should be added to the list of eligible provider types. In addition, employer eligibility criteria should be expanded to include a wider variety of behavioral health service sites, such as crisis intervention call centers, mobile response teams, and stabilization centers. To make these programs available to more clinicians, additional funding is needed. As of April 2018, HRSA reported that, though the number of clinicians recruited through these programs had increased in recent years, applications for awards exceeded available funding and there were 4,605 open NHSC positions that could not be filled because the NHSC field strength was insufficient to meet the needs of sites eligible to receive an NHSC provider—a reflection of both the NHSC appropriation and the balance of loan repayment and scholarship awardees. Increasing funding for LRPs and expanding scholarship eligibility would also improve the debt-to-income ratio of behavioral health providers, incentivize service in Health Professional Shortage Areas, and help health plans meet network adequacy standards by increasing the pipeline of available providers.

- **Should federal licensing and scope of practice requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?**

State scope of practice and licensure requirements are often cited as impediments to interstate telehealth services. According to a 2018 report by the Federal Trade Commission (FTC) Economic Liberty Task Force, the associated administrative burden, extended application periods, and additive costs of multistate licensure prevent full use of the currently available workforce.[15] The task force recommended improving licensure portability by incentivizing state participation in voluntary professional licensure compacts or adoption of a mutual recognition model with a single license for member states.[16] While the role of states cannot be overstated, federal barriers exist.

Federal law requires providers be licensed in the state in which services are provided, as a condition

of reimbursement under Medicare, Medicaid, and CHIP. In response to COVID-19, the HHS secretary used 1135 waiver authority to temporarily suspend the federal in-state licensure requirement, when a provider is licensed in another state.[17] Although licensure remained under the purview of the states, all 50 states and the District of Columbia subsequently waived similar requirements for the duration of the public health emergency. Notably, the CMS has issued guidance recognizing licensure compacts for meeting federal licensure requirements.[18]

Interstate licensure compacts offer a streamlined and expedited licensure process for providers located in member states. Compacts are currently available for six health professions—medicine, nursing, physical therapy, psychology, audiology and speech language pathology, and emergency medical services. In March 2021, the Department of Defense announced a series of grants for the development of additional compacts, including for social workers and massage therapists, to assist military spouses with licensure portability.[19] In 2019, HRSA awarded the Federation of State Medical Boards a five-year grant to support the work of the Interstate Medical Licensure Compact, including funding to raise the profile of compacts through education and outreach. The grant also assists member states with the costs of conducting provider background checks. Despite incentives and funding, only 35 states are currently participating in compacts.[20]

Although licensure compacts are established through state legislation, federal law requires criminal background checks on all applicants within the compact. The FBI reviews the statutory language for each compact to ensure compliance with federal law before granting State Identification Bureaus the authority to perform the background checks. The FBI has withheld approval for a variety of reasons, including concerns regarding privacy and fingerprinting processes. The Interstate Medical Licensing Compact Commission has determined the specific concerns cited are expressly obviated by state legislative language. Moreover, denials have been issued for compacts with statutory language that is identical to that of previously approved compacts. The commission has requested greater transparency and guidance, as the inconsistency has resulted in administrative roadblocks to participation for some states.

To promote the provision of telehealth services across state lines, federal policy should build on the COVID-19 1135 waiver authority to remove federal barriers to licensure portability. Congress should either eliminate the federal in-state licensure requirement for practitioners licensed in another state, or expand the secretary's authority to waive the requirement outside of a declared emergency. While continuing to defer to the states of jurisdiction on licensure requirements, this would enable the secretary to improve access to providers in shortage areas. In addition, the United States Attorney General should direct the FBI to issue additional guidance for State Identification Bureaus regarding federal requirements for authorization to perform background checks. Alternatively, the FBI could approve sample legislative language, which it deems compliant with Public Law 92-544, for use by state lawmakers when drafting compact legislation.

There are several opportunities for federal leadership to promote interstate recognition of licensure. Policy options range from broad and disruptive to more moderate in nature.
To further accelerate the recognition of cross-state licensure, Congress could do for Medicare beneficiaries what has already been done for Veterans Affairs – mandate that any physician with a valid medical license be allowed to deliver services via telehealth to Medicare beneficiaries residing in any state.

Modeling prior legislation that mandated licensure reciprocity in the context of Veterans Affairs, Congress should consider:

- Allowing any physician with a valid medical license to deliver services via telehealth to Medicare beneficiaries residing in any state.
- Authorizing telehealth services for Medicare beneficiaries based on the location of the provider, rather than the location of the patient. This could apply to both issues of licensure as well as provider liability.

To minimize existing barriers to compact participation and incentivize more states to join, Congress and the administration should consider:

- Additional federal incentives to promote increased state participation in licensure compacts, such as further prioritizing future military investments by the Armed Services in states which participate in licensure compacts.
- Directing an impartial entity, such as the Government Accountability Office, to review existing health professional compacts and identify persistent barriers to provider and state participation, including, but not limited to, costs to providers and barriers to providers' exporting services out of state (especially to medically underserved areas).
- Additional federal incentives to promote increased adoption of telehealth-specific licenses or telehealth-specific exceptions to licensure, especially for behavioral health services, for states that continue to opt out of licensure compacts.

To promote interstate provider licensure recognition, federal leaders should also consider:

- Eliminating the federal requirement for Medicare, Medicaid, and the Children's Health Insurance Program providers to be licensed in the state where a patient receives services, when the provider is licensed in another state. Congress should either eliminate the federal in-state licensure requirement for practitioners licensed in another state or expand the HHS secretary's authority to waive the requirement outside of a declared emergency.
- Directing the Federal Bureau of Investigation to issue guidance to State Identification Bureaus regarding statutory requirements for authorization to perform background checks, as this has been a challenge for states. Alternatively, the FBI could approve sample legislative language for use by state lawmakers when drafting compact legislation.

- **What public policies would most effectively reduce burnout among behavioral health practitioners?**

In addition to the benefits for patients, integrated, team-based care may help prevent burnout for both primary care and behavioral health providers and improve quality of care and retention. In one study, behavioral health practitioners who worked primarily in fully integrated care settings reported higher rates of personal accomplishment in their everyday job and those who worked more than 10 years in these types of settings reported both higher personal accomplishment and lower rates of depersonalization. Therefore, public policies that incentivize and enable the transition to more integrated models of care by providing financial support, training, and technical assistance,

and promoting the use of technology and telehealth to support integrated care may aid also in reducing burnout among practitioners.

Section 2: Increasing Integration, Coordination, and Access to Care

Comorbid behavioral and physical health diagnoses are common, particularly among individuals enrolled in Medicaid and Medicare. According to CMS, more than half of the Medicaid enrollees in the top 5% of expenditures who had asthma or diabetes also had a behavioral health condition. Similarly, about 80% of Medicare beneficiaries with a behavioral health diagnosis had at least four additional physical comorbidities from 2010-2013. Addressing physical and behavioral health diagnoses together through integration can provide a patient-centered approach that can be cost-effective for payers and providers, reduce health disparities, and improve patient outcomes.

The task force recommendations emphasize the need to both incentivize primary care and behavioral health providers to participate in integration models and hold them accountable for meeting key quality and performance metrics. The recommendations also build upon overall health care trends, including the increased use of such value-based models as Medicare Advantage (MA) plans, accountable care organizations (ACOs), and Medicaid managed care organizations (MCOs), and highlights the enhanced ability to drive policy change through these structures.

- **What are the best practices for integrating behavioral health with primary care? What federal payment policies would best support care integration?**

  Establish core, minimum standards essential for integration
  To advance integration, BPC recommends that Congress first establish a strong foundation for integration. Currently, there is no standard definition of integrated care across private and public health programs, nor are there core service and quality standards. In addition, current network adequacy standards do not ensure access to behavioral health providers for many health plan enrollees, as providers may not have availability or be taking on new patients. To address these challenges, **Congress should direct the HHS secretary to define a core set of service elements, quality and performance measures, and health plan network performance standards that apply across payment and health systems.** Together, these reforms would improve accountability for integrating care and ensure enough behavioral health providers are available to provide services.

  Drive Integration in New and Existing Value-based Payment Models
  Value-based payment models have structural elements that make them an ideal home for integration. Existing payment structures in Medicaid MCOs, Medicare accountable care organizations, and Medicare Advantage plans already have well-defined quality metrics, delivery standards, and payment methodologies through which integration can be applied, enforced, and incentivized. To leverage these existing models, **Congress should provide financial incentives and require accountability to build integrated care delivery into existing payment models for Medicaid MCOs, Medicare ACOs, and MA plans**. Additionally, **Congress should create a capitated and risk-adjusted payment model for primary care providers who treat mild to moderate behavioral health**

services. Specifically, as described in more detail in BPC's report, the following recommendations would help drive integration in new and existing value-based payment models.

- **Congress should incentivize integration in Medicaid managed care contracting by:**
  - Directing the HHS secretary to provide early guidance and technical assistance to states and MCOs to help them prepare for upcoming FY 2024 congressionally mandated reporting requirements on Medicaid core measurement sets. The mandatory core set of behavioral health measures should include measures of behavioral health integration.
  - Directing the HHS secretary to review quality measurement initiatives, and through consultation with experts and stakeholders, identify key measures that highlight outcome disparities and encourage integration for populations with behavioral health conditions.
  - Directing the HHS secretary to require states to describe in their managed care quality strategy how the state will advance behavioral health integration.
  - Directing the HHS secretary to reinstate the time and distance-to-provider standards for Medicaid network adequacy and require two additional quantitative measures. Quantitative measures that CMS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period. HMA estimates that this recommendation would save the federal government $105 million over 10 years. This recommendation is estimated to add 800 to 900 additional behavioral health providers to Medicaid MCO networks, improving access for an estimated 500,000 to 800,000 enrollees.[21]
  - Encouraging states to integrate behavioral health in Medicaid by supporting capacity building through a new grant program or 1115 waivers.
  - Directing the HHS secretary to include measures of behavioral health integration in the Medicaid managed care quality rating system and recommend that states set a minimum rating for MCOs on performance measures.
- **Congress should incentivize integration in the Medicare Shared Savings Program by:**
  - Updating the Affordable Care Act to include behavioral health in the Medicare Shared Savings Program requirements.
  - Directing the HHS secretary to include integration in the Medicare Shared Savings Program ACO quality performance standards. HMA estimates that this recommendation would save the federal government nearly $800 million over 10 years.[22]
  - Directing the HHS secretary to provide financial incentives for high-performing ACOs to exceed the Medicare Shared Savings Program performance standards for behavioral health integration. HMA estimates that this recommendation would save the federal government $3.8 billion over 10 years.[23]
- **Congress should incentivize integration in Medicare Advantage by:**
  - Directing the HHS secretary to revise the Medicare Advantage performance rewards system (STAR ratings) to add behavioral health integration measures.
  - Directing the HHS secretary to add and align network performance standards across programs. HMA estimates that this recommendation would cost the federal government $2.3 billion over 10 years, with an increase between 100,000 and 150,000 people receiving behavioral health support.[24]

  - Directing the HHS secretary to include sufficient behavioral health measures in the Medicare Advantage performance rewards system.
  - Directing the HHS secretary to add additional behavioral health conditions to the Hierarchical Condition Categories for risk adjustment.
- **Congress should incentivize integration at the practice level by:**
  - Directing the HHS secretary to create a novel payment model that allows primary care providers to cover the full range of primary care and mild to moderate behavioral health services under enhanced risk-adjusted capitated payments in traditional Medicare. HMA estimates that this recommendation would serve between 200,000 and 800,000 Medicare beneficiaries and cost the federal government $2.9 billion over 10 years.[25]
  - Providing funding for a forgivable-loan program to assist individual providers and small primary care practices with the upfront costs of implementing behavioral health services, and directing the HHS secretary to implement the forgivable loan pilot.
  - Directing the HHS secretary to include additional behavioral health integration measures into Medicare's Merit-based Incentive Payment System (MIPS) to incentivize behavioral health provider participation in integrated care.
  - Removing Barriers to Adoption of the Collaborative Care Model (CoCM) (see Collaborative Care Model Background below).
  - Directing the HHS secretary to provide detailed guidance to states on implementing the collaborative care model in Medicaid. (see Collaborative Care Model Background below).

Collaborative Care Model Background

The National Institute of Mental Health and other researchers have extensively studied the CoCM, which is defined by five core principles: patient centered team care, population-based care tracked in a registry, measurement-based treatment to target, evidence-based care through psychotherapies and medication, and accountable care for quality, not just quantity. The Improving Mood: Promoting Access to Collaborative Treatment study demonstrated that the benefits of collaborative care management were significant when compared to traditional interventions. At 12 months, 45% of participants receiving collaborative care experienced at least a 50% reduction in depressive symptoms, compared with only 19% of those in usual care. In addition, a later study of cost data showed that mean health care costs for participants of the intervention group were $29,422 per person—a 10% cost savings when compared to $32,785 for individuals in the control group. Collaborative care is also an important tool for advancing behavioral health equity. Multiple studies have found that collaborative care reduces health disparities. Given this evidence, Medicare developed codes for the CoCM that capture core elements of integrated care. Additionally, in a 2018 letter to state Medicaid directors, CMS identified the CoCM as an evidence-based approach to behavioral health integration that states may implement in Medicaid through several existing authorities.

To advance this model in traditional Medicare and Medicaid, Congress should remove barriers to the adoption of CoCM in these programs:

Medicare – Providers are reimbursed for up to 70 minutes of work for the first month of CoCM services and 60 minutes for subsequent months. For more complicated or time-consuming patients, add-on codes for additional 20 or 30 minutes of service time may be billed in some settings. However, stakeholders have reported an inability to meet upfront and additional staffing costs at the current reimbursement rates. Start-up costs and insufficient reimbursement have been identified as the principal barriers to the CoCM. A recent study of primary care practices found that the codes reimbursed for some, but not all, of the integrated care activities. Reimbursement should more adequately reflect the work required to provide the service**. Both an increase to the baseline value of the service and compensation for initial start-up costs could encourage uptake of CoCM. Congress should direct CMS to re-evaluate the codes to ensure adequate payment to incentivize practices to participate.** The American Psychiatric Association (APA) has recommended a 75% increase to the current Medicare payment for CoCM billing codes in the first year, a 50% increase in the second year, and 25% in subsequent years. CMS should evaluate evidence from APA and other sources and adjust the payment to increase take up of this evidence- based intervention. This adjustment would help cover the start-up costs associated with staffing, workflow, and infrastructure changes, and encourage practices to adopt this evidence-based practice.

When estimating the costs, HMA used the APA percentages and noted that given the difficulty for CMS to track when a practice is in its first or second year, another option would be **to enact a one-time increase in the payment for the codes by 75% in the first year of the new policy for all practices using collaborative care, 50% in the second year, and 25% in subsequent years.** This would encourage practices to begin using the codes to receive the higher payment for a limited time. HMA estimates that the cost of this would be $152 million over 10 years. This cost would vary depending on the CMS analysis and adjustment of rates.

FQHCs are safety-net providers that receive set reimbursement amounts to care for patients, regardless of complexity. FQHCs may bill for CoCM services at 70 or 60 minutes, but they are not permitted to bill for any additional service time. To adequately reimburse FQHCs for caring for a high-need population, **Medicare should eliminate this restriction to allow them to bill the add-on codes**, which HMA estimates would have a minimal cost of $2.3 million over 10 years.

Beneficiary cost-sharing responsibility and the need for patient consent has also resulted in limited uptake of CoCM services because it is difficult to relay to patients the value of non-face-to-face services. By exempting beneficiaries from co-insurance responsibility and the need for additional consent for these preventive services, the provision of CoCM services would increase. **CMS currently does not require any cost sharing or co-insurance for bundled opioid treatment provider services and should apply the same policy for collaborative care services to encourage usage.** HMA estimates that eliminating the co-payment would increase costs by $70 million over 10 years. The total cost of this recommendation would be $224 million over 10 years.[26]

Medicaid – **Congress should direct the HHS secretary to provide detailed guidance to states on implementing the CoCM in Medicaid.** In the 2018 letter to state Medicaid directors, CMS briefly described the CoCM and listed the potential Medicaid authorities and payment strategies that states could use to implement that model. While this was a valuable step in increasing states' awareness and coverage of the CoCM in Medicaid, more detailed guidance and direction is needed from HHS to increase adoption of the model and reimbursement for the collaborative care codes. Currently, only

17 states reimburse for the collaborative care codes and most of those states activated the codes in 2019. HHS guidance should also encourage states to review coverage of collaborative care as part of their parity compliance to ensure they are applying the same evidentiary standard to coverage.

- **What programs, policies, data, or technology are needed to improve access to care across the continuum of behavioral health services?**

Encourage states to integrate behavioral health in Medicaid by supporting capacity building through a new grant program or section 1115 waivers.
States report that the upfront investment costs for behavioral health integration serve as a barrier for those interested in increasing integration. Without additional resources, many states simply will not be able to invest in delivery system reforms—including advanced value-based payment arrangement initiatives—to increase behavioral health and primary care integration.

Congress should direct the HHS secretary to create a new 1115 waiver opportunity that encourages states to move provider practices toward integrated care through a value-based payment approach with incentives for providers that meet benchmarks for integrated care.
Lessons learned from other 1115 waiver programs can help inform the design of this new 1115 waiver opportunity for behavioral health integration. For example, in accordance with the strategies identified as effective for integration by CMS' independent contractors, the demonstration should encourage states to: foster integration and collaboration at the state level across agencies; address state regulatory barriers to data sharing; allow flexibility to target specific patient populations; include requirements for provider collaborations that support integration; address workforce capacity by supporting overall supply or increasing reliance on community health workers, peer specialists, or others; include integration expectations in MCO contracts; and provide guidance on how to sustain demonstration activities.

To support state implementation of this waiver opportunity, CMS should offer technical assistance to states. It should also authorize federal matching payments for designated state health program expenditures to address barriers to state participation in a budget neutral way. To address CMS' concerns that states were not making a comparable increase in state investment,[27] and the Government Accountability Office's (GAO) concerns focused more broadly on the need for more consistent and transparent criteria for expenditures under 1115 waivers,[28] CMS could encourage states to make a comparable investment and require that state savings generated by state health programs be dedicated to behavioral health integration. CMS could also develop consistent and transparent criteria for determining whether federal match for designated state health programs is likely to promote the objectives of the Medicaid program. How the criteria are satisfied could be documented in the waiver approval.

Congress should also consider establishing a grant to states to support capacity building for behavioral health integration, particularly to help small independent practices integrate care.
States that participated in the Center for Medicare & Medicaid Innovation's (CMMI's) State Innovation Models (SIM) initiative received awards to advance multi-payer health care payment and delivery system reform models.[29] CMS awarded almost $300 million for 25 states to either design or test their models in the first round of SIM from 2013 to 2018.[30] CMS awarded $660 million to 32 states or territories in the second round of SIM from 2015 to 2020.[31] Several states included a focus

on improving behavioral health integration[32] and invested SIM resources in the infrastructure needed to support provider performance under the model.[33] This included investment in capabilities for health information technology (IT), data analytics, and technical assistance.[34] The fifth annual independent evaluation of SIM in 2018 reported that infrastructure investments including technical assistance, learning collaboratives, and peer-to-peer learning opportunities were important for improving behavioral health integration.[35] Other states interested in pursuing integration would likely need to make similar investments in infrastructure and capacity building. Establishing a grant to states to support capacity building for behavioral health integration, which would require congressional action, would support the adoption and success of integration.

Direct the HHS secretary to require states to describe in their managed care quality strategy how the state will advance behavioral health integration.

Under federal rules, states contracting with an MCO must establish a state quality strategy for assessing and improving the quality of care and services provided by the MCO.[36,37] The state quality strategy must include state- defined network adequacy and availability of services standards for MCOs, the state's goals and objectives for continuous quality improvement, a description of quality metrics and performance targets that will be used to measure MCO performance and improvement, a description of performance improvement projects, and the process for independent reviews of MCO performance, among other requirements.[38] The quality strategy, however, is not currently required to address behavioral health integration. To support the coordination of clinical and behavioral health services, CMS should require states to describe in their quality strategy how the state will work with MCOs, any subcontracted entities, and, if applicable, the behavioral health agency in the state to advance behavioral health integration. CMS should work with states to ensure that they have appropriate time to meet this new requirement.

Direct the HHS secretary to reinstate the time and distance-to-provider standards for Medicaid network adequacy and require two additional quantitative measures. Quantitative measures that HHS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period.

In November 2020, CMS released a final Medicaid managed care rule that replaced the time and distance standard with a new, broader quantitative network adequacy standard for providers.[39] Under this rule, states could meet the new requirement by either keeping their time and distance standard or replacing that measure with any quantitative standard. While some stakeholders generally favor the quantitative standard, others that generally favor time and distance standards have expressed concern that a broader quantitative standard could impact access to care for medically underserved regions, such as rural areas. Some stakeholders have also raised concerns that providers who are only available to deliver care virtually are not truly available to meet patients' needs. The new rule also preserves the 2016 requirement that states consider the availability and use of telehealth when developing their network adequacy standards. CMS defers to each state to determine the criteria to be applied to telehealth providers and how such providers will be taken into account when evaluating network adequacy.[40] In the final rule, CMS also reminds states and health plans to be mindful of their responsibilities for mental health and addiction parity in subpart K of 42 CFR § 438 in selecting measures for network adequacy, network development, and evaluation.[41]

To more accurately reflect access to behavioral health providers, HHS should revise the rule to reinstate time and distance to provider standards and should require two additional quantitative measures that would apply across states. Given that Medicaid MCOs are subject to parity requirements, a federal set of network adequacy requirements would promote national compliance. Quantitative measures HHS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period.

HMA estimates this policy change would result in $105 million in federal savings over 10 years, an additional 800 to 900 behavioral health providers in MCO networks, and improved access for approximately 500,000 to 800,000 Medicaid managed care enrollees.[42]

- **What programs, policies, data, or technology are needed to improve patient transitions between levels of care and providers?**

Optimize health information technology for behavioral health care
Behavioral health integration depends on the use of health IT to provide the secure transfer of information to and from primary care settings and support a seamless transition of care across settings. While patient medical health information is primarily shared using health IT meeting interoperability standards, behavioral health settings often lack the electronic health record (EHR) capabilities of more robust systems. The absence of financial incentives may have influenced behavioral health providers, leading them to purchase less expensive platforms lacking the functionality necessary for sufficient integration and interoperability. As a result, EHRs were not optimized for rapid documentation of behavioral health history, nor do they support access to relevant history across settings. Behavioral health integration will not only depend on behavioral health provider adoption of EHRs, but also on the availability of technology that meets interoperability standards and supports the secure transition of information to and from primary care settings.

Provide targeted funding to support health information technology adoption and utilization by behavioral health clinicians.
Congress should direct CMMI to create a targeted funding structure to assist behavioral health providers with startup costs, maintenance, and training for health IT in behavioral health settings. Demonstration participants should be required to integrate behavioral health and primary care services and meet ONC certification and interoperability standards, including the universal Fast Healthcare Interoperability Resource application programming interface (API) standards that enable data-sharing between all platforms. Grants should also support the use of lower cost, cloud-based EHRs and direct API sharing tools.

Require inclusion of common behavioral health terminology in EHRs.
Current EHRs do not support rapid documentation of behavioral health history or access to relevant social and medical history. Inclusion of universal behavioral health and social determinants of health terminology in coding standards is necessary to simplify documentation. The International Statistical Classification of Diseases and Related Health Problems does not mirror the language used in the Diagnostic and Statistical Manual of Mental Disorders. Congress should direct the secretary of HHS to provide crosswalks for these sources to improve EHR performance for behavioral health providers.

Require Certified EHR Technology to include clinical decision support tools for behavioral health screening.
The Office of the National Coordinator for Health Information Technology (ONC) defines the standards for certification of EHR platforms, ensuring a minimum functionality for recording and sharing patient information. Most CMS and CMMI payment models require the use of CEHRT, but behavioral health guidelines have not been sufficiently represented. Clinical decision support tools can be utilized for behavioral health screening by providing screening reminders, offering recommendations for next steps based on screening scores, and tracking follow-up.[43] Congress should direct the secretary of HHS to add clinical decision support functionality to the EHR certification standards and require its inclusion in basic platforms at no additional charge to the consumer.

Include mobile health technology when assessing interoperability in the Medicare Quality Payment Program.
Congress should direct the HHS secretary to recognize apps that enable access to or data sharing with EHRs under the Promoting Interoperability category of the Quality Payment Program. These activities should be progressively valued, through category bonus points, final score bonus points, and, ultimately, be a minimum requirement for reporting under the Promoting Interoperability category. Congress should also direct the HHS secretary to require ACOs, MA plans, Medicaid MCOs, and others providing integrated behavioral health care to report on measures that capture mobile health and EHR interoperability.

The use of mobile technology can both improve the patient experience and simplify access to patient data. Providers can utilize third-party behavioral health apps to produce actionable information about patients. For example, providers regularly employ remote patient monitoring to offer additional data and this qualifies as an Improvement Activity for the CMS Quality Payment Program.

According to a 2019 HealthMine survey of 800 Medicare Advantage patients, 18% of respondents are using a smart device to augment health care.[44] However, only 9% of those using mobile health reported that their health plan was incorporating the data into their medical record.[45] To encourage the incorporation of mobile health data within integrated care models, the use of behavioral health products that support information sharing with EHRs should be similarly leveraged. In addition, applications offering direct patient access to EHRs without the need of a desktop computer should also be encouraged.

Direct an independent third-party to evaluate mobile health product effectiveness in real-world settings.
The American Psychiatric Association has developed a method for assessing patient-specific appropriateness of various applications. However, the true value of mobile health products on patient outcomes is unclear. Because the Food and Drug Administration has exercised its discretion to not monitor claims of effectiveness for third-party behavioral health apps, Congress should require an independent third-party review of applications to ensure claims of effectiveness are legitimate. The evaluation should be performed in real-world patient settings and define a minimum

standard for claims of effectiveness. The information can then inform the development of clinical practice guidelines for use.

Incentivize CCBHCs and FQHCs to strengthen integration of behavioral health and primary care through a voluntary integration bonus payment.
Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA) authorized a state-implemented CCBHC demonstration to improve community behavioral health.[46] To ensure seamless patient transitions across the full spectrum of health services, PAMA requires CCBHCs to coordinate care across settings and providers by having partnerships or formal contracts with FQHCs to the extent that those services are not provided directly through the CCBHC. PAMA also allows CCBHCs to establish formal relationships with other providers, such as FQHCs, to deliver certain required services that are not available directly through the CCBHC. When a CCBHC contracts with an FQHC in this way, the FQHC is known as a designated collaborating organization (DCO). In 2018, about 87% of CCBHCs reported having any relationship with FQHCs, 3% reported a DCO relationship with an FQHC, and 60% reported some other formal relationship with FQHCs. Congress should further encourage and strengthen integration between CCBHCs and FQHCs beyond care coordination and DCO contracts. Formal partnerships for integration between CCBHCs and FQHCs have the potential to provide a more comprehensive range of services and improve care delivery for those with both physical and behavioral health diagnoses. These partnerships would encourage an integrated team-based approach to care and co-locating.

Future rounds of the CCBHC demonstration should include a separate integration bonus payment available to both CCBHCs and FQHCs that partner to meet escalating clinical outcome measures that reflect integration of behavioral health and primary care.
The bonus payment for meeting the integration performance measures should be in addition to, and not a withhold from, the prospective payment rates the clinic and health center each receive. In establishing the integration bonus payment, Congress should consider DCO relationships and should address any barriers to FQHCs receiving that bonus payment when serving as a DCO.

The bonus payment would operate similarly to the quality bonus payment, but with a few key differences. While the quality bonus payment was available only to CCBHCs, this integration bonus payment would be available to both CCBHCs and FQHCs that partner to meet integration performance measures. CMS allows states to design the criteria and payment amounts for the quality bonus payments, and states provide the funding for the quality bonus payment through state general revenue or state appropriations. In contrast, demonstration states would receive federal funding for the integration bonus payment. The amount of this integration bonus payment should be comparable to the value of the quality bonus payment. For comparison, states made on average, roughly $2 million available to CCBHCs for the quality bonus payment. The lowest amount was $350,000 and the highest amount was $4.2 million. The amount available to each demonstration state for the integration bonus payment should also reflect the number of participating CCBHCs and the number of partnering FQHCs in the state.

To increase system level integration between CCBHCs and FQHCs more widely in the long term, **Congress should apply lessons learned from the integration bonus payment opportunity. Best practices that support integration between CCBHCs and FQHCs should also be identified and shared.**

- **What policies could improve and ensure equitable access to and quality of care for minority populations and geographically underserved communities?**

  Require the HHS secretary to review quality measurement initiatives and work with experts and stakeholders to identify key measures that highlight disparities and encourage integration for populations with behavioral health conditions.
  Many physical health measures can indicate disparities in health outcomes when collected for people with mental health and substance use conditions. The Medicaid core set for Health Homes includes emergency room utilization measures and inpatient utilization, but does not separate this information for behavioral health. Similarly, the Medicaid core set for adults includes measures for all cause readmissions, but does not include measures of readmission for primarily behavioral health reasons. A study of 2014 data from the nationwide readmissions database found that the odds of an unplanned 30-day readmission were nearly two times greater for individuals with SMI compared to others. By reporting data separately for populations with behavioral health conditions, data will better highlight these outcome disparities and promote attention to these conditions by primary care and hospitals.

  Require CCBHCs to report data by disadvantaged populations to identify disparities such as race, ethnicity, and language (REL); sexual orientation and gender identity; and social determinants of health.
  Efforts to improve integrated care should promote health equity for disadvantaged populations. Under the CCBHC demonstration, SAMHSA requires states to report on 21 quality measures, including nine clinic-reported measures and 12 state-reported measures. The clinic-reported quality measures are primarily process measures related to service provision targets. According HHS' Office of Assistant Secretary for Planning and Evaluation's 2019 report, the state-reported measures primarily include measures for "consumer characteristics (for example, housing status), screening and treatment of specific conditions, follow-up and readmission, and consumer and family experiences of care." CCBHCS are not currently required to report on these measures by race, ethnicity, and language; sexual orientation and gender identity, or social determinants of health, but such a requirement by SAMHSA and gradual enforcement would help to identify and address disparities. In demonstration year 1, a majority of CCBHCs used quality measures to inform clinical practice. Some CCBHCs used quality measure reports to examine trends, determine areas for improvement, or monitor impacts. Reporting on data by race, ethnicity, and language; sexual orientation and gender identity; and social determinants of health would similarly inform clinical practice. CCBHCs could use this information to identify and address inequities and improve integrated care delivery for disadvantaged populations.

  Significant technical assistance should be available to CCBHCs to help them meet this new requirement. SAMHSA and CMS could also work with entities that are already convening collaboratives to support CCBHCs with data collection and reporting.

  Direct the HHS secretary to require FQHCs to align with core integrated care measures and ensure accountability, particularly with respect to health disparities.
  FQHCs report on a quality measure for depression screening and follow up care and the number of screenings and brief interventions for alcohol use. In 2020, FQHCs were also required to report on

depression remission in 12 months. In accordance with Recommendation A-2, HHS should develop core quality measures for integration and apply them across HHS programs, including health centers. As previously noted, experts have raised concerns about remission because response or remission is a more appropriate clinical outcome so revisiting and aligning measures after careful consideration will help the health centers in their efforts to integrate. Centers performing poorly in these areas should be accountable for improvement. In addition, HRSA currently analyzes and publishes disparities by race and ethnicity for low birth weight, blood pressure, and diabetes. Given the effect of COVID-19 and longstanding behavioral health disparities for people of color, HRSA should include behavioral health measures in its analysis of health disparities.

- **How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?**

  Crisis intervention models can help connect people to more coordinated and accessible systems of care and wraparound services because they tend to (1) utilize a "no wrong door" approach and (2) already exhibit some integration with other providers, including clinical mental health care providers, social workers, peer support specialists and others. In models like CAHOOTS, for instance, this means that individuals entering the crisis intervention continuum at any entry point (via a call center, interaction with a mobile crisis response team or entry into a short-term stabilization facility) can feel confident they will be directed to the care most appropriate for their needs and, in the best cases, connected with an individual who can help track their care and recovery.

- **How can providers and health plans help connect people to key non-clinical services and supports that maintain or enhance behavioral health?**

  Promote strategic coordination among HHS agencies on behavioral health integration. Congress should require CMS, HRSA, and SAMHSA to advance the integration of physical and behavioral health services through a strategic plan for greater coordination between the agencies. Congress should require CMS, HRSA, and SAMHSA to advance the integration of physical and behavioral health services through a strategic plan for greater coordination between the agencies. **This strategic plan should include the establishment of a working group on behavioral health integration with representatives from the respective agencies**. CMS should ensure representation from all of its core components, such as CMS' Center for Medicaid and CHIP Services (CMCS), Center for Medicare, Medicare- Medicaid Coordination Office (MMCO), Center for Consumer Information and Insurance Oversight (CCIIO), and other components. The behavioral health integration working group could build on the efforts of the recently formed HHS Behavioral Health Coordinating Council, which works across HHS to facilitate collaboration and strategic planning in implementing HHS' behavioral health agenda.

  To provide whole-person, integrated care to Medicaid beneficiaries, a strategic approach is needed at the federal level. Fragmentation of behavioral health policy and Medicaid policy is a barrier for states interested in improving the integration of physical and behavioral health services. While these entities have demonstrated effective collaboration through joint policy guidance and may participate in various workgroups that touch on behavioral health integration, there is opportunity to build on this success through a federal strategic plan for behavioral health integration. **This strategic plan should be publicly available and should detail how CMS, HRSA, and SAMHSA will**

establish an interagency working group, specifically focused on promoting and advancing behavioral health integration.

This working group may also participate in the proposed HHS effort to work with partners and stakeholders in identifying the core elements and quality measures for integration—ensuring those are seeded throughout programs with follow up, coordinated technical assistance, and financing. To support whole-person care and streamline the delivery of behavioral health services, physical health services, and other social services addressing the health- related social needs of an individual, this working group should also develop recommendations to help states develop collaborative funding models, such as braiding or blending funding from various HHS funding streams into a single funding pool. For example, some state officials have suggested aligning funding cycles, application processes, and reporting requirements across federal grants to help states applying for and implementing those grants. The working group should explore similar policy changes that would remove barriers to states braiding or blending federal funding sources. Collaborative funding can strengthen coordination and reduce fragmentation between otherwise siloed programs that serve the same individual.[47] The working group's recommendations should aim to improve the beneficiary experience and remove barriers to accessing physical and behavioral health care, housing, transportation, job skills training, nutrition, and other health- related social needs.

Section 3: Ensuring Parity

Congress passed the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act to require most health plans to cover treatment for mental health and substance use disorders no more restrictively than treatment for physical health conditions. The Parity Act's requirements apply to financial requirements (e.g. copays and deductibles), quantitative treatment limitations, and non-quantitative treatment limitations (NQTLs). However, the law does not apply to Medicaid beneficiaries receiving benefits only through fee-for-service or alternative payment models. And, except for beneficiaries served through special needs plans, the law also does not apply to Medicare beneficiaries served through fee-for-service or stand-alone Medicare Advantage plans.

- **How can Congress improve oversight and enforcement of mental health parity laws that apply to private plans offering coverage under the federal health programs? How can we better understand and collect data on shortfalls in compliance with parity law?**

Civil Monetary Penalties

While the U.S. Department of Labor is authorized to investigate and take enforcement action under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), it does not have the direct authority over plans that are sold to multiple employers and it lacks **authority to assess civil monetary penalties**. Both parties have embraced extending authority for parity. President Trump's Commission on Combating Drug Addiction and the Opioid Crisis made expanding authority to levy fines on insurers and funders a key bipartisan recommendation for addressing the opioid crisis. Legislation has been introduced that would extend the department's civil monetary penalty authority to enforce the Genetic Information NonDiscrimination Act to the federal parity law. Congress giving the Labor Department power to issue civil monetary penalties was also a key recommendation of President Obama's Parity Task Force.

Claims Transparency

Congress should require the secretaries of the departments of Labor and Health to require plans to **publicly report comparative mental health and substance use disorder claims data versus medical claims.** The goal of the federal parity law is equitable coverage that increases access to care, and data is needed to assess progress toward that goal. New York State recently passed a bipartisan bill mandating bi-annual data reporting from plans that compares areas such as utilization review, denial rates, reimbursement, and provider networks. Congress recently passed legislation requiring plans to conduct analyses of their non-quantitative treatment limitations and to submit those analyses to states when the secretary of the Labor Department requests them. Congress should build on that by requiring plans to conduct analyses with additional components of a comprehensive parity enforcement program.

Medicare Advantage

Congress should ensure mental health and addiction parity in Medicare by expanding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 provisions to Medicare fee-for-service and Medicare Advantage. The 2008 parity law does not apply to Medicare beneficiaries served through fee-for-service or stand-alone Medicare Advantage plans (Medicare-Medicaid beneficiaries are the exception). The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) improved parity in Medicare fee-for-service and Medicare Advantage, but treatment limitations still exist. MIPPA required equal copayments for outpatient behavioral health and medical/surgical benefits in Medicare fee-for-service, but Medicare still has a 190-day lifetime limit on inpatient psychiatric care that does not exist for inpatient medical care. Importantly, cost-sharing in Medicare Advantage plans must be actuarially equivalent to Medicare fee-for-service, but these plans can still apply specialty copayments for mental health treatment. **To apply the 2008 parity law to Medicare Advantage plans, Congress should amend Title XVIII of the Social Security Act to incorporate requirements for parity.** CMS should then release new federal regulations implementing the new parity requirements. CMS should implement this requirement in close partnership with health plans and should provide ample time for plans to comply.

Medicaid FFS and Alternate Payment and Delivery Models

Congress should ensure mental health and addiction parity in Medicaid by expanding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 provisions to all Medicaid fee-for-service and alternate payment and delivery models. The 2008 parity law applies to Medicaid beneficiaries receiving services through managed care organizations, CHIP, and alternative benefit plans serving the Medicaid expansion population. Under current federal parity rules, once an individual is enrolled in an MCO, their entire benefit package is subject to parity, including any services delivered through another type of managed care plan or fee-for-service. The 2008 parity law, however, does NOT apply to Medicaid beneficiaries receiving benefits only through fee-for-service or alternative payment models. While the majority of Medicaid beneficiaries are enrolled in managed care, several states either exclude certain populations from managed care or primarily deliver services through fee-for-service. Extending parity requirements to Medicaid beneficiaries served in fee-for-service or alternative payment models would address the current inequity between those beneficiaries and others receiving benefits subject to parity requirements. Accordingly, Congress should amend Title XIX of the Social Security Act to incorporate requirements for parity in Medicaid FFS and alternate payment and delivery models.

- **How can Congress ensure that plans comply with the standard set by Wit v. United Behavioral Health? Are there other payer practices that restrict access to care, and how can Congress address**

them?

A key barrier to care access is inadequate network performance for psychiatrists, psychologists and other behavioral health specialists. Many behavioral health specialists do not participate in insurance networks, creating a system whereby people with the means to pay for out-of-network care receive services are more likely to receive treatment. For their part, behavioral health specialists argue that payers provide insufficient reimbursement. In the case of private insurance and also private plans offering coverage under federal health programs, it is critically important to bring more providers into networks. By improving network performance standards, as described below, payers would be expected to improve reimbursement for the services of behavioral health specialists to bring them into networks.

Also, these improved network performance standards would encourage payers to adopt integration practices, which would make better use of the existing workforce. Integration would provide the supports necessary for primary care providers to treat more mild-to-moderate cases, with greater confidence that they will be able to access behavioral health specialists to receive consultation services.

- **Are there structural barriers, such as the size of the provider network, travel time to a provider, and time to an appointment, that impede access to the behavioral health care system?**

Network Performance Standards

In addition to the overall shortage of behavioral health providers, their lack of availability in health plan networks is a major barrier to care. Health plan networks often include participating behavioral health providers who are not taking new patients or have long wait times for appointments. Methods for ensuring network adequacy are not standardized and vary significantly. Qualified Health Plans participating in the ACA Marketplaces, for example, are required to identify whether providers are accepting new patients, but Medicaid and Medicare Advantage do not include such requirements. For Medicaid and Qualified Health Plans, states use various metrics, such as wait times, provider-to-patient ratios, and geographic standards.

Congress should direct the HHS secretary to hold health plans accountable for time and distance standards and develop core network performance metrics for application across HHS regulated plans. These metrics should include a defined set of quantifiable measures, such as wait times, providers who are taking on new patients, and those who have not submitted a behavioral health claim during the past six months. Having a core set of network adequacy standards across programs would facilitate compliance for plans subject to parity laws and also align and simplify requirements for insurers that participate in multiple federal programs.

Access to culturally competent care and any care in rural areas is also a problem, and increased access to providers through telehealth could help. Performance bonuses should be considered for addressing the lack of diversity among behavioral health providers and for encouraging a more diverse and culturally competent workforce. SAMHSA and CMS should fund the development of cultural competence network adequacy and performance measures for behavioral health. The secretary should also make reported network adequacy data public.

Congress should direct the HHS secretary to develop network adequacy requirements that:

- Include time and distance standards
- Consider telehealth, while considering relevant accessibility issues and patient choice
- Are reported specifically for behavioral health providers
- Include a uniform set of quantitative performance measures
- Are transparent and publicly reported
- Define adequate diversity and cultural competence

Background on Medicaid Network Adequacy Requirements

Aligning network adequacy requirements across programs would require changes to Medicaid network adequacy requirements**.** CMS' 2016 Medicaid managed care rule required states to establish time and distance standards that Medicaid managed care plans must meet to demonstrate network adequacy. States also had the option of establishing measures in addition to the time and distance standard. In developing the time and distance standards, states were able to consider several factors, including access to services through telehealth. Several states have since updated their telehealth policies or expanded their coverage of services delivered through telehealth in response to COVID-19. States must decide whether they will retain these telehealth policies after the COVID-19 public health emergency ends.

In November 2020, CMS released a final Medicaid managed care rule that replaced the time and distance standard with a new, broader quantitative network adequacy standard for providers. Under this rule, states could meet the new requirement by either keeping their time and distance standard or replacing that measure with any quantitative standard. While some stakeholders generally favor the quantitative standard, others that generally favor time and distance standards have expressed concern that a broader quantitative standard could impact access to care for medically underserved regions, such as rural areas.

Some stakeholders have also raised concerns that providers who are only available to deliver care virtually are not truly available to meet patients' needs. The new rule also preserves the 2016 requirement that states consider the availability and use of telehealth when developing their network adequacy standards. CMS defers to each state to determine the criteria to be applied to telehealth providers and how such providers will be taken into account when evaluating network adequacy. In the final rule, CMS also reminds states and health plans to be mindful of their responsibilities for mental health and addiction parity in subpart K of 42 CFR in selecting measures for network adequacy, network development, and evaluation.

To improve and align network adequacy standards, Congress should direct the HHS secretary to reinstate the time and distance-to-provider standards for Medicaid network adequacy and require two additional quantitative measures. Quantitative measures that HHS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period. HMA estimates that this recommendation would save the federal government $105 million over 10 years. This recommendation is estimated to add 800 to 900 additional behavioral health providers to Medicaid MCO networks, improving access for an estimated 500,000 to 800,000 enrollees.[48]

- **How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicaid fee-for-service**

programs impact access to care and patient health?

Mental health and addiction parity is central to ensuring fair and equal access to critical services for the, on average, approximately 25% of Medicaid and 20% of Medicare beneficiaries treated for at least one behavioral health condition. Currently, the limited application of mental health and addiction parity requirements in Medicaid creates inequities for beneficiaries across the managed care and fee-for-service delivery systems. These two delivery systems have different standards for mental health and substance use treatment access. Beneficiaries served in Medicaid managed care benefit from a higher standard for equal access to these services, while those served in fee-for-service continue to experience treatment limitations that harm access to these services. Similarly, Medicare beneficiaries are not guaranteed equal access to behavioral health and physical health benefits. **To ensure equal access to behavioral health and physical health benefits for beneficiaries in Medicare fee-for-service, Medicaid fee-for-service, and alternative payment models, Congress should require that the 2008 parity law apply for beneficiaries served through these delivery systems**.

In addition to the above recommendations, **Congress should direct the HHS secretary to require states to describe in their managed care quality strategy how the state will advance behavioral health integration**. Under federal rules, states contracting with an MCO must establish a state quality strategy for assessing and improving the quality of care and services provided by the MCO. The state quality strategy must include state-defined network adequacy and availability of services standards for MCOs, the state's goals and objectives for continuous quality improvement, a description of quality metrics and performance targets that will be used to measure MCO performance and improvement, a description of performance improvement projects, and the process for independent reviews of MCO performance, among other requirements. The quality strategy, however, is not currently required to address behavioral health integration. To support the coordination of clinical and behavioral health services, CMS should require states to describe in their quality strategy how the state will work with MCOs, any subcontracted entities, and, if applicable, the behavioral health agency in the state to advance behavioral health integration. CMS should work with states to ensure that they have appropriate time to meet this new requirement.

Congress should require the HHS secretary to review quality measurement initiatives and work with experts and stakeholders to identify measures highlighting disparities and encouraging integration for populations with behavioral health conditions. Many physical health measures can indicate disparities in health outcomes when collected for people with mental health and substance use conditions. The Medicaid core set for Health Homes includes emergency room utilization measures and inpatient utilization, but does not separate this information for behavioral health.[49] Similarly, the Medicaid core set for adults includes measures for all cause readmissions, but does not include measures of readmission for primarily behavioral health reasons.[50] A study of 2014 data from the nationwide readmissions database found that the odds of an unplanned 30-day readmission were nearly two times greater for individuals with SMI compared to others.[51] By reporting data separately for populations with behavioral health conditions, data will better highlight these outcome disparities and promote attention to these conditions by primary care and hospitals.

Section 4: Expanding Telehealth

In response to the COVID-19 pandemic, policymakers and administrators introduced numerous telehealth flexibilities to expand access to health care services and prevent health care delivery disruptions. As the country returns to a new normal, policymakers and key stakeholders are actively debating what the telehealth policy environment should look like moving forward and whether to maintain the new flexibilities. Telehealth services, while helping to maintain access to care during the pandemic, have yet to be fully understood in terms of impacts on cost, quality, and clinical outcomes.

- **How do the quality and cost-effectiveness of telehealth for behavioral health care services compare to in-person care, including with respect to care continuity?**

  Clinical Outcomes and Patient Satisfaction
  Evidence demonstrates that the quality of tele-behavioral health care services is generally equivalent to in-person care. Studies that BPC reviewed often assessed quality by looking at clinical outcomes and patient satisfaction.
    - Systematic literature reviews and meta-analyses found that for behavioral health services, telehealth generally produced equivalent outcomes (symptom reduction) to in-person care, though there was some variation in comparative outcomes related to psychiatric condition.[52] For example, PTSD treatment administered via video did not result in significantly different symptom severity in the short-term (compared to in-person care), but worse outcomes were reported at three-to-six-month follow-ups compared to in-person care. The opposite was true for depressive symptoms.
    - For studies that focused specifically on clinical outcomes for Medicare beneficiaries, virtual consultations for psychiatric conditions delivered to nursing home residents showed that consultations were comparable to in-person assessments.[53]
    - Studies comparing in-person and video behavioral health services to audio-only services revealed evidence of little difference between modes in terms of therapeutic alliance (cooperative relationship between patient and behavioral health provider), patient openness, empathy, attentiveness, or participation.[54]
    - Multiple studies showed high levels of satisfaction for mental health services delivered via telehealth.[55]
    - With respect to continuity of care, telehealth has the potential to create low-barrier pathways to entry for patients, increasing the likelihood that they will continue to see their provider and attend scheduled appointments.[56] Studies demonstrate that rates of missed appointments decreased after outpatient psychotherapy clinics transitioned to telehealth.[57]
    - A few studies indicated that patient satisfaction with telehealth during the pandemic tended to be higher when they had an existing relationship with the clinician.[58] Across specialties, studies highlighted a need for providers to build rapport with their patients. Providers can do this by: keeping expectations for symptom improvement and recovery high to maintain a similar value to in-person care; presenting the modality in positive terms rather than as a second tier option to in-person care; conveying the partnership and collaboration with the patient; and working closely with support staff. [59]

  Cost-Effectiveness
  Several factors contribute to telehealth's cost-effectiveness, including payer reimbursement rate; the degree to which convenience of services creates new utilization; the balance of additive versus substitutive services; service type; and clinical outcomes. Telehealth flexibilities introduced during

the pandemic allowed for continued access to behavioral health services; depending on how utilization stabilizes, and the aforementioned factors, it could have a substantial impact on health care costs.

BPC's extensive literature review of telehealth's cost-effectiveness found:

- For veterans specifically, there is ample evidence to suggest that health care costs associated with treatment for depression did not differ between the telemedicine and in-person delivery methods.[60,61]
- A systematic review and meta-analysis found E-health interventions for depression in primary care were cost-effective.[62]
- A randomized control trial found that tele-cognitive behavioral therapy for bulimia nervosa patients had comparable cost-effectiveness to in-person treatment.[63]
- Tele-mental health for the elderly was shown to be feasible for inpatient and nursing home consultation, cognitive testing, dementia diagnosis and treatment, depression in integrated and collaborative care models, and psychotherapy; however, there is limited data on cost-effectiveness.[64]
- Telehealth is more likely to be cost effective if used for individuals with high clinical needs. For example, among older, sicker nursing home residents, after hours coverage generated substantial savings by deterring costly emergency department and inpatient stays.[65]
- A retrospective cohort study looking at the impact of telehealth services for urgent and nonurgent care for seniors (60+) who were affiliated with three major health systems in the U.S. found telehealth encounters were successful in resolving urgent and non-emergent needs in 84–86.7% of cases. When visits required follow-up, over 95% were resolved in less than three visits for both telehealth and in-person cohorts. Results suggest that when deployed within the confines of a patient's existing primary care and health system provider, telehealth can be an effective alternative to in-person care for urgent and non-emergent needs of seniors without increasing downstream utilization.[66]
- Telehealth is less likely to be cost-effective if positioned as a triage tool, paid at parity with in-person visits, and used for low-acuity conditions.[67]

- **How can Congress craft policies to expand telehealth without exacerbating disparities in access to behavioral health care?**

While telehealth has the potential to significantly reduce consumer barriers to accessing health care, it also has the potential to exacerbate existing inequities and disparities. Telehealth policies should seek to mitigate these risks without sacrificing access to needed care.

Payment Structure and Parity

Payment parity may rebalance provider incentives in a way that discourages providers from offering in-person health care services, ultimately limiting consumer access to in-person services over time. There is anecdotal evidence from state representatives that behavioral health practices across several states are moving to fully virtual. Providers offering telehealth services exclusively over a virtual platform could exacerbate disparities for a few reasons:

- Limited access for patients with technology-related barriers who could access in-person care
- Impact on continuity of care if patients see different providers through direct-to-consumer

applications
- More difficulty integrating and coordinating behavioral health care and primary care

Ultimately, patients should have the ability to choose whether to see their provider in-person or via telehealth. Across specialties, studies highlighted a need for providers to build rapport with their patients and showed that while telehealth was well-accepted, a small percentage of patients did prefer face-to-face consultations and showed resistance to video consultations.[68] An analysis of perspectives on the PROVIDE model, which aims to improve coordination between primary care physicians and psychosocial care through video consultations, found that patients valued the importance of establishing a trusting relationship with their therapist but expressed doubt about being able to do so through video consultations. Most participants also indicated that the model would be most beneficial for people in rural areas or ones who had impaired mobility.[69]

Payment parity policies should not only incentivize providers to make an initial investment in telehealth but also ensure that providers maintain access for patients who prefer to see providers in-person.

Promote Cultural Awareness and Competency Training
Cultural competence, or a provider's ability to deliver care in a manner that meets a patient's social, cultural, and linguistic needs, has a direct impact on patient satisfaction. Encouraging cultural awareness and competency training could lead to better access and continuity of care for marginalized populations. Studies show that an increase in clinician cultural competence is associated with increased patient satisfaction, treatment adherence, and information sharking and seeking.[70]

Coverage for Audio-only Visits
Coverage for audio-only services has the potential to extend access to populations with technology-related barriers, but there is some concern that it could lead to the creation of a two-tiered health care system in which disadvantaged beneficiaries receive audio-only care, while others receive telehealth care through video services. Of course, the exclusion of audio-only services also encourages a two-tiered system in which some people have access to video services while others lack access altogether. To avoid exacerbating inequities, potential guardrails could include:
- For providers in fee-for-service, limit audio-only services to established patients, unless a practitioner who has an established relationship with a patient attests to the need for audio-only services.
- Lower reimbursement rate for audio-only services.
- Require patient consent to bill for audio-only services. The decision to deliver audio-only services should be driven by the patient, not the provider

- **How has the expanded scope of Medicare coverage of telehealth for behavioral health services during the COVID-19 pandemic impacted access to care?**

In 2020, health care spending dropped as providers' offices closed, stay at home orders were declared throughout the country, and hospitals cancelled elective care. It was the first year ever to show an annual decline in overall health spending since CMS began tracking health care spending in 1960.[71] Telehealth was a crucial tool for keeping access to care available.

Telehealth flexibilities introduced during the pandemic allowed for a significant increase in tele-behavioral health services. Specialties such as psychiatry, endocrinology, and neurology had the greatest uptake of telemedicine and the smallest decline of total visits over the pandemic. The same study found that during the pandemic, 53% of all visits to treat depression were conducted via telemedicine (55% bipolar disorder and 54% anxiety).[72] Prior to COVID-19, 4-5% of psychologists, psychiatrists, and social workers delivered some outpatient care via telemedicine).[73] After the pandemic, a McKinsey analysis of E&M codes also found wide variation of telehealth by specialty, with the highest penetration as a share of outpatient and office visit claims being in psychiatry (50%) and substance use treatment (30%).[74] In contrast to office-based care, telemedicine was more commonly used for established patients and substantially greater delivery of psychiatric or behavioral treatments than preventive care.[75]

- **How should audio-only forms of telehealth for mental and behavioral health services be covered and paid for under Medicare, relative to audio-visual forms of telehealth for the same services?**

Older, rural, and minority populations face disproportionate barriers to accessing traditional, web-based telehealth services. Coverage of telephone visits was one of the most common COVID-19 temporary telehealth policy expansions. Because of the ongoing need to maintain access to care, eighteen state Medicaid programs now reimburse the modality permanently in some way (e.g., sometimes only for mental health or case management). Coverage for audio-only services has the potential to extend access to populations with technology-related barriers, but there is some concern that it could lead to the creation of a two-tiered health care system in which disadvantaged beneficiaries receive audio-only care, while others receive telehealth care through video services.

Studies comparing in-person and video behavioral health services to audio-only services revealed evidence of little difference between modes in terms of therapeutic alliance (cooperative relationship between patient and behavioral health provider), patient openness, empathy, attentiveness, or participation. However, audio-only therapy sessions were significantly shorter than those conducted face-to-face.[76]

- Studies reported findings of no significant difference between third-party ratings of counselor empathy in the telephone vs. face-to-face modes.
- No significant difference was found in patient self-exploration across telephone and face-to-face modes. However, a post-intervention revealed that 78% of patients felt that their counselor understood and aided their self-exploration to a greater degree in the face-to-face mode than when communicating via telephone.
- Spizman's 'connection' measure (a composite measure to assess therapist listening behaviors) produced significantly higher ratings from patients who received telephone counseling than those in a face-to-face setting

Guardrails should balance enhancing health care access to populations with technology-related barriers while limiting risk. Policy options to consider:

- For providers in fee-for-service, limit audio-only services to established patients, unless a practitioner who provides continuous, comprehensive, and longitudinal face-to-face care attests to the need for referral.
- Lower reimbursement rate for audio-only services
- Require patient consent to bill for audio-only services. The decision to do audio-only should

be driven by the patient, not the provider

- **Are there specific mental health and behavioral health services for which the visual component of a telehealth visit is particularly important, and for which an audio-only visit would not be appropriate? For which specific mental and behavioral health services is there no clinically meaningful difference between audio-visual and audio-only formats of telehealth? How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?**

  BPC believes those in the clinical community are in the best position to address these questions in more detail.

  For consideration, BPC's literature review of studies comparing in-person and video services to audio-only services revealed:
  - Evidence of little difference between modes in terms of therapeutic alliance, disclosure, empathy, attentiveness, or participation. However, audio-only therapy sessions were significantly shorter than those conducted face-to-face.[77]
  - Studies reported findings of no significant difference between third-party ratings of counselor empathy in the telephone vs. face-to-face modes.[78]
  - In early 2020, SAMHSA, DEA, and HHS issued guidance allowing for use of audio-only telehealth for buprenorphine induction without requiring an in-person evaluation or video interface. This policy environment allowed for novel delivery models of addiction treatment.[79] For example, the Rhode Island Buprenorphine Hotline is a hotline that functions as a 24/7 "tele-bridge" clinic where people with moderate to severe opioid use disorder can be linked with a DATA 2000 waivered provider. That provider can provide an initial assessment and, if appropriate, prescribe buprenorphine for unobserved induction and linkage to outpatient treatment. The use of telehealth for buprenorphine initiation had previously not been possible.[80,81]
  - A cross-sectional analysis of family medicine encounters during the pandemic found among all telehealth visits that the likelihood of a full audio-video telehealth visit was reduced for patients who were older, Black, from urban areas, or who were self-pay, Medicaid, or Medicare payer status.[82]
  - A comparative study in JAMA found implementation of audio-only virtual prenatal visits was not associated with changes in perinatal outcomes and increased prenatal visit attendance in a vulnerable population during the COVID-19 pandemic when used in a risk-appropriate model.[83] Similar findings of increased visit compliance for audio-only virtual prenatal were found for vulnerable populations in other studies as well.[84]

- **How should Medicare pay for the practice expense portion of Medicare's telehealth payment for mental and behavioral health services? Should the practice expense resources needed for telehealth forms of these services be independently measured, or should Medicare rely on the practice expense values used for in-person forms of Medicare payment for the services?**

  Paying at parity may encourage more providers to adopt telehealth, but then it is less likely telehealth will lead to lower overall spending. Because telehealth services tend to be shorter and include fewer diagnostic services than in-person visits, there are questions regarding if parity is the appropriate level of reimbursement.[85] In many cases, health systems can provide telehealth services

at a lower cost than in person services (i.e., providers can work from home or in lower cost facilities). Additionally, lower reimbursement for telehealth services versus in-person has the potential to spur increased competition and innovation through new, more-efficient providers entering the fray and may deter lower-value uses of telemedicine. Similar dynamics to increase competition are at play when facilitating inter-state telemedicine, such as through reforms to state licensure laws.

BPC is working closely with a group of experts spanning the health care industry and academia to explore options for how to best reimburse the practice expense portion of Medicare's telehealth payment for mental and behavioral health services. Options include independently measuring practice expense resources needed for telehealth services; paying for telehealth services at a fixed percentage or at the facility rate for distant site providers.

- **Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care (in addition to flexibilities already provided on a permanent basis in the SUPPORT for Patients and Communities Act and the Consolidated Appropriations Act, 2021)? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?**

  Building off the existing permanent telehealth flexibilities for behavioral health care, including the Consolidated Appropriations Act passed into law in 2021 which made permanent Medicare beneficiaries' access to tele-mental health services from home, and the SUPPORT Act, which authorized Medicare coverage of services via telehealth for the treatment of substance use disorders and co-occurring mental health disorders, Congress could consider:
  - Removal face-to-face visit requirement for tele-behavioral health services when home is the originating site. The face-to-face requirement does not apply to behavioral health services that would be eligible outside of what was required by the Consolidated Appropriations Act (CAA). For example, the in-person requirement does not apply to people who were receiving behavioral health services in rural areas. It also does not apply to patients being treated for substance use disorder or co-occurring SUD and mental health disorder. To create more commonality across federal telehealth policy, Congress could consider additional legislation.
  - Permanent expansion of tele-primary care services. Given that many Americans receive behavioral health care from their primary care providers, as well as the behavioral health provider shortage, tele-primary care services could be expanded on a permanent basis for Medicare beneficiaries. Additional guardrails could be considered, such as:
    - Capping the total number of primary care visits delivered via tele-health for Medicare fee-for-service providers.
    - Limiting this flexibility to certain provider types, such as Federally Qualified Health Centers and Community Mental Health Centers.
    - Requiring the primary care clinician to have an established relationship or attest to that patient's need for telehealth services. This could be structured to conform to the Medicare home health services' face-to-face requirement established through the ACA.[86]
    - Imposing in-person visit requirements, such as what are currently required for tele-behavioral health services.

- **What legislative strategies could be used to ensure that care provided via telehealth is high-**

quality and cost-effective?

Structure Payment Differently for Fee-for-Service and APMs
To ensure continued access, while addressing concerns of overutilization and fraud, policymakers could take a more targeted approach by implementing different payment approaches for providers in fee-for-service Medicare vs ones in alternative payment models. Fee-for-service models incentivize volume rather than value and may not be in the best position to adopt higher value telehealth applications. Consider the following Medicare policy options:

- Cap the number of telehealth visits a patient can have with a given fee-for-service provider
- Reimburse telehealth services at the facility rate (or other discounted rate compared to in-person services)
- Differential payment for telehealth accredited or credentialed Medicare providers

OIG Provider Monitoring
One of the biggest challenges with developing permanent telehealth recommendations is balancing access and risk mitigation. There is growing concern about telehealth's potential to increase fraud, waste, and abuse. BPC's literature review found limited evidence of telehealth-related fraud, though high-profile examples have surfaced over the last year and need to be considered.

- In a charge announced by the DOJ in September 2020, criminal defendants submitted $4.5 billion in false and fraudulent claims related to unnecessary durable medical equipment (DME), as well as genetic and diagnostic testing ordered via telehealth.[87]
- An OIG analysis found that though criminals did not bill for a fake telehealth visit, they conducted fraudulent billing for other items or services like DME and genetic testing.[88]
- A 2021 GAO report surfaced concerns about fraud and abuse after CMS issued program waivers and enacted other flexibilities to increase access to telehealth. The agency stated that non-enforcement of certain privacy rules to expand telehealth flexibilities and the lack of complete data to determine how audio-only services are being used creates risk. They recommended careful monitoring and oversight to prevent fraud.[89]

To mitigate some of these risks, OIG should monitor providers for outliers and consider additional reporting requirements. Upcoding and prescribing patterns for durable medical equipment and expensive lab tests could have serious implications on health care spending.

- **What barriers exist to accessing telehealth services, especially with respect to availability and use of technology required to provide or receive such services?**

Older, rural, and minority populations face disproportionate barriers to accessing traditional, web-based telehealth services.

- A national survey conducted by the Bipartisan Policy Center and Social Sciences Research Solutions (SSRS) showed that 45% percent of adults reported technology-related difficulties accessing telehealth, including digital literacy, access to high-speed internet, and securing the appropriate devices. Thirty-five percent of rural residents and 42% of older adults said access to high-speed broadband was an obstacle, compared to 24% of non-rural residents and 21% of younger adults.
- A study using data from 2018 found 26.3% of Medicare beneficiaries lacked digital access at home. The proportion of beneficiaries who lacked digital access was higher among those with low socioeconomic status, those 85 years or older, and in communities of color.[90]

- An analysis of Medicaid managed care members in 14 states found Black patients had the lowest combined rate of mental health visits before the pandemic, with 56% of those needing mental health services reporting an in-person or telehealth visit, and the rate only declined amid COVID-19, down to 49%. Black members also had 7% fewer mental health visits than white members with a similar socioeconomic, demographic, and clinical background.[91]
- A survey conducted by the Pew Research Center found that Black respondents were more likely to use telehealth during the pandemic than white respondents, particularly when they perceived the pandemic as a threat to their own health.[92] A retrospective study of adult patients evaluated in hepatology at Duke University Health System found that Hispanic and Black adults were nearly twice as likely to complete a phone telehealth visit rather than a video visit compared to non-Hispanic white adults.[93]
- The Federal Communications Commission has emphasized the need to increase broadband access in rural communities and provide eligible health care providers with funding for telecommunications and broadband services.[94] According to the Federal Communications Commission's 2019 Broadband Deployment Report, approximately one-quarter of rural Americans and one-third of those living on tribal lands lack broadband access, compared to 1.7% of urban Americans. In 2017, the FCC estimated the cost of expanding broadband to 98% of Americans would be $40 billion; it would cost an additional $40 billion to reach the final 2%.[95]
- Barriers to telehealth include inaccessibility to technological devices, a lack of digital literacy, and unreliable internet coverage. These barriers disproportionately affect older individuals, persons of color, and those of lower socioeconomic status.[96] More than one in three U.S. households headed by a person aged 65 or older does not have a desktop or laptop computer and fewer than half have a smartphone device.[97] Even with access to a computer, 52 million Americans do not know how to use it properly.[98]
- According to a recent JAMA study, a sampling of Medicare beneficiaries found 38% of elderly adults were not ready to participate in telehealth visits because of unfamiliarity with technology and physical or cognitive difficulties.[99]
- A 2019 Pew Research study also found income, education, race, and ethnic disparities between those using traditional broadband internet and smartphone internet access. Half of those without traditional broadband internet state cost as the reason; one-third cite the cost of a computer.[100] Approximately one-quarter of Blacks and Hispanics do not have traditional high-speed internet access and rely solely on their smartphones.[101]

Section 5: Improving Access for Children and Young People

The shortage of children's behavioral health care providers is significant, and the need is immediate. It is important to increase the supply of these providers, although any meaningful progress could take some time. Moreover, many specialists do not participate in health plan networks, placing specialized behavioral health care for children out of reach for families that cannot afford out-of-network costs.

BPC's Behavioral Health Integration Task Force embraced two categories of recommendations that could address the immediate need for children's behavioral health services (improving network performance and increasing the ability of pediatricians to provide mild-to-moderate behavioral health services). Children already rely heavily on primary care for a variety of health care services, making it important to empower pediatricians to handle more mild-to-moderate behavioral health care.

- **How should shortages of providers specializing in children's behavioral health care be addressed?**

Network Performance
First, to improve access to behavioral health specialists, the task force recommended **updating network performance standards across payers**. This would help to ensure adequate specialty care for both referrals and also for consultations to primary care providers treating mild-to-moderate conditions. At the heart of the problem, health plan networks often include participating behavioral health providers who are not taking new patients or have long wait times for appointments.

Given inadequate behavioral health networks are a key barrier to integrated care, the secretary of HHS should hold health plans accountable for time and distance standards and develop core network performance metrics for application across HHS regulated plans. These metrics should include a defined set of quantifiable measures, such as wait times, providers who are taking on new patients, and those who have not submitted a behavioral health claim during the past six months. Having a core set of network adequacy standards across programs would facilitate compliance for plans subject to parity laws and also align and simplify requirements for insurers that participate in multiple federal programs.

CMS should develop **network adequacy requirements** that:

- Include time and distance standards
- Consider telehealth, while considering relevant accessibility issues and patient choice
- Are reported specifically for behavioral health providers
- Include a uniform set of quantitative performance measures
- Are transparent and publicly reported
- Define adequate diversity and cultural competence

Behavioral Health Integration
Promoting the adoption of behavioral health integration in pediatrics would reduce the need for additional behavioral health specialists. The task force recommended empowering and incentivizing pediatricians and other primary care providers by providing enhanced payments, training, and technical assistance. Importantly, the task force recommendations would increase the ability of pediatricians to consult with behavioral health specialists to treat patients, reducing the number of necessary referrals. Behavioral health specialists would spend less time on consultations than they would if the pediatrician referred the patient for treatment.

Value-based payment models have structural elements that make them an ideal home for integration. The existing payment structure in Medicaid MCOs, through which many children receive care, already has well-defined quality metrics, delivery standards, and payment methodologies through which integration can be applied, enforced, and incentivized. The task force recommended providing financial incentives and requiring accountability to build integrated care delivery into existing payment models for Medicaid MCOs.

The task force also recommended creating a capitated and risk-adjusted payment model for primary care providers who treat mild to moderate behavioral health services. While this proposal was aimed at beneficiaries of the traditional Medicare program, it could also be adjusted to fit

pediatricians in states that do not use Medicaid MCOs.

To assist with the upfront costs of implementing behavioral health services, Congress should direct the secretary of HHS to establish a forgivable-loan pilot to support small primary care practices initiating behavioral health integration. The prospective financing should be used to assist with the upfront capital necessary to implement behavioral health services. CMS should provide outreach and guidance targeted to small practices on effective ways to use the loan program to achieve integration. The secretary should define stringent criteria for loan eligibility, including meeting specific quality and performance metrics. Those failing to implement the required services or meet quality performance benchmarks should be required to repay the loan.

Expand, train, and diversify the workforce

Pediatricians and other primary care clinicians already handle some behavioral health care needs of their patients, but primary care providers in general report feeling overwhelmed, ill-equipped, and underpaid. To incentivize and enable pediatricians to take on a greater role in providing behavioral health care to their patients, they will need training, technical assistance, and access to a larger pool of behavioral health providers for both consultations and referrals.

The task force recommended **creating a nationwide technical assistance program for primary care practices to receive the training necessary to deliver integrated care and participate in value-based payment models.** It also recommended increasing grant funding for state-wide psychiatric consultation services to provide primary care providers with behavioral health expertise for treating mild to moderate conditions. This is particularly important in ensuring that pediatricians have the access to consultations with behavioral health specialists that they will need to increase their behavioral health care services to their patients.

The task force recommended **increased appropriations to HRSA for statewide primary care-to psychiatric consultation services.** Psychiatric consultations are essential in providing pediatricians and other primary care clinicians with the guidance they need to effectively manage some behavioral health conditions. Consultation services allow integrated care teams to access psychiatric services without necessitating an on-site psychiatric provider. These consultations can help fill knowledge gaps in primary care learning and improve care through real-time training.

The CoCM already embeds regular psychiatric consultations in its workflow, and this has been shown to improve patient outcomes and reduce health care costs. Importantly, this policy solution has received widespread support from key stakeholders that represent primary care providers. The Massachusetts Child Psychiatry Access Project (MCPAP) for Moms is a model for grantees looking to establish regional psychiatric consultation services. In this model, full-time perinatal psychiatrists are accessible to primary care providers who need assistance in managing their patients' mental health and substance use care. This program relies on state and federal funding and is an extension of a HRSA and state-funded program focused on psychiatric consultation for children's behavioral health issues.

For the maternal health program, HRSA currently provides seven states with approximately $600,000 per year for five years, but this modest amount must support robust program operations and a required evaluation component. Since MCPAP for Moms is a regional program, larger states

face more severe funding issues. Noting this deficiency in current funding, Congress should appropriate more dollars for HRSA grant-funded statewide primary care-to psychiatric consultation services to make these services more widely available in pediatrics and other primary care settings.

- **How can peer support specialists, community health workers, and non-clinical professionals and paraprofessionals play a role in improving children's behavioral health?**

  As with adults, peer support services are important in enhancing engagement in behavioral health services, education, navigation of systems, promoting well-being, and connecting to community. Both youth peer support specialists and family peer support specialists exist, and the National Federation of Families has a national family peer specialist certification. Also, Youth MOVE National operates a SAMHSA-supported peer center that offers training, resources, and support to youth, individuals with lived experience, and the mental health workforce.

- **How can federal programs support access to behavioral health care for vulnerable youth populations, such as individuals involved in the child welfare system and the juvenile justice system?**

  Value-based payment models have structural elements that make them an ideal home for integration. The existing payment structure in Medicaid MCOs, through which many children receive care, already has well-defined quality metrics, delivery standards, and payment methodologies through which integration can be applied, enforced, and incentivized. The task force recommended providing financial incentives and requiring accountability to build integrated care delivery into existing payment models for Medicaid MCOs. Specifically, Congress should:

  - Direct the HHS secretary to provide early guidance and technical assistance to states and MCOs to help them prepare for upcoming FY 2024 congressionally mandated reporting requirements on Medicaid core measurement sets. The mandatory core set of behavioral health measures should include measures of behavioral health integration.
  - Direct the HHS secretary to review quality measurement initiatives, and through consultation with experts and stakeholders, identify key measures that highlight outcome disparities and encourage integration for populations with behavioral health conditions.
  - Direct the HHS secretary to require states to describe in their managed care quality strategy how the state will advance behavioral health integration.
  - Direct the HHS secretary to reinstate the time and distance-to-provider standards for Medicaid network adequacy and require two additional quantitative measures. Quantitative measures that HHS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period. HMA estimates that this recommendation would save the federal government $105 million over 10 years. This recommendation is estimated to add 800 to 900 additional behavioral health providers to Medicaid MCO networks, improving access for an estimated 500,000 to 800,000 enrollees.[102]
  - Encourage states to integrate behavioral health in Medicaid by supporting capacity building through a new grant program or 1115 waivers.

- Direct the HHS secretary to include measures of behavioral health integration in the Medicaid managed care quality rating system and recommend that states set a minimum rating for MCOs on performance measures.
- Ensure mental health and addiction parity in Medicaid and Medicare by expanding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 provisions to all Medicaid fee-for-service and alternate payment and delivery models, Medicare fee-for-service, and Medicare Advantage.

- **What key factors should be considered with respect to implementing and expanding telehealth services for the pediatric population?**

  While there was a substantial cumulative reduction in visits across all specialties over 2020, pediatric visits experienced one of the most dramatic drop-offs in utilization during the pandemic. Among children ages 3 to 17, weekly visit volumes in 2020 fell after October and ended 2020 substantially lower than what would be expected in a typical year; weekly visits to pediatricians were well below baseline and the long-term impacts of this delayed or deferred care for children is still unknown.[103]

  One way to increase access is to encourage telemedicine use for children. However, telemedicine use for children is lagging that for adults, which partly explains major gaps in child well visits since the pandemic began.[104]

  Other factors to be considered with respect to implementing and expanding telehealth services for the pediatric population:
  - Privacy issues that pertain to children
  - Efficacy of services delivered via telehealth for younger children

For additional details, please see BPC's report, *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration.*

Endnotes

[1] Centers for Disease Control and Prevention, "Provisional Drug Overdose Death Counts," December 16, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.
[2] Alexa Lardieri, "Coronavirus Pandemic Causing Anxiety, Depression in Americans, CDC Finds," U.S. News & World Report, August 13, 2020. Available at: https://www.usnews.com/news/health-news/articles/2020-08-13/coronavirus-pandemic-causing-anxiety-depression-in-americans-cdc-finds.
[3] Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders," April, 30, 2020. Available at: https://www.samhsa.gov/find-help/disorders.
[4] Substance Abuse and Mental Health Services Administration, "Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S.," 2020. Available at: https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf.
[5] Tracey L. Henry, Anuradha Jetty, Stephen Petterson, et. al., "Taking a Closer Look at Mental Health Treatment Differences: Effectiveness of Mental Health Treatment by Provider Type in Racial and Ethnic Minorities," *Journal of Primary Care & Community Health*, 11: 1-9, October 22, 2020. Available at: https://doi.org/10.1177%2F2150132720966403.

[6] Nirmita Panchal, Rabah Kamal, Cynthia Cox, and Rachel Garfield, "The Implications of COVID-19 for Mental health and Substance Use," *Kaiser Family Foundation*, February 10, 2021. Available at: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.
[7] Centers for Disease Control and Prevention, "Overdose Deaths Accelerating During COVID-19," December 18, 2020. Available at: https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html
[8] Mark E. Czeisler, Rashon I. Lane, Emiko Petrosky, et al., "Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020," *Morbidity and Mortality Weekly Report (MMWR)*, 69:1049–1057, August 14, 2020. Available at: http://dx.doi.org/10.15585/mmwr.mm6932a1.
[9] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[10] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[11] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[12] Congress.gov, "H.R.6 - SUPPORT for Patients and Communities Act," 2018. Available at: https://www.congress.gov/bill/115th-congress/house-bill/6.
[13] S. 5000, CARA 2.0 Act of 2020. Available at: https://www.congress.gov/bill/116th-congress/senate-bill/5000?q=%7B%22search%22%3A%5B%22CARA+2.0%22%5D%7D&r=1&s=1
[14] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[15] Federal Trade Commission, *Policy Perspectives: Options to Enhance Occupational License Portability*, 2018. Available at: https://www.ftc.gov/reports/options-enhance-occupational-license-portability.
[16] Ibid.
[17] Centers for Medicare & Medicaid Services, "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," 2021. Available at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.
[18] Centers for Medicare & Medicaid Services, "MLN Matters: Medicare Clarifies Recognition of Interstate License Compacts," 2020. Available at: https://www.cms.gov/files/document/SE20008.pdf.
[19] U.S. Department of Defense, "DOD Receives Approval for Grants to Develop Interstate Compacts for Licensure Portability," 2021. Available at: https://www.defense.gov/Newsroom/Releases/Release/Article/2537098/dod-receives-approval-for-grants-to-develop-interstate-compacts-for-licensure-p/.
[20] Interstate Medical Licensure Compact, "Participating States," 2021. Available at: https://www.imlcc.org/participating-states/.
[21] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[22] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[23] Ibid.
[24] Ibid.
[25] Ibid.
[26] Ibid.

[27] Centers for Medicare & Medicaid Services (CMS), "RE: Phase-out of expenditure authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations," SMD# 17-005, December 15, 2017. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17005.pdf.
[28] United States Government Accountability Office, "Medicaid Demonstrations, Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives," April 2015. Available at: https://www.gao.gov/assets/670/669582.pdf.
[29] Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), "State Innovation Models Initiative: General Information." Available at: https://innovation.cms.gov/innovation-models/state-innovations.
[30] Centers for Medicare & Medicaid, "State Innovation Models, Round 1 Model Test, Fifth Annual Evaluation Report," Findings at a Glance. Available at: https://innovation.cms.gov/files/reports/sim-mt-fg-fifthannrpt.pdf.
See also Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), "State Innovation Models Initiative: General Information." Available at: https://innovation.cms.gov/innovation-models/state-innovations.
[31] Centers for Medicare & Medicaid Services, "State Innovation Models, Round 2 Model Test, Third Annual Evaluation Report," Findings at a Glance. Available at: https://innovation.cms.gov/files/reports/sim-rd2-test-ar3-fg.pdf.
See also Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), "State Innovation Models Initiative: General Information." Available at: https://innovation.cms.gov/innovation-models/state-innovations.
[32] RTI International, "State Innovation Models (SIM) Initiative Evaluation, Model Test Year Five Annual Report," December 2018, ES-1. Available at: https://downloads.cms.gov/files/cmmi/sim-rd1-mt-fifthannrpt.pdf.
See also RTI International, "State Innovation Models (SIM) Round 2, Model Test Annual Report Three," 33-36. Available at: https://downloads.cms.gov/files/cmmi/simrd2-test-ar3.pdf.
[33] RTI International, "State Innovation Models (SIM) Initiative Evaluation, Model Test Year Five Annual Report," December 2018, 20. Available at: https://downloads.cms.gov/files/cmmi/sim-rd1-mt-fifthannrpt.pdf.
[34] Ibid.
[35] RTI International, "State Innovation Models (SIM) Initiative Evaluation, Model Test Year Five Annual Report," December 2018, 34. Available at: https://downloads.cms.gov/files/cmmi/sim-rd1-mt-fifthannrpt.pdf.
[36] § 1932(c)(1) of the Social Security Act.
[37] 42 CFR § 438.340.
[38] Ibid.
[39] Centers for Medicare & Medicaid Services, "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care," 85 FR 72754, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care.
[40] Ibid.
[41] Ibid.
[42] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[43] Timothy E. Burdick, Rodger S. Kessler, "Development and use of a clinical decision support tool for behavioral health screening in primary care clinics," Applied Clinical Informatics, 8: 412–429, April 26, 2017. Available at: https://www.thieme-connect.de/products/ejournals/abstract/10.4338/ACI-2016-04-RA-0068.
[44] HealthMine, Medicare Advantage Plan Beneficiary Insights: Connecting with Beneficiaries, September 2019. Available at: https://www.healthmine.com/resources/healthmineresearch/.
[45] Ibid.
[46] Section 223, "Protecting Access to Medicare Act of 2014," Pub. Law 113-93, April 1, 2014. Available at: https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf.

[47] Association of Government Accounts, "Blended and Braided Funding: A Guide for Policy Makers and Practitioners," December 2014, 17. Available at: https://www.agacgfm.org/Intergov/More-Tools/Blended-and-Braided-Funding-A-Guide-for-PolicyMa.aspx.
[48] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[49] Centers for Medicare & Medicaid Services, "2020 Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set)." Available at: https://www.medicaid.gov/state-resource-center/medicaid-state-technicalassistance/health-home-information-resource-center/downloads/2020-health-homecore-set.pdf.
[50] Centers for Medicare & Medicaid Services, "2021 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)." Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-core-set.pdf.
[51] Hayley D. Germack, et al, Association of Comorbid Serious Mental Illness Diagnosis With 30-Day Medical and Surgical Readmissions, JAMA Psychiatry, Jan 2019; 76(1): 96–98. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6583450/.
[52] Erin Shigekawa, Margaret Fix, et al., "The Current State Of Telehealth Evidence: A Rapid Review," *Health Affairs,* 37(12): 1975–82, 2018. Available at: https://doi.org/10.1377/hlthaff.2018.05132.
[53] Melanie Gentry, et al., "Geriatric Telepsychiatry: Systematic Review and Policy Considerations" *The American Journal of Geriatric Psychiatry* 27(2), 2019. Available at: https://pubmed.ncbi.nlm.nih.gov/30416025/.
[54] Annie Irvine, Paul Drew, et al., "Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies," *Journal of Affective Disorders,* 265: 120-131, 2020. Available at: https://doi.org/10.1016/j.jad.2020.01.057.
[55] Samuel Yeroushalmi, et al., "Telemedicine and multiple sclerosis: A comprehensive literature review." *Journal of telemedicine and telecare* vol. 26,7-8 (2020): 400-413. Available at: https://doi.org/10.1177/1357633X19840097.
[56] SAMHSA, "Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders," June 2021. Available at: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf.
[57] Silver, Zoe, Mikaela Coger, Sebastian Barr, and Rebecca Drill. "Psychotherapy at a Public Hospital in the Time of Covid-19: Telehealth and Implications for Practice." *Counselling Psychology Quarterly*, 2020, 1–9. Available at: https://doi.org/10.1080/09515070.2020.1777390.
[58] Fiona Imlach, et al., "Telehealth consultations in general practice during a pandemic lockdown: survey and interviews on patient experiences and preferences," *BMC Family Practice,* 21(1), December 2020. Available at: https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-020-01336-1.
[59]"Relias Learning, "Best Practices for Delivering Telehealth," August 2021. Available at: https://content.relias.com/resources/CoronaVirusToolKit/TelehealthBestPractices/story_html5.html?lms=1&lms=1.
[60] Leonard Egede, Clara Dismuke, et al., "Cost-Effectiveness of Behavioral Activation for Depression in Older Adult Veterans: In-Person Care Versus Telehealth," *Journal of Clinical Psychiatry*, August 2018. Available at: https://www.psychiatrist.com/jcp/psychotherapy/cost-effectiveness-of-psychotherapy-via-telehealth/.
[61] Leonard Egede, Mulugeta Gebregziabher, "Trajectory of cost overtime after psychotherapy for depression in older Veterans via telemedicine," *Journal of Affective Disorders*, January 2017. Available at: https://pubmed.ncbi.nlm.nih.gov/27721190/.
[62] Btissame Massoudiam, FloorHolvast, et al., "The effectiveness and cost-effectiveness of e-health interventions for depression and anxiety in primary care: A systematic review and meta-analysis," *Journal of Affective Disorders*, February 2019. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0165032717321535?via%3Dihub.

[63] Hunna Watson, Nicole McLagan, "Cost-Effectiveness of Internet-Based Cognitive-Behavioral Treatment for Bulimia Nervosa: Results of a Randomized Controlled Trial," *Journal of Clinical Psychiatry*, January/February 2018. Available at: https://pubmed.ncbi.nlm.nih.gov/29228517/.
[64] Melanie Gentry, Maria Lapid, and Teresa Rummans, "Geriatric Telepsychiatry: Systematic Review and Policy Considerations," *The American Journal of Geriatric Psychiatry*, February 2019. Available at: https://doi.org/10.1016/j.jagp.2018.10.009.
[65] David Grabowski and A. James O'Malley, "Use Of Telemedicine Can Reduce Hospitalizations Of Nursing Home Residents And Generate Savings For Medicare," *Health Affairs*, February 2014. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0922.
[66] Paul Bernstein, Kelly Ko, et al., "Urgent and non-emergent telehealth care for seniors: Findings from a multi-site impact study," *Journal of Telemedicine and Telecare*, April 2021. Available at: https://journals.sagepub.com/doi/10.1177/1357633X211004321.
[67] Sharron Rushton, Joel Boggan, et al., "Effectiveness of Remote Triage: A Systematic Review," Department of Veterans Affairs, July 2019. Available at: https://www.ncbi.nlm.nih.gov/books/NBK553039/.
[68] Hassan Khader Almathami, et al., "Barriers and Facilitators That Influence Telemedicine-Based, Real-Time, Online Consultation at Patients' Homes: Systematic Literature Review," *Journal of Medical Internet Research*, 22(2), February 2020. Available at: https://www.jmir.org/2020/2/e16407/.
[69] Hoffmann, Mariell et al. "Perspectives of Psychotherapists and Psychiatrists on Mental Health Care Integration Within Primary Care Via Video Consultations: Qualitative Preimplementation Study." *Journal of medical Internet research* vol. 22,6 e17569. 18 Jun. 2020. Available at: https://doi.org/10.2196/17569.
[70] Hilty, Donald M., Melanie T. Gentry, Alastair J. McKean, Kirsten E. Cowan, Russell F. Lim, and Francis G. Lu. "Telehealth for Rural Diverse Populations: Telebehavioral and Cultural Competencies, Clinical Outcomes and Administrative Approaches." *mHealth* 6 (2020): 20–20. Available at: https://doi.org/10.21037/mhealth.2019.10.04.
[71] George Miller, Corwin Rhyan, et al., "COVID-19 Shocks The US Health Sector: A Review Of Early Economic Impacts," *Health Affairs*, December 2020. Available at: https://www.healthaffairs.org/do/10.1377/hblog20201214.543463/full/.
[72] Sadiq Patel, Ateev Mehrotra, et al., "Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States," *Health Affairs*, February 2021. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01786.
[73] Sadiq Patel, Ateev Mehrotra, et al., "Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States," *Health Affairs*, February 2021. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01786.
[74] Oleg Bestsennyy, Greg Gilber, et al., "Telehealth: a quarter trillion dollar post COVID reality," McKinsey & Company, July 2021. Available at: https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.
[75] Cecilia Cortez, Omar Mansour, et al., "Changes in Short-term, Long-term, and Preventive Care Delivery in US Office-Based and Telemedicine Visits During the COVID-19 Pandemic," *JAMA Health Forum*, 2021. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2781917.
[76] Annie Irvine, Paul Drew, et al., "Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies," *Journal of Affective Disorders,* 265: 120-131, 2020. Available at: https://doi.org/10.1016/j.jad.2020.01.057.
[77] Ibid.
[78] Ibid.
[79] Substance Abuse and Mental Health Services Administration, "FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency," April 2021. Available at: https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf.

[80] Elizabeth Samuels, Seth Clark, et al., "Innovation During COVID-19: Improving Addiction Treatment Access," *Journal of Addiction Medicine*, Aug 2020. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7236851/.
[81] Seth Clark, Corey Davis, et al., "Using telehealth to improve buprenorphine access during and after COVID-19: A rapid response initiative in Rhode Island," *Journal of Substance Abuse Treatment*, May 2021. Available at: https://pubmed.ncbi.nlm.nih.gov/33771282/.
[82] Robert Pierce and James Stevermer, "Disparities in use of telehealth at the onset of the COVID-19 public health emergency," *Journal of Telemedicine and Telecare*, October 2020. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7578842/.
[83] Elaine Duryea, Emily Adhikari, et al., "Comparison Between In-Person and Audio-Only Virtual Prenatal Visits and Perinatal Outcomes," *JAMA Network Open*, April 2021. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2778558.
[84] Denisse Holcomb, Mary Ann Faucher, et al., "Patient Perspectives on Audio-Only Virtual Prenatal Visits Amidst the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Pandemic," *Obstetrics & Gynecology*, August 2020. Available at: https://pubmed.ncbi.nlm.nih.gov/32544144/.
[85] Carmel Shachar, Jaclyn Engel, and Glyn Elwyn "Implications for Telehealth in a Postpandemic FutureRegulatory and Privacy Issues," *JAMA*, May 2018. Available at: https://jamanetwork.com/journals/jama/fullarticle/2766369.
[86] Centers for Medicare & Medicaid Services, "Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices," November 2010. Available at: https://pubmed.ncbi.nlm.nih.gov/21090146/.
[87] Ibid.
[88] Office of Inspector General, "Principal Deputy Inspector General Grimm on Telehealth," February 2021. Available at: https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp.
[89] Government Accountability Office, "Medicare and Medicaid: COVID-19 Program Flexibilities and Considerations for Their Continuation," May 2021. Available at: https://www.gao.gov/assets/gao-21-575t.pdf.
[90] Eric Roberts and Ateev Mehrotra, "Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine," *JAMA Internal Medicine*, October 2020. Available at: https://pubmed.ncbi.nlm.nih.gov/32744601/.
[91] Paige Minemyer, "Anthem study: Telehealth helped address pandemic health disparities, but gaps remain," *Fierce Healthcare*, July 2021. Available at: https://www.fiercehealthcare.com/tech/anthem-study-telehealth-helped-address-pandemic-health-disparities-but-gaps-remain.
[92] Celeste Campos-Castillo and Denise Anthony, "Racial and Ethnic Differences in Self-Reported Telehealth Use during the Covid-19 PANDEMIC: A Secondary Analysis of a US Survey of Internet Users from Late March," *Journal of the American Medical Informatics Association,* 28(1): 119–25, 2020. Available at: https://doi.org/10.1093/jamia/ocaa221.
[93] Kara Wegermann, Julius Wilder, et al., "Racial and Socioeconomic Disparities in Utilization of Telehealth in Patients with Liver Disease during Covid-19." *Digestive Diseases and Sciences*, 2021. Available at: https://doi.org/10.1007/s10620-021-06842-5.
[94] Gaby Galvin, "Study: Broadband a Boost for Rural Telemedicine Use," US News and World Report, July 29, 2019. Available at: https://www.usnews.com/news/healthiest-communities/articles/2019-07-29/study-broadband-a-boost-for-rural-telemedicine-use.
[95] Federal Communications Commission, "Improving the Nation's Digital Infrastructure," January 19, 2017. Available at: https://www.fcc.gov/document/improving-nations-digital-infrastructure.
[96] Hyunwoo Yoon, Yuri Jang, et al. "Older Adults' Internet Use for Health Information: Digital Divide by Race/Ethnicity and Socioeconomic Status," *Journal of Applied Gerontology*, 39(1): 105-110, April 16, 2018. Available at: https://doi.org/10.1177%2F0733464818770772.
[97] Ibid.

[98] U.S. Department of Education, *Stats in Brief: A Description of U.S. Adults Who Are Not Digitally Literate,* May 2018. Available at: https://nces.ed.gov/pubs2018/2018161.pdf.
[99] Lam K, Lu AD, Shi Y, Covinsky KE. Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic. *JAMA Intern Med.* 2020;180(10):1389–1391. Available at: https://doi.org/10.1001/jamainternmed.2020.2671.
[100] Pew Research Center, *Mobile Technology and Home Broadband 2019,* June 13, 2019. Available at: https://www.pewresearch.org/internet/2019/06/13/mobile-technology-and-home-broadband-2019/.
[101] Ibid.
[102] Health Management Associates, *Estimated Federal Costs of Behavioral Health Integration Policy Proposals*, March 2021. Available at: https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/20210322-BPC-Health-Management-Associates-Behavioral-Health-Integration-Policy-Proposals-Final.pdf.
[103] Ateev Mehrotra, Michael Chernew, et al., "The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases," Commonwealth Fund, February 2021. Available at: https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge.
[104] Ibid.