State of California—Health and Human Services Agency
Department of Health Care Services

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November 1, 2021

The Honorable Ron Wyden, Chairman
The Honorable Mike Crapo, Ranking Member
U.S. Senate Committee on Finance
Washington, D.C 20510-6200

Dear Senators:

Thank you for the opportunity to provide input in support of the bipartisan process initiated by the U.S. Senate Committee on Finance to examine behavioral health (BH) care needs and data-driven policy proposals. We provide the following recommendations, consistent with the priorities outlined in your letter.

Strengthening the Behavioral Health Workforce

- **Expand the workforce through funding and financial incentives**. In many communities, substance use disorder (SUD) counselors and peer support providers earn less income than do retail and service workers. The limited remunerable opportunities available to non-licensed BH professionals contribute to BH workforce and capacity issues. Please consider funding national stipends and/or loan forgiveness programs for the BH workforce. In addition, consider targeted enhanced federal funding opportunities for state Medicaid agencies to invest in BH workforce expansions, similar to the Health and Community-Based Services (HCBS) opportunities available through the American Rescue Plan Act (ARP Act; Pub. Law 117-2), which has enabled states to invest in critical service and delivery system expansions, and in follow up to the SUD planning grant opportunity offered through the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; Pub. Law 115-271).
- **Enhance training opportunities and qualifications.** Consider funding/developing clinical training opportunities for BH practitioners to develop and demonstrate expertise in specific clinical specialties, such as working with the criminal justice and forensic populations, individuals experiencing homelessness, individuals with comorbidities, etc., which could lead to enhanced provider payment rates and employee salaries. Consider targeted enhanced federal funding opportunities for state Medicaid agencies to implement BH workforce credentialing and competency development and investments, similar to the HCBS opportunities available through the ARP Act.

- **Strengthen research and Medicaid coverage opportunities for employment supports and services**. There is a strong body of evidence for employment supports and services for individuals with disabilities and mental illness, including supported employment models such as Individual Placement and Support (IPS). However, we lack research data about the most effective employment supports and services for individuals with SUD. Some states, such as Washington, have implemented IPS for individuals with SUD and have demonstrated positive health and social outcomes (see https://www.hca.wa.gov/assets/program/mtp-interim-report.pdf). Consider funding research, training and technical assistance, pilot programs, and enhanced federal funding opportunities for state Medicaid agencies to cover employment supports and services for individuals with SUD as well as mental illness. Some of these individuals may be interested in participating in the BH workforce as a career.

Increasing Integration, Coordination, and Access to Care

- **Revise federal regulations pertaining to methadone.** Methadone is one of the most heavily regulated drugs in the United States. We recommend Congress instruct the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide additional flexibility for clinical discretion in regard to all aspects of opioid treatment program (OTP) regulations and standards. We have learned that increased flexibility for take-home medication, for example, has increased patient satisfaction, improved patient quality of life, and not resulted in diversion or unintended consequence. In addition, we recommend Congress fund technical assistance to state Medicaid agencies and Single State Agencies for Substance Abuse Services to develop strategies to expand access to OTPs in rural settings, including but not limited to technical assistance in developing regulations, policies, coverage criteria, and payment rates and methodologies that would support OTPs to develop medication units and mobile delivery units consistent with recent rulemaking from the U.S. Drug Enforcement Administration. Finally, we recommend Congress allow for the provision of methadone to treat opioid use disorder in primary care settings and behavioral health care settings other than OTPs.
- **Remove buprenorphine DATA 2000 waiver requirements**. While the training requirements have been waived and the eligible prescribers have expanded to include non-physician primary care providers, the X-waiver is still required. We recommend removing the X-waiver and treating buprenorphine similar to other medications, including opioids – so that any clinician with prescribing authority can prescribe the medication consistent with the individual clinical needs of the particular patient and with the clinician's particular expertise.
- **Require evidence-based treatment in critical health care settings.** We recommend Congress explore opportunities for requiring hospitals and emergency departments to deliver medication assisted treatment (MAT) in

inpatient and emergency settings through Medicare Conditions of Participation and accreditation requirements. In addition, we recommend Congress require every federal health care program and health insurance plan to reimburse for screening, brief intervention, and referral to treatment, and MAT in emergency departments (similar to recently added Medicare billing codes). In addition, we recommend requiring all local, state, and federal correctional facilities to provide all forms of FDA-approved MAT.

- **Revise confidentiality requirements.** We recommend Congress develop legislation directing SAMHSA to issue guidance providing additional flexibility with respect to 42 CFR Part 2, as to SUD treatment confidentiality records. While the 2017 rulemaking provided modest improvements, achieving further alignment with Health Insurance Portability and Accountability Act (HIPAA) privacy and consent requirements, with strong guardrails retained around disclosures pertaining to court orders, will help improve clinical care coordination for individual patients. In addition, streamlining 42 CFR Part 2 criteria will further lessen the fragmentation of the specialty addiction treatment providers from the medical care system, and help to "de-stigmatize" individuals seeking help for substance use and misuse.

Ensuring Parity

- **Continue to strengthen parity enforcement.** The recent documentation changes made to the Mental Health Parity and Addiction Equity Act by the Continued Appropriations Act, 2021 (Pub. Law 116-260) , as summarized in the April 2021 FAQ, are an important and critical step to achieving the goals of parity. We recommend Congress direct the Department of Health and Human Services, the Department of Labor, and the Treasury to continue expanding parity oversight efforts through comprehensive guidance, consistent communication, and deadline enforcement. This could include providing guidance to plans and direct technical assistance to stakeholders who seek to adhere to or maintain consistency with the judicial outcome of *Wit v. United Behavioral Health*, Case No. 14-cv-02346-JCS (N.D. Cal. Nov. 3, 2020).
- **Expand Essential Health Benefits or other requirements to achieve parity goals.** Consider exploring opportunities for mandating marketplace and ERISA plans to expand coverage of BH benefits consistent with the full continuum of mental health and SUD care. Currently, health plans and insurers regulated by California law must cover all medically necessary forms of mental health and SUD treatment services, such as OTP services, mobile crisis response, all sublevels of outpatient and residential treatment, etc. However, self-insured plans governed by ERISA are not subject to these California state requirements. In particular, these efforts would support efforts by state Medicaid agencies to implement multi-payer financing mechanisms for 9-8-8 consistent with the National Suicide Hotline Designation Act and mobile crisis intervention services

consistent with the enhanced federal funding opportunity made available through the ARP Act.

- **Strengthen state oversight requirements of health plan provider directories validation.** Currently, many health plans operate "ghost networks" for mental health providers, whereby their provider directories list providers who do not participate in the plan. True access to mental health care is often much lower than attested and marketed. Consider strengthening federal and state insurance oversight requirements regarding provider directory and network validation methodologies for plans participating in the marketplace and overseen by ERISA.
- **Enhance Medicaid managed care network adequacy requirements.** Currently, Medicaid network adequacy regulations require a State to adopt one or more quantitative standards for behavioral health providers furnishing services under a managed care arrangement. However, specifying network adequacy requirements, including quantitative standards, for providers delivering mandatory benefits per the SUPPORT Act, such as OTPs, buprenorphine prescribers, etc., could help expand access to these services, in addition to evidence-based practices and therapies covered under optional Medicaid benefit categories, such as assertive community treatment, mobile crisis, intensive care coordination for children and youth, etc. We recommend providing technical assistance to state Medicaid agencies on enhanced BH network adequacy policy design and oversight.

Telehealth

- **Permanently sustain flexibilities for MAT, including OTPs, introduced during COVID.** These should include the flexibilities (at a minimum) related to telehealth- or telephone-prescribing of buprenorphine, in-person evaluations at OTPs, and take-home medication flexibilities at OTPs. Such flexibilities, in conjunction with broader telehealth coverage and payment flexibilities, allow for greater access to lifesaving services, leading to increased rates of initiation, engagement, and retention in treatment.

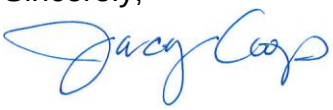
Improving Access for Children and Young People

- **Services for children and youth should be age, culturally, and developmentally appropriate.** While it may seem obvious**,** some programs for children and youth attempt to apply models and strategies designed for adults. The United States, and California in particular, is growing increasingly diverse. Services for children and youth must incorporate and address cultural values, perspectives, and norms in service delivery. Consider education, technical assistance, and funding opportunities to support culturally-centered youth behavioral health care inclusive of family-based multi-generational care models.

- **School-linked health services help reach children and youth.** Continue to work toward means to increase school-linked services regardless of insurance coverage status and payer.
- **Youth can benefit from higher utilization of technology to access supports and services.** Youth are generally more comfortable with using chat and text technology to communicate. Providing supports and services in these modes may increase utilization of such services by youth. Some areas and some youth may lack broadband or technology, which should be addressed.
- **Look at population-level efforts to shift norms about accessing services and providing support earlier to reduce the need for higher-level services.** Efforts to reduce stigma around behavioral health services and shifting norms of acceptability in accessing services can help intervene earlier to reduce the need for higher-level services.
- **Continue to prioritize crisis care and suicide prevention efforts.** Suicide is a leading cause of death among children and youth, and self-injury is a leading cause of emergency department visits. In the wake of the pandemic and rising behavioral health needs, substantial investments in preventing crisis and suicide should be a top national priority.

Thank you for the opportunity to provide input on the legislative proposals that the U.S. Senate Committee on Finance is considering to improve access to health care services for Americans with mental health and substance use disorders. If you have any questions or need additional information, please contact Tyler Sadwith, Assistant Deputy Director, Behavioral Health, at (916) 440-7800 or by email at Tyler.Sadwith@dhcs.ca.gov.

Sincerely,



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