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November 1, 2021

The Honorable Ron Wyden
United States Senate
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Michael Crapo
United States Senate
239 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Los Angeles County Department of Public Health Input to Improve Access to Behavioral Health Services

Dear Senators Wyden and Crapo,

The Los Angeles County Department of Public Health (L.A. County Public Health) appreciates the opportunity to respond to your request for information on proposals that will improve access to behavioral health (BH) services and care across the United States. Thank you for your steadfast leadership and bipartisan efforts to examine substance use disorder (SUD) and mental health (MH) needs and to assess the factors contributing to gaps in care nationally.

As the nation's largest county public health department, serving a diverse population of over 10 million people, L.A. County Public Health is responsible for providing a full continuum of SUD care to safety net populations across Los Angeles County. Under California's Section 1115(a) Medicaid Waiver, L.A. County Public Health provides Medicaid-reimbursable services for specialty SUD treatment through the Drug Medi-Cal Organized Delivery System (DMC-ODS). Serving over 35,000 patients annually, L.A. County Public Health strives to deliver integrated, coordinated, and patient-centered care.

Our input reflects the experience of a county SUD system serving some of society's most vulnerable and complex patients. L.A. County Public Health appreciates the Senators' work in building a policy agenda for a modern, streamlined, and robust BH system. The following proposals will enable our national leaders to advance this goal.

Strengthening Workforce

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

  Increasing Medicaid Rates

  Policies that increase Medicaid reimbursement rates and simplify payment/reimbursement mechanisms for BH services will increase provider participation. Medicaid's comparatively lower reimbursement rates impact providers' ability to maintain the costs for day-to-day service delivery. Providers that contract with multiple entities, including commercial payers, often prioritize non-Medicaid beneficiaries because of the higher private reimbursement rates. This creates access issues for Medicaid patients in instances when service capacity is limited. As such, policies that ensure Medicaid BH rates are competitive across health care systems will support greater parity and encourage new BH providers to participate in Medicaid and other public programs.

  Streamlining Contracting Mechanisms

  Medicaid contracting can be costly and complex to navigate for new providers due to multiple and prolonged applications, certifications, and licensing processes. At the local level, BH systems do not have the authority and ability to directly enroll/certify their providers and sites. Like managed care plans, local BH systems must comply with federal and state network adequacy time and distance standards. However, the current state-led process and significant delays limit local jurisdictions' ability to contract with new providers and sites to expand their treatment network and ensure compliance with these federal and state requirements. Streamlining contracting mechanisms such as enabling local jurisdictions to directly enroll/certify new BH providers will reduce some of the contracting delays to support new provider enrollment and participation.

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

  Chronic Underinvestment of the SUD Workforce

  The significant and persistent SUD workforce shortage across various staffing levels including counselors, licensed clinicians, and physicians creates service delays, high workloads, provider burnout, and high turnover, all of which prevent patients from accessing SUD services. This shortage is particularly acute for SUD professionals working in underserved communities. These gaps are amplified further when considering the need for a diverse workforce that reflects the community and patient population it serves.

  Commendably, the Affordable Care Act (ACA) and other federal and state policies have substantially expanded coverage for BH services. With this coverage expansion, the need for SUD counselors and licensed staff (e.g., social workers) has only increased. In many local communities, SUD counselors are the backbone of the SUD workforce. Counselors, among BH workers, are projected to see the lowest increase in supply at three percent but with the highest growth in worker

demand at 15 percent, according to the Human Resources and Services Administration (HRSA) BH Workforce Projections.[1]

However, hiring and retaining trained and qualified SUD professionals have traditionally presented challenges. Nationally, approximately one in four SUD counselors leave the field each year. Aside from being generally underpaid, the job demands have increased with the local implementation of DMC-ODS and the recent rise in SUD and overdoses deaths. Additionally, the weight of taking on the emotional pain of their patients makes burnout among the SUD workforce a common occurrence.

Other specific challenges include historical lack of investments in the specialty SUD system; lack of awareness of systems-level modernizations that present many exciting opportunities for professionals looking to enter the health care field; and cost barriers, particularly for individuals with lived experience and low economic opportunities. As the SUD system continues to move towards an interdisciplinary and coordinated whole-person care approach to improve health outcomes, strengthening the SUD workforce becomes paramount.

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

SUD Workforce Pipeline Programs Focused in Diverse Communities

In addition to financial support and incentives, increasing workforce cultural/linguistic capacity and establishing pipeline programs focused on socio-economically and culturally diverse communities, including LGBTQ+, can strengthen, broaden, and diversify the BH workforce. A BH workforce that reflects the clientele, and therefore can more effectively address nuanced aspects of serving communities most impacted by substance use, is integral in fostering an inclusive and responsive treatment landscape. For example, research shows that individuals who identify as part of LGBTQ+ communities often site adverse negative experiences in relation to sexual identity or gender identity as a deterrent to accessing treatment, despite having a greater risk of substance use and mental health issues when compared to their cisgender or heterosexual counterparts[2]. This occurrence emphasizes the need for clinicians and other BH workers that identify with or are adequately trained to provide services to these communities.

L.A. County Public Health developed the Tuition Incentive Program (TIP) to recruit, train, and develop new SUD counselors from diverse areas with low economic opportunity. The TIP was explicitly designed to create new certified SUD Counselors by covering education-related costs and facilitating employment in the public SUD system. L.A. County Public Health partnered with a statewide certifying body to administer the coursework and a nonprofit agency to establish a learning collaborative to help participants overcome barriers to completing the program. In addition to the certification coursework, the TIP required participants to become Registered Alcohol and Drug Technicians (RADT) that enabled them to provide Medicaid-reimbursable SUD services; complete training on the American Society of Addiction Medicine (ASAM) criteria; and

[1] https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health
[2] https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf

complete training on the L.A. County Public Health SUD electronic health record. Programs like the TIP pilot have demonstrated the high demand and potential to cultivate new SUD workforce members with lived experience from diverse and underserved communities to increase the SUD workforce.

Additionally, cultural and social sensitivities and stigmas associated with BH conditions can be barriers to access. They can negatively impact the perception of BH care among different racial and ethnic groups.[3,4] These negative impacts and barriers are also present for those who identify as LGBTQ+. The lack of LGBTQ-specific services in non-affirming facilities results in lower rates of treatment utilization.[5] Thus, Congress should encourage school-based BH partnerships to introduce early integration of BH career options in schools and colleges, including historically black colleges and universities (HBCUs), to increase awareness and attractiveness of the BH care field.

Strengthening Workforce Training

Congress should also encourage the implementation of workforce training frameworks, available to all levels of staff, that incorporate LGBTQ+ specific and racially/culturally relevant approaches, such as Substance Abuse and Mental Health Service Administration's (SAMHSA) LGBT Training Curricula for Behavioral Health and Primary Care to enhance BH workforce capacity and effectiveness.

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

Residents in rural, low-resourced, and Health Professional Shortage Areas (HPSA) experience higher BH accessibility disparities than their urban and suburban counterparts.[6] Studies have shown retention rates in medically underserved or rural areas increased when financial incentives such as scholarships or loan repayment programs were provided.[7,8] Intentional recruitment among populations with personal ties to rural communities has also positively affected retention in rural areas.[9] Federal policies can support the BH workforce through expanding loan repayment programs, funding and broadening pipeline programs, increasing scholarship opportunities, and expanding educational and training capacity in professional schools to improve the quality and quantity of the BH workforce in underserved areas.

Structuring higher Medicaid payments for geographic regions that are underserved would allow providers to offer higher salaries for BH workforce in these regions, which would help to address workforce shortages in these areas.

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[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5347358/
[4] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0029
[5] https://casatondemand.org/2019/12/19/4489/
[6] https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities
[7] https://www.jstor.org/stable/4640788
[8] https://aspe.hhs.gov/reports/provider-retention-high-need-areas-0
[9] https://www.chcf.org/wp-content/uploads/2021/04/HealthWorkforceStrategiesReviewEvidence.pdf

- ***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?***

  The Coronavirus Aid, Relief, and Economic Security (CARES) Act reformed SUD confidentiality laws in 2020. While the U.S. Department of Health and Human Services (HHS) develops the guidelines, it will be important that the regulations consider the shifts in the health care landscape, such as the widespread and growing adoption of electronic health records (EHR) and telehealth, to ensure that BH providers, particularly SUD providers, can easily share information and form part of appropriate care teams while maintaining confidentiality. As 42 CFR Part 2 was the standard of SUD confidentiality for decades, the federal government must ensure that updated information regarding SUD confidentiality laws is integrated into Health Insurance Portability and Accountability Act (HIPPA) and other required confidentiality trainings.

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

  L.A. County Public Health strongly maintains that our nation continues to lack sufficient investment to build the necessary SUD workforce infrastructure critical to designing the BH system of the future. Promising strategies related to SUD workforce development include:

  - *Uplifting the Non-Medical SUD Workforce* - Many safety-net workforce recruitment programs are often aimed at physicians or other medical staff. Considering the centrality of both SUD Counselors and licensed clinicians within the SUD system, targeting recruitment and development efforts aimed at those staffing categories is essential. New or existing safety-net workforce recruitment programs should be expanded to recruit non-physician level professionals such as licensed clinicians into specialty SUD and other treatment systems.

  - *Scholarships for SUD Counselor Certification Programs* – Programs such as Los Angeles County's TIP Pilot have demonstrated the high demand and potential to cultivate new staff from underserved communities. Though the TIP pilot was limited in scope and funding, similar programs should be expanded via formal partnerships with certifying bodies, local SUD academies, and community colleges.

  - *Expanding SUD Pipeline Programs* – Other states have shown that early engagement of youth and young adults in high school and college can lead to them pursuing careers in BH. Nebraska's Behavioral Health Ambassador Program recruits and mentors students from high school to college to BH careers, including licensed clinicians and SUD Counselors. A pipeline program in California similar to the Nebraska Ambassador Program could add up to 5,700 professionals within ten years at approximately $11,000 per person.

- *Developing Loan Repayment Programs for SUD Professionals* – Creating a sustainable and local version of HRSA's Substance Use Disorder Workforce Loan Repayment Program will ensure an influx of new talent.

- *SUD Provider Recruitment Grants* – To support SUD providers in identifying and recruiting new staff, specific grants can be used to subsidize recruitment-related and professional development expenses such as sign-on bonuses, first-year salary/benefit costs, relocation costs, costs of maintaining certification/licenses, media and advertising costs, and paying for existing staff to pursue certification, loan repayment, etc.

- ***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?***

  SUD counselors have long been a critical part of the SUD treatment system. With advancements in the field and healthcare overall, some SUD counselors are now working within managed care environments and are required to understand the American Society of Addiction Medicine (ASAM) criteria, Diagnostic and Statistical Manual of Mental Disorders (DSM-5), electronic health record systems, case management, care navigation, social determinants of health, cultural competency, etc. As the specialty SUD system integrates itself more into the broader health care system, SUD counselors will be required to adjust to more comprehensive managed health care requirements where standardized approaches to evaluating the effects of their work will be necessary.

  Nationally, SUD counselor workforce standards are decentralized and overseen by a wide range of credentialing bodies requiring varying levels of the minimum education, training, and skills development, resulting in a mix of standards that vary state-by-state or organization-by-organization. Even within some states like California, the SUD counselor certification process is managed by various organizations.

  Developing national licensing standards will elevate SUD counselors' contributions to the health care field and enhance professional prestige, similar to national training standards for physicians, psychologists, and other health professionals. It will ensure that SUD counselors across the country have a baseline competency and are well equipped for future system changes. Specifically, national standards will increase minimum education and training requirements, establish practice efficacy and efficiency, develop national competencies, improve reciprocity to practice across states, standardize performance expectations, and ensure continuous support and training.

  As part of its workforce development strategy, Congress should lead the vision for national licensing standards to strengthen the future direction of the SUD counselor profession.

Increasing Integration, Coordination, and Access to Care

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

Eliminate the IMD Exclusion

Medicaid's Institutions for Mental Disease (IMD) exclusion (§1905(a)(B) of the Social Security Act) prohibits using federal Medicaid funds to pay for care for individuals who require inpatient BH services.[10] It is the only portion of the Medicaid law that prohibits federal funds to support providing medically necessary care based on the condition.

While the original intent of the IMD exclusion was to discourage long-term institutionalized care in favor of community-based services, the IMD exclusion currently represents an obsolete approach and a substantial barrier to accessing treatment. The IMD exclusion discriminatorily and specifically impacts individuals who require complex and individualized care that may only be provided in inpatient settings, limiting the availability and timely access to these services.

Although some states have leveraged 1115 Medicaid waivers to address gaps resulting from the IMD exclusion, they are temporary solutions to a statutory problem. By repealing the IMD exclusion, Congress can permanently ensure that individuals with more severe BH conditions requiring services in inpatient settings are not discriminated against and enable states and counties to support medically necessary inpatient BH care in parity with other states medically necessary care across the health care system.

Allow Federal Funding for Residential Room and Board Costs in IMD Waivers

In the absence of a full repeal of the IMD exclusion, Congress should allow for room and board (R&B) costs for medically necessary residential treatment within Medicaid waivers. While there have been regulatory efforts to reform the IMD exclusion rule, these updates still do not allow for reimbursement of R&B costs in residential treatment settings, even within Medicaid waivers, as the prohibition on financing IMD coverage is in the statute.[11]

As such, while L.A. County Public Health can offer broader residential SUD treatment services under California's 1115(a) Medicaid Waiver, Medicaid will not pay for R&B costs associated with residential treatment programs, leaving this responsibility to states and counties, resulting in a diversion of funds from other priority areas to support R&B.

This contrasts with other health conditions that may require an inpatient hospital stay while the patient stabilizes and recovers. In these cases, Medicaid does not split out, nor does it decline to cover, the cost of R&B as it does for SUD and other BH conditions. Much like inpatient hospital stays, R&B costs are integral to SUD and other BH residential treatment programs. From a parity standpoint, this unequal policy reinforces institutionalized discrimination against people with acute SUD and other BH conditions (i.e., mental health and co-occurring disorders) that are severe enough to require residential or inpatient treatment.

[10] https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/
[11] https://sgp.fas.org/crs/misc/IF10222.pdf

Reforming the IMD exclusion to allow Medicaid to cover R&B costs within approved Medicaid waivers is a significant and positive step Congress can take towards increasing BH parity and reducing BH discrimination.

Repeal the X-Waiver for Prescribing Medications for Addiction Treatment

To broaden access to medications for addiction treatment (MAT), recent regulatory flexibilities waive the buprenorphine practitioner's requirement to complete an eight-hour training course to obtain a Drug Enforcement Administration (DEA) X-waiver.[12] Unfortunately, this is a temporary fix to a statutory problem. From a clinical and policy standpoint, maintaining stricter policies for a partial agonist like buprenorphine, which has a safer risk profile than full agonist opioids such as hydrocodone and oxycodone, creates unnecessary barriers and challenges that limit access to MAT for the public. As part of any BH reform effort, Congress should remove this statutory barrier to prescribing MAT.

Amend the Anti-Kickback Statute's "Safe Harbor Provisions" to Support Contingency Management

Contingency management (CM) is an evidence-based behavioral intervention for substance use disorders that provide monetary or non-monetary rewards to reinforce target behaviors such as treatment adherence or abstinence. It has been recommended by the National Institutes of Health (NIH), the U.S. Surgeon General, and ASAM, among others. CM has effectively treated various substances and is an alternative intervention for stimulant use disorders that cannot be treated with medication, such as methamphetamine.[13]

The federal Anti-Kickback Statute (AKS) (42 USC § 1320a-7b) is a criminal statute that prohibits the exchange or offers to exchange of anything of value to induce or reward the referral of business reimbursable by Medicare and Medicaid. Non-monetary gifts, such as in-kind items and services, must possess a retail value of no more than $15 per item and cannot exceed $75 annually per beneficiary.

The AKS also possesses specific regulatory exceptions, termed "safe harbor" provisions, outlined under 42 CFR§1001.952, which define payment and business practices that will not be considered kickbacks that unlawfully induce payment by federal healthcare programs. Because CM treatment provides cash and cash-equivalent incentives, the AKS prohibits providers from implementing publicly-funded contingency management programs. The absence of a specific safe harbor within 42 CFR§1001.952 requires providers to request case-by-case approval of their CM programs, significantly inhibiting the availability of CM treatment.

Methamphetamine use and addiction are growing issues affecting much of the Western United States and impacting other regions. Congress can help local communities implement evidence-

[12] https://www.ama-assn.org/delivering-care/opioids/biden-administration-boosts-access-overdose-prevention-treatment
[13] Ginley, Meredith K., Rory A. Pfund, Carla J. Rash, and Kristyn Zajac. "Long-Term Efficacy of Contingency Management Treatment Based on Objective Indicators of Abstinence From Illicit Substance Use up to 1 Year Following Treatment: A Meta-Analysis." Journal of Consulting & Clinical Psychology 89, no. 1 (January 2021): 58–71. https://doi.org/10.1037/ccp0000552

based strategies to treat complex substances like methamphetamine use disorder by including CM in the AKS "safe harbor" provisions and supporting this health care strategy.

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

  Track Racial, Ethnic, Language (REL) and Sexual Orientation/Gender Identity (SOGI) Disparities in BH Outcomes

  Many healthcare systems, plans, and providers do not consistently track data on patients' self-reported REL or SOGI preference to identify inequities, particularly within BH. The lack of standardized data collection and reporting further hinders racial and geographic disparity information and frequently overlooks smaller populations whose population-level outcomes are often unreported in population-level data. The repercussions of limited race and ethnicity data have reverberated throughout the COVID-19 public health crisis and initially masked the disproportionate toll of COVID-19 and slowed public health responses to the pandemic.

  As the United States is experiencing an alarming rise in overdose deaths and BH disorders, the standardized collection and analysis of REL and SOGI data will assist states and counties in understanding the complexities of BH issues in their communities. In addition, it will guide the implementation of appropriate BH treatment programs, services, and initiatives to reduce and eliminate racial, ethnic, and other disparities in BH outcomes.

  As the United States modernizes its BH system, Congress should encourage and incentivize healthcare providers, plans, and systems to collect and report REL and SOGI data related to BH outcomes.

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

  Investing in Recovery-Oriented Housing

  Individuals recovering from SUD face complex and unique challenges. Access to safe and appropriate housing and environment is a central challenge to support sustained recovery, particularly for people experiencing homelessness (PEH). Recovery-oriented housing is a sober, safe, and shared living environment that supports individuals in recovery from SUD by allowing them to build on resources that support their long-term recovery goals.

  Individuals with SUD must access recovery-oriented housing and "low barrier" (i.e., Housing First) housing to accommodate various needs and preferences. Though both are extremely valuable, individuals with SUD in recovery-oriented housing experience lower substance use rates and relative MH outcomes when compared to Housing First programs. Therefore, it is critical to ensure that the housing system has sufficient investment to provide the supportive environments necessary for individuals in recovery. This is particularly important as housing is increasingly

shown to be a critical social determinant of health and thus needs to be a responsibility of both the health and housing systems.

Congress should build the framework to facilitate and guide a national investment of specified recovery-oriented housing for individuals in recovery and ensure that a portion of housing-related funds is dedicated to recovery-oriented housing.

Ensuring Parity

- ***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?***

Remove the IMD Exclusion

The IMD exclusion (§1905(a)(B) of the Social Security Act) prohibits using federal Medicaid funds to pay for care for individuals that require inpatient BH services.[14] It is the only portion of the Medicaid law that prohibits federal funds to support the cost of providing medically necessary care based on the condition.

While the original intent of the IMD exclusion was to discourage long-term institutionalized care in favor of community-based services, the IMD exclusion now represents an obsolete approach and a substantial barrier to accessing treatment. The IMD exclusion discriminatorily and specifically impacts individuals who require complex and individualized care that may only be provided in inpatient settings, limiting the availability and timely access to these services.

While some states have leveraged 1115 Medicaid waivers to address gaps resulting from the IMD exclusion, they are temporary solutions to a statutory problem. By repealing the IMD exclusion, Congress can permanently ensure that individuals with more severe BH conditions requiring services in inpatient settings are not discriminated against and enable states and counties to support medically necessary inpatient BH care in parity with other states medically necessary care across the health care system.

Allow Federal Funding for Residential Room and Board Costs in IMD Waivers

While a full repeal of the IMD exclusion is recommended, Congress should consider in the alternative allowing for room and board (R&B) costs for medically necessary residential treatment within Medicaid waivers. While there have been regulatory efforts to reform the IMD exclusion rule, these updates still do not allow for reimbursement of R&B costs in residential treatment settings, even within Medicaid waivers, as the prohibition on financing IMD coverage is in the statute.[15]

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residential treatment programs, leaving this responsibility to states and counties and thus diverting funds from other priority areas to support R&B.

This contrasts with other health conditions that may require an inpatient hospital stay while the patient stabilizes and recovers. In these cases, Medicaid does not split out, nor does it decline to cover, the cost of R&B as it does for SUD and other BH conditions. Much like inpatient hospital stays, R&B costs are integral to SUD and other BH residential treatment programs. From a parity standpoint, this unequal policy reinforces institutionalized discrimination against people with acute SUD and other BH conditions (i.e., MH and co-occurring disorders) that are severe enough to require residential or inpatient treatment.

Reforming the IMD exclusion to allow Medicaid to cover R&B costs within approved Medicaid waivers is a significant and positive step Congress can take towards increasing BH parity and reducing BH discrimination.

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From a clinical and policy standpoint, maintaining stricter policies for a partial agonist like buprenorphine, which has a safer risk profile than full agonist opioids such as hydrocodone and oxycodone, creates unnecessary barriers and challenges that limit access to MAT for the public. As part of any BH reform effort, Congress should remove this statutory barrier to prescribing MAT.

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The federal Anti-Kickback Statute (AKS) (42 USC § 1320a-7b) is a criminal statute that prohibits the exchange or offers to exchange of anything of value to induce or reward the referral of business reimbursable by Medicare and Medicaid. Non-monetary gifts, such as in-kind items and services, must possess a retail value of no more than $15 per item and cannot exceed $75 annually per beneficiary.

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The AKS also possesses specific regulatory exceptions, termed "safe harbor" provisions, outlined under 42 CFR§1001.952, which define payment and business practices that will not be considered kickbacks that unlawfully induce payment by federal healthcare programs. Because CM treatment provides cash and cash-equivalent incentives, the AKS prohibits providers from implementing publicly-funded contingency management programs. The absence of a specific safe harbor within 42 CFR§1001.952 requires providers to request case-by-case approval of their CM programs, significantly inhibiting the availability of CM treatment.

Methamphetamine use and addiction is a growing substance issue affecting much of the Western United States and spreading to other regions. Congress can help local communities implement evidence-based strategies to treat complex substances like methamphetamine use disorder by including CM in the AKS "safe harbor" provisions and supporting this health care strategy.

- ***To what extent do payment rates or other payment practices (e.g., timeliness of claims payment to providers) contribute to challenges in mental health care parity in practice?***

  Medicaid's comparatively lower reimbursement rates, and its interim payment system, impact providers looking to maintain the costs to support day-to-day service delivery. For multi-contracted-funded programs, higher private rates incentivize the prioritization of non-Medicaid beneficiaries, causing access issues specifically for Medicaid patients. Additionally, prolonged cost settlement processes within some Medicaid county-delivered substance use disorder (SUD) programs (such as California) prevents providers from investing in capital improvements and program expansions. Therefore, policies that ensure Medicaid BH rates are competitive across health care systems will support greater parity and encourage new BH providers to participate in Medicaid and other public programs.

  States have the flexibility to determine the types of services included in Federally Qualified Health Center (FQHC) encounters or visits and can specify limits on the number of encounters an FQHC can bill per member per day. For varying reasons, every state does not allow for same-day billing for primary care and BH visits on the same day, including California.[18] As a result, some FQHCs provide physical and BH services on the same day but are only reimbursed for one.[19] Considering that FQHCs serve a significant portion of the safety net population, including many with complex BH conditions, these policies exacerbate community health inequalities. As a result, federal policies should encourage and incentivize states to limit structural barriers, within state FQHC reimbursement policies, such as limits on same-day billing.

- ***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?***

[18] https://www.chcf.org/publication/same-day-billing-medical-mental-health-services-fqhcs/#introduction
[19] https://www.manatt.com/getmedia/0a575827-de63-48cd-8968-119aac4dfb27/PSP-CA-Options-Paper_i_1

While there is plenty of warranted attention on increasing BH parity with physical health care, there is an existing gap between specialty SUD and MH systems that also needs to be addressed. Compared to MH systems which have a more mature regulatory and financing framework, many organized county-delivered SUD treatment systems are relatively new and have recently transitioned from largely outside mainstream health care into Medicaid delivery models.[20] This discrepancy has meant that specialty SUD systems' regulatory standards are different from MH, at times in ways that disadvantage SUD systems. For this reason, as Congress acts to ensure parity for BH systems, it should also prioritize parity *within* BH systems.

Expanding Telehealth

- ***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?***

One of the primary benefits of offering BH services via telehealth is access, both from client access and workforce shortage perspectives. Increasing access clearly does contribute to quality of care, as lack of access to needed services clearly will not improve health and outcomes. That said, there are advantages to in-person care that will never be adequately addressed by telehealth. For example, a good clinician may notice in an in-person session that when someone in MH treatment talks about their husband, they always fidget their feet. This may be related to domestic violence or other clinically relevant details, but would be very difficult to detect during a telehealth interview. As such, removing the clear benefits of access from both a client access and workforce shortage perspective, in-person encounters are likely preferred from a quality of care perspective compared to telehealth. While quality care can be delivered via telehealth, it's typically easier to deliver quality care via in-person services.

However, in the real world, benefits and drawbacks must be assessed and there are benefits to telehealth that cannot be ignored. From a cost-effectiveness perspective, particularly in rural areas, a BH system would be able to serve more people via telehealth and would be able to access a workforce that often does not exist to provide those services—and some services are better than no services.

The key takeaway is that there is value in both in-person and telehealth services, and thus an ideal BH system would offer both, while monitoring through data the use of telehealth to ensure that any one-sided utilization of telehealth is evaluated and understood, with interventions as needed to ensure balance in the mode of service delivery.

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

Disparities in access to appropriate BH telehealth services can be seen as a social determinant of health. According to the Office of the Assistant Secretary for Planning and Evaluation at HHS,

[20] https://www.chcf.org/publication/how-medi-cal-expanded-substance-use-treatment-access-care/

more than one in six people in poverty have no internet access, with internet access and digital literacy less common among older people.

Congress should collaborate with health organizations in crafting telehealth-related policies to promote and support telehealth infrastructure, increase broadband access, strengthen health data security, improve device affordability and access, and provide digital-literacy training and technical assistance programs. Policies can also impose set-aside funds and expand reimbursements related to telehealth activities, such as supporting translators for telehealth services for beneficiaries with limited English proficiency. Congress can also require a commitment from payers to include payment parity across the various telehealth modalities (video, phone, and in-person) to improve telehealth sustainability. Another policy strategy to consider in ensuring equitable access to BH care is to strengthen monitoring and oversight activities of remote services through secure data collection, reporting, and analysis to understand the impact of telehealth services on plans, providers, and beneficiaries.

- ***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?***

Though audio-only is more readily accessible and provides access to populations without a broadband connection, intentional use of audio-only options needs to be balanced with services where in-person or visual interaction is appropriate and effective. For outpatient, residential, inpatient, and recovery levels of care, group counseling and patient education sessions typically benefit from, at minimum, visual interaction and discussion among participants. For this reason, the federal government should strongly encourage group/patient education to be practiced using a video platform where patients cannot use the camera function rather than giving providers the option to deliver these services solely via telephone.

When considering the severity of one's BH condition, considering the appropriateness of telehealth often relates to the consequences of a poor outcome. While quality care can be delivered via telehealth, it's typically easier to deliver quality care via in-person services. As such, the benefits of telehealth (most notably access and ensuring a workforce to provide services) must be weighed against the consequences of a poor outcome should a telehealth visit result in a clinician missing a clinical detail that otherwise would be more easily captured and considered in an in-person encounter. For people with severe BH conditions, the consequences may be more severe (hospitalization, relapse, overdose, etc.). In some instances, telehealth services will be very appropriate because there will be no other options for an individual with a severe BH condition to access services. In other cases, telehealth services may not be appropriate because a clinician could see someone in-person and result in a more quality clinical encounter but simply chose to offer telehealth out of the clinician's convenience as opposed to the client's convenience. In short, both telehealth and in-person services are important and ensuring a balance of these modalities of service delivery will ensure the optimal balance of access and quality.

- ***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?***

    - *Platforms and Network Adequacy* - Congress should have a more explicit definition of allowable telehealth platforms. At a minimum, platforms should be video capable even if the patient is permitted to turn off the camera; staff should be able to use a camera if in an office or home office. Additionally, Congress should clarify the impact of telehealth services on network adequacy, given that the traditional metric of physical site locations within a given region becomes less of an issue.

    - *Establishing Care for New Clients* - L.A. County Public Health strongly feels that the initial SUD assessment, which can be conducted many weeks following the patient's initiation of care, should require audio-visual telehealth or an in-person component. Also, at minimum, platforms should be video-capable even if the patient is permitted to turn off the camera. However, intake activities, which involve registration and collecting basic demographics, can be done via audio-only telephone without concerns.

    - *Information Technology Considerations* – Congress should consider establishing minimum technology infrastructure specifications and requirements such as stable internet, scanners, and e-signatures to be able to effectively deliver virtual services without avoidable interruption (e.g., freezing, dropped connections, etc.). Of particular importance are easily accessible mechanisms for patients to place secure signatures on documents or otherwise securely confirm their participation in the treatment.

- ***What legislative strategies could be used to ensure that care provided via telehealth is high-quality and cost-effective?***

  Congress should consider the following strategies to support high-quality and cost-effective telehealth:

    - Identifying financial mechanisms to support or reimburse for upfront telehealth investments, including hardware and software costs, security, training, ongoing maintenance, and continuing education.
    - Establishing set-aside funds dedicated to implementing broadband networks in areas that have limited to no broadband infrastructure, improvements in areas with low bandwidths and speed to support all types of telehealth modalities, training and technical assistance to improve digital literacy, and investments towards updating and maintaining health data security.
    - Establishing federal recommendations for patient-centered, evidence-based BH care that incorporate specific considerations for telehealth-delivered treatment, including access, cultural competency, care coordination, and care quality standards.
    - Ensuring language integration in telehealth-delivered BH care for clients with limited English proficiency and people with hearing disabilities.

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

  National studies have identified disparities in telehealth use among underserved populations, specifically among Medicaid-eligible, low-income, and non-metropolitan populations.[21] Many barriers and challenges exist that contribute to the disparity in telehealth accessibility for both providers and beneficiaries, including:

  - Limited availability of high-speed broadband internet access in underserved areas – Congress should support and invest in broadband, high-speed internet in areas with limited access or low bandwidth and speeds.
  - Privacy concerns – Congress should strengthen policies to safeguard beneficiary data collection and transmission between providers and across the United States.
  - Upfront costs – Congress should identify financial mechanisms to support or reimburse for upfront telehealth investments, including hardware and software costs, security, training, ongoing maintenance, and continuing education.
  - Reimbursement costs – Congress should support payment parity with in-person to telehealth services to increase provider-level telehealth adoptability over time.

Improving Access for Children and Young People

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

  Peer Support Specialists (PSS) and other BH paraprofessionals have played vital roles in BH care and treatment. PSS are most notable for sharing their own lived experiences and practical guidance to support youth, develop their own goals, become empowered, and take actionable steps towards building a fulfilling life. PSS provides a range of BH services, including therapeutic activities, outreach and engagement, and educational groups. PSS offers a level of acceptance, understanding, and validation not found in many other professional relationships. With significant shortages among the BH workforce, PSS can narrow the gap in providing supplemental support services to clinical treatment and care. [22] Over the past decade, peer support services have been shown to reduce the use of inpatient services, increased social functioning, increased self-esteem and confidence, increased empowerment and hope, increased engagement in self-care and wellness, and increased quality of life, which lead to an overall decreased cost on the health care system. [23,24]

- ***Are there different considerations for care integration for children's health needs compared to adults' health needs?***

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[21] https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00823
[22] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf
[23] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf
[24] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peer-support-2017.pdf

Sixteen percent of children and youth have BH challenges that do not meet the criteria for a diagnosis but need support to address emerging risk issues where early intervention services are vital to determine. [25] Children, youth, young adults, and adults are heterogeneous populations from varied backgrounds and have different levels of exposure to adverse events requiring different approaches to effective care integration. With greater dependence upon the family, community, and educational systems, children and youth are in higher need of medical and behavioral interventions.[26] While pediatric primary care providers are well-positioned to provide early detection services and promote social-emotional development, many pediatricians are limited in managing BH conditions. The shortage in the BH workforce, limited versatile training in pediatric BH treatment, and financing exacerbate the challenges in implementing care integration among youth. Adverse experiences in early childhood development and potential health outcomes, especially in vulnerable populations, should be considered when evaluating care integration for children and youth populations.

Some key differences in terms of care for children include an elevated importance of engaging family and school systems that may be impacting youth in unique ways, unique risks related to various forms of trauma (physical, emotional, sexual), and greater reliance on therapy and counseling as opposed to medications.

- ***How can federal programs support access to behavioral health care for vulnerable youth populations (welfare and juvenile justice systems)?***

While federal programs such as Medicaid, Title-IV-E child welfare services, and special education, provide critical support to vulnerable children and youth populations, eligibility criteria and policies for each program limits accessibility to all services for children with complex BH needs. These policy limitations magnify a siloed and fragmented healthcare delivery system, stunting cross-system collaboration and reform to meet the high-needs population. Flexibility in federal program policies would allow and expand comprehensive, high-quality program services to disadvantaged populations.

Children and youth populations with BH needs face unique challenges that can benefit from integrated care coordination. An integrated system involving wraparound care combined with case management can effectively address the challenges for vulnerable children, youth, and adolescent populations with varying levels of BH needs. [27] Local and community-based organizations can expand their services with additional government support. Congress can allocate funds to bolster support for local wraparound services and provide incentives to promote care coordination.[28]

In addition, Congress can further support access to BH care by:

- Integrating BH prevention and treatment services in school-based settings.
- Expanding training and technical assistance in early childhood development and education to integrate BH intervention practices.

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[25] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.14.3.147
[26] https://theinstitute.umaryland.edu/media/ssw/institute/hub-resources/policy-systems-and-financing/Care-Integration-Opportunities-v3-ELECTRONIC.pdf
[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4278946/
[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3086808/

- Broadening insurance reimbursement of family-focused intervention services.
- Bolstering information dissemination of prevention, early identification, and early intervention for families.

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

  The exponential development and use of telehealth during the COVID-19 pandemic has highlighted the need to clarify best practices and parameters for telehealth services in BH care. Though telehealth is used to improve access to care and health care equity, a few key considerations need to be factored into implementing and expanding telehealth services for the pediatric population.
  - Infrastructure - Lack of high-speed broadband internet access and limited access to adequate technology and devices for either the provider or beneficiary can limit the use of telehealth services.
  - Quality of Care Standards - Telehealth services should not replace standard in-person treatment and care. They should only be used during emergencies or to supplement current treatment, including in-person services. While telehealth services may positively impact the adult population, remote services may have a different impact on the provision of care for pediatric services.
  - Payment reform - As states progress towards value-based care, consider the appropriate payment, reimbursement, and incentives for utilizing remote services. Ensure safeguards are in place for monitoring and oversight of remote services to prevent "telefraud."
  - Health data security – Providing high-quality and comprehensive care requires improvements in patient safety through health data protection. Investments in implementing and maintaining secure data collection and transmission will support the sustainable use of telehealth services.
  - Initial cost - Initial investments in broadband internet improvements and device purchases hinder providers from quickly switching to telehealth services without government or private company support. Government subsidies, set-aside funds, or incentives will improve technology adaptability.

In summary, L.A. County Public Health appreciates your leadership and bipartisan efforts to address BH challenges for millions of Americans. We hope to engage your offices around some of our recommendations to improve patient care and outcomes.

Thank you for this opportunity to provide comments.

Respectfully,

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Director

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