November 1, 2021

Honorable Ron Wyden
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington D.C. 20510-6200

Honorable Mike Crapo
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington D.C. 20510-6200

Re: Response to Senate Finance Committee's Request for Information

Dear Chairman Wyden and Ranking Member Crapo:

Magellan Health, Inc. (Magellan) welcomes the opportunity to respond to the U.S. Senate Committee on Finance's request for information (RFI) to assist in developing a bipartisan legislative package that helps address many of the nation's behavioral health challenges. We appreciate your leadership on these very critical issues.

Magellan is a leader in managing the fastest growing, most complex areas of health care. We connect mental, physical, pharmacy, and social needs with high-impact, evidence-based clinical and community support programs to ensure the care and services provided to our members are individualized, coordinated, fully integrated, and cost effective. Our perspective on mental health is informed by 56 years of experience providing a tailored spectrum of services and employee assistance programs for health plans, employers and various military and government agencies and public health care programs, including active-duty service members and their families, state Medicaid programs and individuals dually eligible for Medicare and Medicaid.

We contract with more than 77,000 credentialed behavioral health providers nationwide and provide behavioral health care services to approximately 1.8 million public-sector members through a range of innovative state programs.

In response to the Senate Finance Committee's RFI, our recommendations are focused on the areas outlined below. We include general information and background, and, as appropriate, comments to the specific questions raised in the RFI.

Magellan HEALTH

Magellan's Responses

I. Strengthening Workforce

For over 56 years, Magellan has worked with and relied on providers, institutions, and caregivers. The concerns about workforce development in health care, and more specifically in treating mental health issues, is becoming increasingly urgent. The COVID-19 crisis continues to exacerbate this pre-existing mental health workforce shortage, one that is particularly acute in rural areas and minority communities.

Nearly 6,000 areas are designated as mental health care professional shortage areas (HPSAs), meaning these areas had a population-to-provider ratio of at least 30,000 to one.[1] Meanwhile, more than half of counties in the U.S. do not have a single practicing mental health professional.[2] By examining underlying issues that contribute to the scarcity of services, it is possible to alleviate workforce shortages and expand service delivery. Inadequate training opportunities, low compensation, and a high turnover rate, contribute to the issue and create gaps in the continuum of care. Further, the general aging of the behavioral health workforce further exacerbates this issue.[3]

We continually look for ways to support and grow providers' practices to ensure they remain a viable part of the continuum of care. Throughout the pandemic we have provided technical support to meet telehealth requirements, supported continuing education, and developed innovative payment models to assist providers.

During the pandemic, various federal and state flexibilities have helped to mitigate the workforce shortage in ways we have not seen before. For example, the U.S. Department of Health and Human Services (HHS) allowed specific non-physician providers, such as licensed clinical social workers to bill for certain Medicare services, thus recognizing that non-physician providers play a vital role in the health care system. In addition, various telehealth flexibilities and considerations removed what had been historic barriers to behavioral health treatment.

The increased public awareness of the importance of mental well-being, combined with the lasting impacts of the pandemic, create an urgency for action to address the severe shortage of psychiatrists and other mental health professionals.

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[1] Kaiser Family Foundation. (2020). State Health Facts: Mental Health Care Health Professional Shortage Areas (HPSAs). Retrieved September 27, 2021 from https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Mental%20Health%20Care%20HPSA%20Designations%22,%22sort%22:%22desc%22%7D

[2] New American Economy, "The Silent Shortage: How Immigration Can Address the Large and Growing Psychiatrist Shortage in the United States," October 2017. Retrieved October 20, 2021 from http://www.newamericaneconomy.org/wp-content/uploads/2017/10/NAE_PsychiatristShortage_V6-1.pdf

[3] Satiani A, Niedermier J, Satiani B, et al., "Projected workforce of psychiatrists in the United States: a population analysis." Psychiatr Serv. 2018. Retrieved October 20, 2021 from https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700344

Magellan HEALTH

Responses

Please find below our responses to several of the questions you pose in your RFI related to strengthening the behavioral health workforce.

WHAT POLICIES WOULD ENCOURAGE GREATER BEHAVIORAL HEALTH CARE PROVIDER PARTICIPATION IN THESE FEDERAL PROGRAMS?

Coverage Expansion and Incentives for Collaboration

Finding ways to bolster the use of the Collaborative Care Model (CoCM) is critical. CoCM is an evidence-based model of care that provides behavioral health treatment in a patient's primary care office by pairing that office with a behavioral health care manager and psychiatric consultant. **While CMS has taken steps to expand the use of CoCM, Congress should explore proposals that would further increase the use and adoption of CoCM by both primary care providers and psychiatrists including more detailed guidance to increase adoption of the model, reimbursement for the collaborative care codes, and incentives for state Medicaid plans.**

Coverage expansion will also contribute to increased access to behavioral health services.[4] According to one study, "ACA-Medicaid expansion increases the probability that a [specialty mental health provider] accepts Medicaid by 1.69 percentage points…" [5] Providing adequate reimbursement will increase provider's ability to accept various forms of coverage. Not surprisingly, evidence from states that increased Medicaid rates in recent years demonstrates that increases contributed to greater provider participation in Medicaid. **Congress should continue to seek coverage expansion opportunities and adequate reimbursement for behavioral health services**[6]

WHAT BARRIERS, PARTICULARLY WITH RESPECT TO THE PHYSICIAN AND NON-PHYSICIAN WORKFORCE, PREVENT PATIENTS FROM ACCESSING NEEDED BEHAVIORAL HEALTH CARE SERVICES?

Remove Licensing Barriers by Promoting Mutual Recognition Compacts

Policymakers need to find ways, including removing licensing barriers, to address the severe behavioral health workforce shortage and meet the growing demand. Licensure standards for behavioral health professionals are set by the states, which regulate licensing, provision of care, discipline, prescribing, and scope of practice. Providers practicing in multiple states or offering care across state lines encounter a patchwork of requirements and costs associated with licensing.

Promoting mutual recognition compacts, while not a solution to address the larger workforce issue, would alleviate shortages in certain areas of the country by allowing practitioners to provide care across state

[4] Sullivan *et al.*, "To Improve Behavioral Health, Start by Closing the Medicaid Coverage Gap. October 4, 2021," Retrieved October 20, 2021 from https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-medicaid-coverage-gap

[5] Elson Oshman Blunt *et al.*, "Public insurance expansions and mental health care availability," *Health Services Research*, 55(4), August 2020, https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13311

[6] Government Accountability Office, "Medicaid: States' Changes to Payment Rates for Substance Use Disorder Services," January 30, 2020, https://www.gao.gov/products/gao-20-260.

lines. In addition, given the expanding role of telehealth in mental health treatment, finding ways to promote cross state licensure is necessary.

Congress should direct HHS to develop a voluntary model compact whereby states would engage in a system of mutual recognition, designed to alleviate the burdens associated with licensing in multiple states. One way to encourage states to adopt compacts would be the use of federal funding to aid states in implementing the model compact (e.g., conducting criminal background checks).[7] Furthermore, the Secretary of HHS should be encouraged to engage with relevant stakeholders to facilitate the compact process and provide opportunity for public comment.

Peer Support Specialists Face Unique Challenges with Background Screening Laws

In recent years, we have seen an increased focus on using peer support specialists (individuals who use their own experience recovering from mental health (MH)/substance use disorder (SUD) challenges to support others) to help address workforce shortages. Background screening laws often create a barrier because the lived experience that makes peers valuable is often what prohibits them from working with vulnerable populations.

In 2007 CMS recognized peer support services as an evidence-based mental health model of care and established minimum requirements for states seeking federal Medicaid reimbursement for peer support services.[8] The requirements for certifying peer support specialists vary by state, as do the certifying entities.[9] According to CMS, peer support specialists must complete a training and certification program as defined by the state, receive supervision from a "competent mental health professional." Each state defines the amount, scope, and duration of the supervision as well as who is considered a competent mental health professional. **Congress should consider ways to address inconsistencies across states and work to ensure peer support specialists are integrated into the mental health and substance use disorder system.**

WHAT POLICES WOULD MOST EFFECTIVELY INCREASE DIVERSITY IN THE BEHAVIORAL HEALTH CARE WORKFORCE?

Improve Mental Health Literacy

Education and community awareness of behavioral health issues and treatment is an essential step to addressing the issue of diversity in the behavioral health care workforce. Mental health literacy is the basis for prevention, stigma reduction, and increased awareness to both behavioral health issues and available treatment options.[10] Understanding and placing an emphasis on addressing cultural norms is essential to increasing diversity in the behavioral health care workforce. **Improving mental health literacy should be a focus of policymakers in order to educate, engage, and encourage community awareness of the importance of behavioral health.**

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[7] Bipartisan Policy Center. (2021). *Behavioral Health Integration Report*. Retrieved October 20, 2021 from https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R01.pdf

[8] Smith, D. (August 15, 2007). States interested in peer support services under the Medicaid program. CMS SMDL #07-011. Retrieved October 21, 2021, from https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf

[9] Government Accountability Office. (2018) Leading Practices for State Programs to Certify Peer Support Specialists. (GAO Publication No. 19-41). Retrieved on October 21, 2021 from https://www.gao.gov/assets/gao-19-41.pdf

[10] Stan Kutcher, Yifeng Wei, Connie Coniglio. Mental Health Literacy: Past, Present, and Future. Can J Psychiatry. 2016 Mar; 61(3): 154–158. Published online 2016 Mar 3. Retreived October 26, 2021 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4813415/

Improve Access to Higher Education

The lack of diversity in the health care workforce, and specifically the behavioral health care workforce, is not new. Considering the increasing demand for behavioral health services, the issue is now more critical than ever. According to the Association of American Medical Colleges (AAMC) one of the key issues that need to be addressed is higher education.[11] **In order to diversify the workforce, a greater emphasis must be placed on improving access to higher education to disadvantaged and minority individuals.**

WHAT FEDERAL POLICIES WOULD BEST INCENTIVIZE BEHAVIORAL HEALTH CARE PROVIDERS TO TRAIN AND PRACTICE IN RURAL AND UNDERSERVED AREAS?

Mental Health Professionals Workforce Shortage Loan Repayment

The pandemic exacerbated the pre-existing mental health workforce shortage, one that is especially severe in rural and underserved areas. Rural and underserved areas face unique challenges in recruiting and retaining health professionals.

We need to create financial incentives for individuals to choose career paths in treating mental health. Demanding caseloads, stress, compensation, and student loan debt contribute to recruitment and retention challenges of providers.[12] Several states have employed creative solutions to address the issue. For example, some states have employed public-private partnerships to fund loan repayment programs and scholarships, and fund pipeline/pathway programs.[13]

Congress should act on S.2500/H.R.2431, the Mental Health Professionals Workforce Shortage Loan Repayment Act. This proposal would offer federal loan forgiveness to encourage more professionals to select MH/SUD concentrations and be incentivized to continue delivering mental health services.

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?

Incentivize Adoption of Collaborative Care by Primary Care Providers

As discussed below in response to questions raised around "Increasing Integration, Coordination, and Access to Care," significant challenges exist as it relates to financing and reimbursement for collaborative care that need to be addressed to advance integration efforts. Not the least of which is finding ways to increase the education and engagement of primary care providers as it relates to implementation of CoCM. **Congress should explore proposals to expand and incentive the use and adoption of collaborative care.**

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[11] https://bhbusiness.com/2021/08/31/identifying-behavioral-healths-workforce-diversity-issue-how-to-fix-it/

[12] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *Technical Documentation for HRSA's Health Workforce Simulation Model*. Rockville, Maryland: U.S. Department of Health and Human Services, 2021. Retrieved from https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/technical-documentation-health-workforce-simulation-model.pdf

[13] https://chrt.org/wp-content/uploads/2020/02/Recruitment-and-Retention-of-BH-Providers-Toolkit-2.21.2020-.pdf

SHOULD FEDERAL LICENSING AND SCOPE OF PRACTICES REQUIREMENTS BE MODIFIED TO REDUCE BARRIERS FOR BEHAVIORAL HEALTH CARE WORKERS SEEKING TO PARTICIPATE IN FEDERAL HEALTH CARE PROGRAMS? IF SO, HOW?

Expansion of Medicare/Medicaid coverage (mental health counselors, certified peer support)

Federal barriers must be addressed in order to achieve integration and help address the behavioral health workforce shortages. Eligible Medicare providers should include marriage and family therapists (MFTs), mental health counselors (MHCs), and certified peer support specialists. The following proposals help to remove these barriers:

Congress should pass the Mental Health Access Improvement Act (S.828/H.R. 432). This proposal recognizes MHCs and MFTs as covered Medicare providers. Acknowledgment of MHCs and MFTs as Medicare providers would increase the pool of eligible mental health professionals and boost critical provider needs.

The Promoting Effective and Empowering Recovery Services in Medicare (PEERS) Act of 2021 (H.R. 2767/S.2144) is an important bill that recognizes the unique role peer support specialists play in the continuum of care. Certified peer specialists are vital in providing support to people living with mental health conditions and SUDs to become active members of their community.

II. Increasing Integration, Coordination, and Access to Care

Accelerating the integration of mental health and SUD services and supports into primary care is critical to promoting the health and wellness of those living with these conditions. Integration provides a pathway to delivering care that is person-centered and responsive to the whole person's needs. Primary care has become the de facto location to access mental health and SUD care, yet the majority of the treatment and services available in this setting are often less than optimal.

Thirteen percent of people diagnosed with a mental health condition receive minimally adequate treatment in a general medical setting; for substance use, that number falls to five percent.[14] Further, numerous studies indicate that primary care providers (PCPs) often do not have the time or resources to effectively treat many mental health and substance use conditions. Conversely, many people living with serious mental illness (SMI) tend not to receive quality, comprehensive health care. A substantive amount of research exists on the benefits of integrated care programs, including cost-savings, better treatment outcomes, and lower rates of mortality. By addressing barriers to the development of a fully integrated system of care, we can improve services and supports for millions of individuals living with mental health and substance use disorders by securing care that considers the whole person.

[14]The Kennedy Forum. (2015). Fixing Behavioral Health Care in America: A National Call for Integrating and Coordinating Specialty Behavioral Health Care with the Medical System. Retrieved on October 20, 2021 from https://chp-wp-uploads.s3.amazonaws.com/www.thekennedyforum.org/uploads/2017/06/KennedyForum-BehavioralHealth_FINAL_3.pdf.

Responses

WHAT ARE THE BEST PRACTICES FOR INTEGRATING BEHAVIORAL HEALTH WITH PRIMARY CARE? WHAT FEDERAL POLICY PAYMENT POLICIES WOULD BEST SUPPORT CARE INTEGRATION?

Expand the Use and Adoption of CoCM

In 2017, the Centers for Medicare and Medicaid Services (CMS) approved specific Medicare billing codes for CoCM, an evidence-based mode of care to deliver MH/SUD services in primary care.[15] The model has been proven as an effective way to provide access to mental health treatment and integrate care.[16]

CoCM provides for patients to be treated in their primary care office while pairing that office with a behavioral health care manager. Data has proven CoCM to be an effective model that integrates care, expands access, and improves outcomes. Additionally, CoCM makes primary care providers more comfortable with discussing and managing behavioral health issues with their patients, resulting in an expanded workforce capable of treating mental health and SUDs, with earlier intervention.

Despite the proven benefits of CoCM, it has not yet been widely embraced. Presently, only 19 state Medicaid agencies reimburse the collaborative care codes.[17] Complexities in implementing this model have slowed progress and implementation, despite evidence of its impact in expanding access to mental health care. According to experts, "its unconventional workflow and team structure, which include elements of care outside of face-to-face visits, have posed significant challenges to financing and reimbursement."[18] The perception that the model may be financially unsustainable appears to be slowly dissipating as additional opportunities for reimbursement of CoCM arise and clear data emerges to support both its financial integrity and clinical efficacy.

Congress should explore proposals that would help expand the use and adoption of CoCM including more detailed guidance to increase adoption of the model, reimbursement for the collaborative care codes, and incentives for stakeholders.

For example, proposals like H.R. 5218, the Collaborate in an Orderly and Cohesive Manner (COCM) Act, provides primary care practices with start-up funds and technical assistance to adopt the model and funds research to build the evidence base for other models of integrated behavioral health care are important steps in moving toward greater adoption of integration models.

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[15] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

[16] Unützer, MD, MPH, Harbin, MD, et al. *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes (*"More than 70 randomized controlled trials have shown collaborative care for common mental disorders … to be more effective and cost-effective than usual care..."). Retrieved October 1 from https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

[17] Retrieved from https://www.chcf.org/publication/cracking-codes-state-medicaid-approaches-reimbursing-psychiatric-collaborative-care/

[18] Carlo, MD, Unutzer, MD et al. Financing for Collaborative Care – A Narrative Review. September 2018. Retrieve from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6075691/

WHAT PROGRAMS, POLICIES, DATA, OR TECHNOLOGY ARE NEEDED TO IMPROVE ACCESS TO CARE ACROSS THE CONTINUUM OF BEHAVIORAL HEALTH SERVICES?

Create Sustainable Funding and Financial Incentives for Certified Community Behavioral Health Centers (CCBHCs)

The Centers for Disease Control and Prevention (CDC) estimates that 93,331 people died of drug overdoses in 2020, an increase of nearly 30% from 2019.[19]

While many public health agencies are working to respond to the overdose crisis and expand access to effective treatment, more resources are critical. CCBHCs provide 24-hour crisis care and evidence-based services to anyone in need of mental health or substance use treatment services, regardless of ability to pay. Through collaborations with law enforcement, CCBHCs divert people in crisis from jails, reduce hospitalizations and emergency department visits and generate cost savings for taxpayers. CCBHCs create a critical point of entry for individuals needing access to mental health treatment.

CCBHCs do not currently have dedicated funding. CCBHCs are on a two-year funding cycle and the funding must be continually renewed by Congress. This lack of financial certainty and continuity undermines the potential for CCBHC's long-term sustainability and effectiveness. Furthermore, the varied flow and allocation of funding for creates additional challenges. **Congress should provide ongoing and enduring support to the CCBHC program.**[20]

In addition, while CCBHCs are required to track and report certain data to maintain their certification, there are no existing financial incentives for improved outcomes. **In order to foster a more sustainable system of community mental health services, clear and consistent financial incentives (e.g., improved outcomes and quality metrics) should be part of the solution.**

Expand Recipients of Community Mental Health Services Block Grants (MHBGs)

Currently MHBGs are awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide community mental health services. The MHBG program's objective is to support the grantees in carrying out plans for providing comprehensive community mental health services. Unfortunately, those dollars do not typically flow beyond traditional behavioral health providers. **Congress should work with regulators to create more flexibility with the use of MHBG dollars (e.g., certified health homes based in primary care setting and increased opportunities for federally qualified health centers to benefit from MHBG monies.**

Align 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA)

On March 27, 2020, Congress enacted the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). The CARES Act included several revisions that allow for better coordination of care. The new law requires greater alignment of the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2 or Part 2) regulations with HIPAA's Privacy Rules. Section 3221 of the CARES Act amends Part 2's underlying

[19] Retrieved from https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[20] Excellence in Mental Health and Addiction Treatment Act (S. 2069/H.R. 4323)

statute and allows for disclosures for treatment, payment, and health care operations in the same manner as the HIPAA regulations once an initial written consent from the patient has been obtained.

Magellan appreciates the recent strides made to improve care coordination. The recent revisions to 42 CFR Part 2 regulation were a positive step forward. The provisions in the CARES Act, once incorporated into the regulation, will further align Part 2 with HIPAA for the purposes of health care treatment, payment and operations, and strengthen protections against the use of substance use disorder records in criminal proceedings. **We urge Congress to work with HHS to ensure that the requirements for Part 2 stated in the CARES Act are reflected in the next Part 2 Rule.**

WHAT PROGRAMS, POLICIES, DATA, OR TECHNOLOGY ARE NEEDED TO IMPROVE PATIENT TRANSITION BETWEEN LEVELS OF CARE AND PROVIDERS?

Incentivize Use of Electronic Health Records (EHRs)

Initiatives to drive EHR adoption among mental health and substance use treatment providers is critical. According to a recent report to congress by the Medicaid and CHIP Payment and Access Commission, "behavioral health providers are often unable to invest in the expensive hardware, software, and training necessary for EHR adoption."[21] The report notes the importance of strengthening the behavioral health EHR adoption through new health IT incentives.

In addition, the Centers for Medicare and Medicaid Innovation (CMMI), as directed by Section 6001 of the SUPPORT Act, allows them to finance a demonstration furnishing health IT incentive payments to behavioral health providers, including but not limited to, psychiatric hospitals, community mental health centers, and addiction treatment providers. [22]

Congress should consider ways to advance the use and adoption of EHRs by behavioral health providers, including mandatory CMMI demonstrations.

WHAT POLICIES COULD IMPROVE AND ENSURE EQUITABLE ACCESS TO AND QUALITY OF CARE FOR MINORITY POPULATIONS AND GEOGRAPHICALLY UNDERSERVED COMMUNITIES?

As discussed above, the best-designed mental health systems are responsive to varied community characteristics and the infrastructure and delivery system capabilities within that community. Equitable access to different types and levels of services across all communities within a state, ability to identify gaps in services, and supporting development of expanded capabilities, such as CCBHCs, are critical.

HOW CAN CRISIS INTERVENTION MODELS, LIKE CAHOOTS, HELP CONNECT PEOPLE TO A MORE COORDINATED AND ACCESSIBLE SYSTEM OF CARE AS WELL AS WRAPAROUND SERVICES?

Prior to the pandemic, the prevalence of mental illness and suicidal ideation in the US was already increasing. In 2019, 61.2 million American adults (24%) had a mental illness and/or substance use disorder,

[21] https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-4-Integrating-Clinical-Care-through-Greater-Use-of-Electronic-Health-Records-for-Behavioral-Health.pdf
[22] 42 U.S.C. 1315a(b)(2)(B)

an increase of 5.9% over 2018.[23] Depression for those under age 50 increased steadily from 2016 to 2019: 22.6% increase among those aged 12-17, 35.1% increase among those aged 18-25, and 23.6% increase among those aged 26-49. From 2009 to 2019, suicidal thoughts, plans and attempts increased among young adults aged 18-25, 95%, 98.8% and 62.4%, respectively, and among adults aged 26-49, 23.3%, 50% and 24.5%, respectively.[24]

Increased stressors brought about by the pandemic (e.g., grief and loss, social isolation, financial instability, fear, etc.) have exacerbated the state of mental health in the nation. More people from January – September 2020, compared to all of 2019, sought help for anxiety (93% increase) and depression (62% increase).[25] Since COVID-19 began, suicidal ideation in the US has more than doubled, with younger adults, racial/ethnic minorities, essential workers and unpaid adult caregivers experiencing disproportionately worse effects.[26]

Among those who experience a mental illness, more than half do not receive treatment.[27] In fact, what we've seen in our data is that 60% of patients who are admitted to inpatient care were first seen in a primary care setting within 6-12 months of the admission and the behavioral health condition was either missed or not addressed.

Magellan has partnered with states and local governments to develop crisis systems for more than a decade. We have extensive experience managing behavioral health crisis through numerous risk-based Medicaid behavioral health managed care programs and many contracts for Employee Assistance Programs for commercial and public programs.

Most existing mental health crisis systems are loosely organized around some common practices, standards, and features, which may not be shared across all participants. Individuals experiencing a mental health crisis often find themselves in settings that do not adequately meet their needs, such as emergency rooms. There is often a lack of clear definition of where crisis services begin and end, and where the crisis system should live organizationally – police and first responders, or mental health/health and community programs. As a result, we see inconsistent and ill-defined program goals and performance metrics and measures. Integration and information sharing are limited between key stakeholders (e.g., emergency departments, mental health programs, Medicaid, suicide prevention lifeline, criminal justice, and social services). Resources remain limited, where they exist at all.

The inconsistency across programs, inadequate and varied funding sources each with its own obligations (e.g., reporting requirements), multiple stakeholders and often conflicting mandates and priorities creates significant challenges. The best-designed crisis systems are responsive to varied community characteristics and the infrastructure and delivery system capabilities within that community. Equitable

[23] https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf
[24] Id.
[25] https://mhanational.org/issues/state-mental-health-america
[26] https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm
[27] https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf

access to different types and levels of services across all communities within the state, ability to identify gaps in services, and supporting development of expanded capabilities such as CCBHCs are critical.

Clear and Consistent Definition of Crisis Continuum of Care and Accompanying Guidelines Are Needed

Too often the term "crisis" is not defined or defined in a manner that does not encompass the full crisis continuum of care. In addition, where definitions do exist, they vary significantly at the state and local level. Each state has different requirements as it relates to licensure and credentialing for those stakeholders involved in the continuum of care.

Funding Is critical for Communities to Implement Effective Crisis Systems

With the enactment of legislation to establish a national 3-digit suicide prevention hotline ("988") several opportunities exist to create a continuum of crisis care that ensures appropriate mental health responses to mental health crises. **Magellan supports policies that fund and support the implementation of 9-8-8, training and education, and increased access to evidence based mental health treatment and crisis services. In addition, we support policies that fund post-crisis services including the use of digital supports to assist in providing a full continuum of care.**

Continue To Support Law Enforcement Training and Diversion Programs

According to the Bureau of Justice Statistics, more than half of those in the criminal justice system suffer from a mental illness. Prioritizing appropriate training and response is critical to ensuring individuals experience a mental health crisis end up in treatment not jail.

HOW CAN PROVIDERS AND HEALTH PLANS HELP CONNECT PEOPLE TO KEY NON-CLINICAL SERVICES AND SUPPORTS THAT MAINTAIN OR ENHANCE BEHAVIORAL HEALTH?

Social Determinants of Health (SDOH) Must Be Considered

Social and economic conditions including housing, employment, food security, and education are well recognized factors in determining physical and mental health outcomes. Our experience suggests behavioral health conditions such as isolation, prolonged stress and substance use can be mitigated, ultimately saving lives by focusing on and addressing a combination of factors including: behavioral health and social needs screenings, faster referrals to mental health services, poverty, food and housing insecurity.

As discussed earlier, the best-designed crisis systems are responsive to varied community characteristics and the infrastructure and delivery system capabilities within that community.

III. Ensuring Parity

Magellan has wholeheartedly supported and actively advocated for parity. Every day, we work with our customers — health plans, employers, state Medicaid clients — to find new solutions on behalf of those we serve, which continues to advance the law, and to reduce the stigma around mental health and substance use issues.

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 changed the landscape of mental health parity and substance use disorder coverage in the United States. MHPAEA led to significant improvements in mental health and SUD coverage over the past decade. While MHPAEA and its predecessor, the Mental Health Parity Act of 1996, as well as the Affordable Care Act of 2010, have done much to advance the mental health and SUD coverage landscape, further opportunities remain to improve access to high-quality and value-based mental health and SUD services and treatments.

Most recently, the parity provisions included as part of the of the Consolidated Appropriations Act, 2021 (the CAA) added a requirement for group health plans and health insurance issuers to prepare a 5-step analysis demonstrating compliance with MHPAEA's nonquantitative treatment limitation (NQTL) requirements. Specifically, the CAA requires the Secretaries of the Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury (collectively, the Tri-Agencies) to request at least twenty analyses per year starting this year. On April 2, 2021, the Tri-Agencies released a set of FAQs to provide guidance with respect to the MHPAEA requirements added by the CAA.

Responses

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?

Develop universal compliance standards related to mental health and addiction parity

Despite all the strides made to increase access to MH and SUD treatment, issues remain. The recently issued FAQs in response to new parity language included in the CAA is a necessary step, but further clarification is necessary to provide payers information to consistently implement MHPAEA. **We urge Congress to work with regulators to develop clear, universal compliance standards related to mental health and addiction parity.** Specifically, our suggestions on how Congress can improve oversight and enforcement include:

- **Promote standardization between state and federal requirements**. State approaches to parity compliance and enforcement vary significantly both amongst states and compared to federal approach. Inconsistencies in interpretation of NQTLs exist both at the federal and state level, across state lines, and in some cases within a state itself.[28] Better coordination between state regulators and the tri-Departments is critical to ensure consistency in implementation and achieve the shared goal of mental health parity.
- **Develop clear, comprehensive examples of NQTL analyses for each NQTL on the focused list.** In order to meet the tri-Department's standards under the requirements of the CAA, plans must us a 5-step framework, which is substantially different than the Self-Compliance Guide issued by the Department of Labor. Wide-ranging NQTL examples would vastly improve the NQTL analyses.

[28] Medicaid and CHIP Payment and Access Commission, *Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP*, p. 13, January 29, 2021, slide 14: "Some interviewees noted that non-quantitative treatment limitations were assessed and interpreted differently both within and across states." https://www.macpac.gov/wp-content/uploads/2021/01/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf, last visited May 21, 2021.

Despite the myriad of guidance issued, significant ambiguity remains (e.g., supporting documentation required for components of CAA's five-step analyses).

- **Establish a core list of NQTLs where documentation may be made available upon request.** The final rule lacks guidance to determine what constitutes a "limit on the scope or duration of benefits for treatment under a plan or coverage." As a result of the ambiguity, proactive development of a 5-step analysis for all NQTLs is unachievable. A well-defined list of NQTLs would allow additional clarity and better use of resources.

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?

Federal law allows states to use federal Medicaid funds for inpatient hospital and nursing facility services in institutions for mental diseases (IMDs) for individuals aged 65 and older and for individuals under age 21. Because IMD services are not covered for those between the ages of 21 and 65, mental health services must be provided in an outpatient setting, or states must pay 100 percent of the cost of the IMD for the Medicaid-eligible individual.

The inability for states to rely on federal funding for certain inpatient care inhibits their ability to adequately address mental health needs and is contrary to the core principles of mental health parity laws. While we commend CMS' efforts to ensure the availability of IMDs as a treatment option through the acceptance of a 15-day stay or state Medicaid waiver, more must be done.

Eliminate the Institutions for Mental Diseases (IMD) Medicaid exclusion

CMS should ensure future regulatory action is not taken with the effect of precluding states' ability to continue with current policies providing more than a 15-day stay in an IMD. **More importantly, Congress should consider a full repeal of the IMD exclusion for behavioral health diagnoses in facilities with more than 16 beds to secure access to needed inpatient psychiatric services for our most vulnerable citizens.**

IV. Expanding Telehealth

Magellan supports innovative ways of accessing better health through technology, while remaining focused on the critical personal relationships that are necessary to achieve a healthy, vibrant life. While telehealth services have been available for years to help remove geographical and other boundaries for people in rural and medically under-served areas, its use has been limited. Driven by the COVID-19 pandemic, including shelter-in-place orders, social distancing, and various federal and state regulatory action, telehealth has grown exponentially since March 2020.[29]

Although telehealth platforms have existed for nearly two decades, many are dedicated exclusively to physical health. Magellan has maintained a behavioral health telehealth network since 2014, improving

[29] Czeisler, M.E. (2020, August 14). *Mental health, substance use, and suicidal ideation during the COVID-19 pandemic – United States, June 24-30, 2020.* Retrieved August 18, 2020 from https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

access to mental health services and providing a cost-effective alternative to traditional doctor visits, urgent care and the emergency room.

Responses

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?

Ensuring Clinical Appropriateness of Telehealth is Critical

During the pandemic, Magellan quickly expanded the availability of telehealth services to ensure our members had continued access to care. Although many of these services existed prior to COVID-19, state and federal regulations, interstate licensing issues, insurance reimbursement, and member and provider preferences limited its use and availability.

As Magellan prepares to shift gears and move from a reactive to a more proactive approach to delivering telehealth services, we continue to evaluate which telehealth solutions should remain as an option for all behavioral health services. **Clinical efficacy and appropriateness should drive decisions as to the most appropriate modality of care.**

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

Continue to Invest in Broadband Access

According to the Pew Research Center, nearly a quarter of adults with household incomes below $30,000 say they don't own a smartphone and over 40% of adults with lower incomes do not have home broadband services.[30] Investment in the expansion of broadband access will allow for increased use of telehealth services. Programs like, the Emergency Broadband Benefit, a new Federal Communications Commission program have helped to lower the cost of broadband service for eligible households during the pandemic and should be made permanent. **Congress must continue to invest in broadband access.**

Eliminate In-Person Requirement in the Consolidated Appropriations Act (CAA)

Given access to behavioral health professionals is extremely limited in many areas of the country, requiring an in-person visit is a significant barrier. **As discussed in greater detail below, Congress should eliminate language included in the CAA that prohibits access to mental health services unless the patient has been seen in person in the previous six months.**

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

Telehealth has Allowed Greater Access to Behavioral Health Treatment at a Critical Time

Throughout the course of the pandemic, Medicare beneficiaries' access to telehealth saw unprecedented growth in no small part due to the extraordinary actions taken by CMS. The expanded scope of Medicare coverage of telehealth for behavioral health services was significant. One of the first steps CMS took in response to the public health emergency (PHE) was to temporarily expand the scope of Medicare telehealth to allow Medicare beneficiaries (not just those in rural areas) to receive telehealth services from any location, including their homes. CMS also added nearly 150 allowable services, more than doubling the number of services that beneficiaries could receive via telehealth.

Legislation is required to permanently authorize these key evidence-based improvements under Medicare. Congress should act to protect health insurance providers' flexibilities in creating telehealth programs and other virtual care solutions that will best serve the needs of their members and can provide convenient access to high-quality behavioral health services in an equitable manner.

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?

Appropriateness of Audio-Only Visits

Magellan recognizes that in certain situations audio-only telehealth may be the only viable option for vulnerable populations who may experience physical limitations or inequities due to a variety of factors. As such, Magellan supports patient access to audio-only visits for established patients receiving mental

[30] https://www.pewresearch.org/fact-tank/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/

and behavioral health counseling and therapy services (including opioid treatment programs) when medically appropriate and where circumstances require it (e.g., lack of broadband access).

In order to ensure that audio-only technology provides quality, evidence-based and clinically appropriate behavioral health services, an audio-only claims coding modifier is necessary. This would allow the ability to monitor utilization and allow comparative effectiveness research to differentiate between audio-visual and audio-only services. **Magellan supports the recently proposed audio-only modifier presented in CMS' CY2022 Physician Fee Schedule.**

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?

Importance of Visual Component in Telehealth Visits

The changes prompted by the COVID-19 PHE allowed the health care industry to rapidly expand the availability and utilization of telehealth. As we move closer to a return to pre-COVID circumstances, and based on the data we have collected to date, we see a key role for telehealth within several levels of care we support.

The significance of the visual component of a telehealth visit is an important factor in determining clinical appropriateness. A behavioral health practitioner takes into consideration visual cues when performing an assessment and conducting therapy. A mental status exam typically includes assessment of level of consciousness, appearance and general behavior, speech and motor activity, affect and mood, thought and perception, attitude and insight, cognitions etc. A provider's ability to perform an adequate assessment and provide an accurate diagnosis is limited without a visual connection.

Audio only services are best reserved for members who are already engaged in treatment and are being used for check-ins (e.g., wellness visits) and to provide quick objective assessments (e.g., PHQ-9). Individuals requiring more intensive services such as partial, group or Intensive Outpatient Programs (IOP), also benefit from visual telehealth. At a minimum, psychological assessments require a visual component. Lastly, telehealth services for individuals with a greater severity of mental illness may not be appropriate (less than ideal). As noted above, in certain situations audio-only telehealth may be the only viable option for vulnerable populations who may experience physical limitations or inequities due to a variety of factors.

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?

CMS has adopted several policies to extend temporary coverage of certain telehealth services available during the PHE and to permanently adopt coverage and payment for other services. **Magellan fully embraces the expansion of telehealth where clinically appropriate.**

We look forward to CMS' implementing practical safeguards to ensure patient safety and clinical effectiveness are upheld. Additionally, given the opportunity for fraud, waste, and abuse with the expansion of telehealth, existing audit claims and other tools should be considered to ensure program integrity. Telehealth expansion will succeed so long as quality care is provided by licensed practitioners when clinically appropriate. As we incorporate and expand the use of telehealth into our models of care, CMS flexibility in benefit design is critical to best serve Medicare beneficiaries.

Eliminate In Person Requirement in the CAA

The CAA language requiring an in-person visit creates an unnecessary barrier to mental health treatment. Elimination of the six-month requirement will allow greater access to those individuals in need of mental health treatment and services. While certain provider visits may require in person visits with some frequency, many adult mental health needs can be met through a clinically appropriate plan of care using telehealth. Failure to remove language that requires an in-person visit could lead to individuals most in need of treatment being unable or unwilling to access such services, including first-time entrants into the mental health system, those who live in underserved or rural locations, those facing transportation barriers or who lack financial means to take time off work or other life commitments.

While progress has been made to encourage the use of telehealth, Congress should eliminate language included in the CAA that prohibits access to mental health services unless the member has been seen in person in the previous six months. [31]

WHAT LEGISLATIVE STRATEGIES COULD BE USED TO ENSURE THAT CARE PROVIDED VIA TELEHEALTH IS HIGH-QUALITY AND COST-EFFECTIVE?

Address Fraud Waste and Abuse in Telehealth

As use of digital technologies in health care continues to expand, so does the risk for fraud, waste, and abuse claims. We have seen an increase in fraud in SUD treatment facilities in areas of licensure, accreditation, administrative and billing practices, quality, and enrollment. **Congress should work with**

[31] P.L. 116-260 permits telehealth (in Medicare) for purposes of diagnosis, treatment or evaluation of mental health disorders *without* geographic restrictions (makes permanent CMS regulations tied to PHE). In addition, beneficiaries may receive telehealth services from their home for purposes of mental health diagnosis, treatment or evaluation (in addition to substance use disorder treatment, which was previously allowed). The new law applies to most tele-mental health services, including counseling, psychotherapy, and psychiatric evaluations. While the law provides for access to mental health telehealth services for Medicare beneficiaries regardless of geographic or originating location, ***the physician must have seen the patient in the previous six months***. (Sec 123 of Division CC).

regulatory agencies to encourage the evaluation of quality standards, and protections against potential fraud, waste, and abuse similar to current efforts in the health care system.

Examine Safety of Mental Health Applications

While mental health applications create opportunities to provide value and improve lives, and are being used more and more today, they also raise questions including in some cases safety concerns. Developers are not necessarily associated with or staffed by mental health professionals, nor are they required to offer emergency information when users are experiencing a mental health emergency while using the application.32 Federal policymakers should continue to examine the risks and opportunities associated with mental health applications.

WHAT BARRIERS EXIST TO ACCESSING TELEHEALTH SERVICES, ESPECIALLY WITH RESPECT TO AVAILABILITY AND USE OF TECHNOLOGY REQUIRED TO PROVIDE OR RECEIVE SUCH SERVICES?

Eliminate the In-person Evaluation Required to Prescribe MAT Via Telehealth

As a result of a variety of factors (e.g., provider shortages, difficulty traveling, etc.) an initial in-person visit with a provider for SUD is not always possible. Unfortunately, current law requires an in-person evaluation before a provider can utilize MAT via telehealth.

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 ("Haight Act") was passed following the death of Ryan Haight as a result of pain medication the teenager purchased through an online pharmacy.[33] While well intentioned, the Haight Act limits the ability of OTPs to prescribe lifesaving medications to treat those suffering from addiction. It requires an in-person evaluation, with exceptions, before a treatment provider can electronically prescribe a controlled substance for OTP (e.g., buprenorphine). Thankfully, the Drug Enforcement Administration ("DEA") acted quickly during the COVID-19 Public Health Emergency to allow the prescribing of controlled substances, like buprenorphine, without an initial in-person visit.[34]

Unfortunately, this DEA action is tied to the PHE and fails to address the underlying barriers to electronic prescribing generally and opioid treatment specifically. One of those barriers is the absence of regulations, as required by the SUPPORT Act, specifying the circumstances and procedures for a provider to obtain a special registration in order to electronically prescribe a controlled substance without an in-person visit.[35]

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[32] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7457894/

[33] Kayla R. Bryant, *Health Law Daily Wrap up, Strategic Perspectives: States Fail to Fully Use Telemedicine to Fight the Public Health Crisis,* Wolters Kluwer (September 28, 2018).

[34] *See* https://www.deadiversion.usdoj.gov/coronavirus.html ("While a prescription for a controlled substance issued by means of the Internet (including telemedicine) must generally be predicated on an in-person medical evaluation (**21 U.S.C. 829(e)**), the Controlled Substances Act contains certain exceptions to this requirement. One such exception occurs when the Secretary of Health and Human Services has declared a public health emergency… On March 16, 2020, the Secretary, with the concurrence of the Acting DEA Administrator, designated that the telemedicine allowance under section 802(54)(D) applies to all schedule II-V controlled substances in all areas of the United States. Accordingly, as of March 16, 2020, and continuing for as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided [certain conditions are met]).

[35] 21 U.S.C. 831(h)(2) ("Not later than 1 year after the date of enactment of the SUPPORT for Patients and Communities Act, in consultation with the Secretary, the Attorney General shall promulgate final regulations specifying— '(A) the limited circumstances in which a special registration under this subsection may be issued; and (B) the procedure for obtaining a special registration under this subsection.").

It has now been more than two years since the SUPPORT Act was signed into law requiring DEA to issue rulemaking to implement this key telemedicine provision, and expand vital access to addiction treatment. **Congress should call on the DEA to immediately promulgate the Special Telemedicine Registration regulation.**

Enact Policies That Increase Use of Prescription Drug Monitoring Programs (PDMPs)

PDMPs are state-based databases that contain information on controlled substance prescriptions. Expanding access to PDMPs to health plans will allow greater integration of care and aid in the prevention of SUDs. Payers can improve care coordination, clinical decision making, patient health care, and patient safety. In addition, increased access to PDMPs will provide an opportunity to prevent and identify fraud, waste, and abuse.

V. Improving Access for Children and Young People

Our perspective on children's behavioral health is guided by decades of experience serving youth with complex behavioral health needs. Magellan has a long-standing reputation as an innovator in the care and coordination of behavioral health services for children and adolescents. Our model of care is evidence-based and built around a compassionate, individualized approach.

We are encouraged by the renewed focus on addressing the mental health needs of our youth. The recognition of the importance of mental well-being on our overall health is a necessary component to address the shortcomings of our mental health system. Equally important is a commitment to adequately fund the system.

Young people and their families must be central to decision-making in order to address individuals' unique needs. Screening, planning and treatment must be guided and driven by the individuals and their families as participation is central to ensuring voice and choice throughout the treatment process. Creating a crisis continuum to ensure that crises are addressed in the moment and stability is maintained for both the child and the family is critical.

Every state is unique, and each requires different considerations to find solutions to improve care coordination for children. The current range of services (schools, medical, mental health, juvenile justice, etc.) is disjointed and creates significant barriers for families and caregivers.

Responses

HOW SHOULD SHORTAGES OF PROVIDERS SPECIALIZING IN CHILDREN'S BEHAVIORAL HEALTH CARE BE ADDRESSED?

Invest in and Support a Pediatric Mental Health Workforce

There is a severe shortage of mental health care providers to treat children and youth, further compounded by the fact that mental health providers experience high turnover rates, ranging between

30-60 percent on average.[36] Shortages are particularly pronounced in rural areas, which face unique challenges in recruiting and retaining health professionals. Due to these and other factors, the mental and behavioral health needs of children often go unmet. **Federal policymakers should continue to examine ways to strengthen the workforce focused on children's mental health services.**

Invest in Early Intervention and Screening

According to SAMHSA, "school-wide universal screening for mental health issues is a practice that has become more prevalent and is now recommended by The National Association of School Psychologists, as well as the National Research Council and the Institute of Medicine, who built upon criteria established by the World Health Organization."[37] Research shows that roughly half of individuals who will develop mental health disorders show symptoms by age 14.[38] Early identification of mental health issues creates an opportunity to intervene before problems progress into more significant and costly, both financially and emotionally.

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, Community Health Workers, and Non-Clinical Professionals Play a Critical Role in Improving Children's Behavioral Health

In partnership with states and other governmental agencies, Magellan manages innovative programs that serve children and youth with complex behavioral health needs, helping them to live at home successfully, achieve in school, enter adulthood and stay out of costly and restrictive inpatient care. Our individualized services provide families the support they need to live happier, healthier, more independent lives.

One of our programs includes the Magellan Youth Leaders Inspiring Future Empowerment (MY LIFE) which leads the nation's approach to support youth with behavioral health and support in foster care systems by providing an opportunity to learn skills needed to help overcome challenges, while inspiring them to be role models for other youth and their communities. 87% of all youth and young adult participants in MY LIFE reported they had more information and resources to help themselves as a result of attending, 83% feel more hopeful about their future after participation, and 77% reported feeling less alone. Magellan works in partnership with detention centers, schools, government offices, and various community partners (mental health, primary care and prevention services) and stakeholders like Boys and Girls Clubs.

[36] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4715798/
[37] SAMHSA. Screening for Behavioral Health Risk in Schools (2019). Retrieved October 21, 2021 from https://www.samhsa.gov/sites/default/files/ready_set_go_review_mh_screening_in_schools_508.pdf
[38] Kessler et al., "Age of Onset of Mental Disorders: A Review of Recent Literature," Current Opinion in Psychiatry. Retrieved October 21, 2021 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925038/

ARE THERE DIFFERENT CONSIDERATIONS FOR CARE INTEGRATION FOR CHILDREN'S HEALTH NEEDS COMPARED TO ADULTS' HEALTH NEEDS?

Strengthen Care Coordination and Integration Among All Stakeholders and Community Partners

States must find ways to incentivize better coordination and communication amongst schools, Medicaid agencies, social services, behavioral health, and other community partners. Congress should consider embracing and expanding models such as CMS' Integrated Care for Kids Model (InCK) as it looks at ways to provide quality coordinated care to children.[39] Routine interactions with pediatricians, school nurses, and counselors create opportunities for screening and care coordination.

As Congress continues to engage in discussions and you explore solutions to improve care coordination and integration between primary care and behavioral health, we recommend solutions that include children and youth access across the care continuum, and an exploration of linkages for facilitating better care coordination, such as use of technology to support integrated care and electronic health records.

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?

Increase the Federal Medicaid Match (FMAP) For Pediatric Mental Health Care Services

Sustainable reimbursement or payment models that support providers are essential to improve children's access to the full continuum of care. This includes screening in primary care settings and at well-child visits, community and school-based services, and increased access through investments in telehealth. **Strengthening federal support for pediatric mental health care services by increasing the FMAP for these services generally or enhancing reimbursement rates for providers of pediatric mental health services will help to address the dire need for resources and ensure better continuity of care and earlier intervention to prevent crises. Congress has acted in the past to provide enhanced FMAP to ensure access to critically needed benefits and services in other areas. It should consider an enhanced FMAP for pediatric mental health care services.**[40]

Provide Investments To Support the Appropriate Treatment, at the Appropriate Place and Time

For example, increased investments in youth and family peer-support, expanded school-based mental health programs, and increased use of telehealth consultation and in-home services to support local needs. **Ensuring the appropriate tools are available and resources exist is critical to meeting the mental health needs of youth and adolescent.**

Increasing Funding for Infant and Early Childhood Mental Health Consultant (IECMHC)

Congress should consider additional funding programs to prevent, evaluate, and intervene with early childhood education providers and families. Implement guidance for youth and young adult skill-building and supports to bridge to successful adulthood, such as the Transition-to-Independence Program (TIP).

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[39] https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model

[40] P.L. 92-603; SSA §1903(a)(5) (States receive 90% federal reimbursement for family planning services and supplies)

Establish Core Quality Standards and Financial Incentives To Improve Accountability and Outcomes

One of the current challenges is the scarcity of data to demonstrate that services being provided, whether through a primary care provider or mental health professional, are adding value and improving outcomes. **Clear quality standards would create more accountability and opportunities for greater adoption of value-based payment models and improved integration.**

Increase Funding for First Episode Psychosis (FEP) Programs

It is common for individuals to experience their first episode of psychosis between the ages of 15 to 30 years.[41] While Congress provides funds to state mental health programs through the MHBG program, and in 2016 enacted a requirement that states "set-aside" 10% of their MHBG funds for early psychosis programs, more resources are needed to maintain and strengthen these programs.[42]

Conclusion

Thank you for your consideration. We look forward to engagement with you on strategies to continue to improve our nation's mental and behavioral health system. Magellan would be glad to answer questions. Please contact Brian Coyne, vice president of federal affairs, at (804) 548-0248 or bcoyne@magellanhealth.com; or, Kristina Arnoux, vice president of government affairs and public policy, at (401) 480-8034 or arnouxk@magellanhealth.com.

Sincerely,

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[41] https://www.uptodate.com/contents/first-episode-psychosis
[42] https://www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf