November 15, 2021

The Honorable Ron Wyden The Honorable Mike Crapo

Chair Ranking Member

Committee on Finance Committee on Finance

United States Senate United States Senate

Washington, DC 20510 Washington DC 20510

Dear Chair Wyden and Ranking Member Crapo:

Mental Health America appreciates your letter highlighting the mental health and addiction crisis in America and seeking input for legislative solutions. We are grateful for your leadership in seeking bipartisan proposals to improve access to critical mental health and substance use treatment and supports.

Mental Health America (MHA) – founded in 1909 – is the nation’s leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the mental health of all. With over 200 affiliates throughout the country, our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care, services, and supports for those who need it, with recovery as the goal. During his stays in public and private institutions, MHA’s founder Clifford Beers witnessed and was subjected to horrible abuse. From these experiences, Beers set into motion a reform movement and advocacy that MHA continues today.

COVID-19 has had a profound negative effect on the mental health of the nation. MHA operates an online mental health screening program, and throughout the COVID-19 pandemic, MHA has witnessed increasing numbers of people experiencing anxiety, depression, psychosis, loneliness, and other mental health concerns. In 2020, over 2.6 million people took a mental health screen, comprising the largest dataset compiled for a mental health help-seeking population during the pandemic, and representing a nearly 200% increase over the number of people who completed a screening in 2019 (N=910,750). Both the number of help-seekers experiencing anxiety and the severity of that anxiety increased in 2020. In total, 545,150 people took an anxiety screen in 2020, which was 234% higher than the total number of anxiety screens taken in 2019. Of those who took a depression screen in 2020, 85% (N=798,585) scored with moderate to severe symptoms of depression. This was equal to the proportion of people who screened at risk for depression in 2019 (85%, N=280,042), although the number of people was significantly higher in 2020.

Mental Health America (MHA) provides the following input in response to the Committee’s questions:

1. Strengthening the Workforce:
   1. Increase access to Peer Support Specialists in the Medicare program by enacting the *Peer Act of 2021* (S. 2144/H.R. 2767)
   2. Expand access to other providers in the Medicare program by passing the *Mental Health Access Improvement Act of 2021 (S. 828/H.R. 432)* and the *Improving Access to Mental Health Act* (S. 870/H.R. 2035)
   3. Increase payment rates by supplementing the RUC/RVU process and enacting the *Medicaid Bump Act* (S. 1727/H.R. 3450)for behavioral health services
2. Increasing Integration, Coordination, and Access to Care:
   1. Direct HHS to adopt cross-cutting initiatives in accordance with The Bipartisan Policy Center Task Force on Integrated Care Recommendations
   2. Increase payment for integrated care through a Medicaid bump and adjustment of the E&M codes or the Medicare RUC/RVU process
   3. Improve access to crisis services by enacting *The Behavioral Health Crisis Services Expansion Act* (S. 1902/ HR 5611)
   4. Ensure access to medications by protecting and reinforcing the value of the six protected classes policy under Part D and establish a standardized electronic prior authorization response system in Medicaid managed care, similar to requirements in Medicare
3. Ensuring Parity
   1. Extend parity protections to fee for service Medicaid programs and fee for service and Medicare Advantage Plans in the Medicare program
   2. Strengthen federal network adequacy requirements across HHS-regulated plans (such as wait times, providers taking new patients, and providers billing for a minimum number of patients to avoid phantom networks) in accordance with The Bipartisan Policy Center Task Force on Integrated Care Recommendations
4. Expanding Telehealth
   1. Remove in-person requirements for telehealth and defer to shared decision-making by enacting the *Telemental Health Care Access Act of 2021* (S.2061/H.R. 4058)
   2. Ensure parity in payment to continue access to tele-mental health by enacting the *Tele-Mental Health Improvement Act* (S.660/H.R. 2264)
5. Improving Access for Children and Young People
   1. Include a comprehensive demonstration program for integrated care for youth in all youth-serving settings, such as pediatric primary care, schools, and community programs
   2. Require CMS to issue updated guidance on administrative billing for school-based mental health services in Medicaid
   3. Advance equity in mental health services for youth

***Strengthening the Workforce***

1. **Increase access to Peer Support Specialists in the Medicare program by enacting the *Peer Act of 2021* (S. 2144/HR 2767)**

Widespread shortages of behavioral health providers across the country leave many people without access to needed services. Half of US counties have no behavioral health clinicians forcing individuals to go without support and care that could prevent the costliest outcomes such as disability, hospitalization, incarceration, and homelessness. However, Peer support specialists could effectively extend the behavioral health workforce by using their lived experiences of mental health conditions and/or substance use disorders, knowledge of systems and services, and formal training to support others in their recovery.

Peer support is an evidence-based practice recognized by the Substance Abuse and Mental Health Administration (SAMHSA) that has existed in behavioral health for decades. Over 45 states certify peer support specialists, and it is authorized as a Medicaid-covered service in most states as well. Both quantitative and qualitative evidence indicates that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services. Peer support also increases the use of outpatient services as individuals determine the services and supports that best meet their needs. Peer support services empower people to better engage in their care while improving quality of life, management of co-morbid health conditions, and physical health outcomes. Research and experience show that peer support specialists have a transformative effect on both individuals and systems. MHA staff have written [an extensive paper](https://www.scattergoodfoundation.org/publication/growing-peer-support-specialized-services-at-a-time-of-crisis/) on how to strengthen the peer support workforce.

Congress should expand coverage of peer services in Medicare by passing *The Peers Act of 2021* (S.2144/H.R.2767). Senators Catherine Cortez Masto and Bill Cassidy and Representatives Judy Chu (D-CA) and Adrian Smith (R-NE) have co-sponsored this bipartisan, bicameral bill which would clarify that peer support specialists can be a covered service in Medicare as part of an integrated care delivery model, such as collaborative care in primary care. Congress should include the provisions of the Peer Act in future legislation as a first step toward expanding access to peer support services.

1. **Expand access to other providers in the Medicare program by passing the *Mental Health Access Improvement Act of 2021* (S. 828/H.R. 432)and the *Improving Access to Mental Health Act* (S. 870/H.R. 2035)**

Given the acute behavioral health workforce shortages detailed above, Congress should expand access to behavioral health professionals by enacting the bipartisan *Mental Health Access Improvement Act of 2021* (S. 828/H.R. 432*)* (which would require Medicare to cover medically necessary behavioral health services provided by licensed mental health counselors and marriage and family therapists, who comprise 40 percent of the mental health workforce) and the bipartisan *Improving Access to Mental Health Act* (S. 870/H.R. 2035) (which would increase Medicare beneficiaries’ access to mental health services in Skilled Nursing Facilities, improve Medicare beneficiaries’ access to Health and Behavior Assessment and Intervention Services, and align Medicare reimbursement rates for Clinical Social Workers with other non-physician providers).

1. **Increase payment rates by supplementing the RUC/RVU process and enacting the *Medicaid Bump Act (S. 1727/H.R. 3450)* for behavioral health services**

Fundamentally, Congress cannot strengthen the behavioral health workforce without confronting the low reimbursement that prevents individuals from entering the profession, affects retention rates, and leads to excessive out-of-network care.

In Medicare, rates are set by the RUC/RVU process, and input is primarily provided to CMS by the American Medical Association. This process has resulted in market failure for behavioral health, as evidenced by the extreme workforce shortages and lack of in-network providers. Congress should mandate that CMS supplement the RUC/RVU process with input from behavioral health provider associations (the National Association of Peer Supporters, the American Psychological Association, the National Association of Social Workers, etc.) and expressly require CMS to take into account both the percentage of providers who are not accepting Medicare and the aforementioned workforce shortages. These changes would not only affect Medicare but also would influence private insurance, as insurers often use Medicare as a base and increase from there.

In Medicaid, rates are set by the states. CMS is responsible for reviewing rates and ensuring adequate networks, but anyone who has tried to find a behavioral health provider that accepts Medicaid insurance knows that the wait for therapy can be weeks or even months long, and it is nearly impossible to find psychiatric care. Those seeking mental health care sometimes describe the Medicaid insurance card as a “license to hunt” due to the extreme difficulties they face trying to find providers. Congress should require that CMS strengthen its oversight of Medicaid managed care to ensure adequate networks and demand that states demonstrate both the relationship between their rate-setting methodology and access to care and that they have set rates sufficient to ensure access. CMS could accompany such requirements with a Medicaid bump for behavioral healthcare by enacting the *Medicaid Bump Act (S. 1727/H.R. 3450)* and requiring states to demonstrate that the bump has been explicitly used to increase rates and address shortages.

***Increasing Integration, Coordination, and Access to Care:***

1. **Direct HHS to adopt cross-cutting initiatives** **in accordance with The Bipartisan Policy Center Task Force on Integrated Care Recommendations**

HHS can improve the measurement of the extent to which children and adults have access to integrated mental health care and the effectiveness of the care provided by implementing a set of integration measures in Medicaid, Medicare, and commercial insurance plans regulated by CMS. These measures should include patient experience measures of access and unmet need, outcomes, and structural measures of practice transformation toward evidence-based integrated care.

HHS can also improve oversight and enforcement of policies governing the provision of integrated mental health services in Medicaid, Medicare, and commercial insurance plans regulated by CMS, including but not limited to: Early and Periodic Screening, Diagnosis, and Treatment (ESPDT), mental health parity, network adequacy, essential health benefits, and Medicaid rate setting. This plan should be developed, executed, and implemented with input from individuals with lived experience of behavioral health conditions and should include quantitative measures of access that consider integration in primary care and schools, racial equity, and virtual care.

MHA is attaching a summary of the legislative recommendations of the Bipartisan Policy Center Task Force on Behavioral Health Integration and fully supports the implementation of those policies.

1. **Increase payment for integrated care through a Medicaid bump and adjusting the E&M codes or the Medicare RUC/RVU process**

Despite several promising policy initiatives to bolster integrated mental health in primary care in Medicare and Medicaid, very few Americans have access to these services. MHA recommends leveraging the Medicare fee schedule and its partnership with states in Medicaid to create stronger incentives nationally. CMS should offer additional reimbursement for mental health services billed from primary care or other integrated settings (such as schools) and for primary care practices that meet specific standards of evidence-based mental health integration (either through enhancements for traditional Evaluation & Management codes or through an add-on payment). Congress could accomplish this by either:

* Allowing CMS to enhance Medicare reimbursement for these services as part of improving access to care and exempting the additional reimbursement from the budget neutrality requirement of the fee schedule; or
* Encouraging CMMI to implement this as a national Medicare demonstration project and provide additional funding to the extent it is found not to be budget neutral.

In either approach, Congress should offer enhanced matching funds to allow States to do the same in their Medicaid programs and require that the enhanced match leads to higher rates for integrated behavioral healthcare.

1. **Improve access to crisis services by enacting *The Behavioral Health Crisis Services Expansion Act* (S. 1902/ HR 5611)**

Even though recent statistics may be startling, the lack of appropriate crisis response is not a new issue, and it encompasses health, behavioral health, and equity. From August 2020 to February of this year, more than 4 in 10 adults reported anxiety or depression.[[1]](#endnote-1) Deaths from overdoses increased by 30% in 2020.[[2]](#endnote-2) And last year, the proportion of children and youth going to emergency rooms for mental health crises[[3]](#endnote-3) and suicide attempts[[4]](#endnote-4) increased dramatically. Yet, people with such acute needs often do not receive any help until they experience a crisis or multiple crises.

The National Suicide Prevention Lifeline has helped millions of people through suicidal and mental health crisis situations, and, with the advent of 988, the new three-digit number will serve as an entry point for many more individuals as it becomes available nationwide in July of 2022. However, few communities have a robust crisis system in place. As this new number comes into widespread use, MHA hopes that 988 will be the beginning of “no wrong door” to meaningful access, help, and care for behavioral health.

But, for this to happen, there must be capacity at local Lifeline call centers, adequate numbers of mobile crisis teams, local peer respite, and crisis stabilization programs for the small number of people whose immediate needs cannot be addressed telephonically (fewer than 10%) and who need more intensive, in-person interventions. Without robust infrastructure that includes 24/7 local call centers, trained emergency medical response, and clinician and peer-led mobile teams, law enforcement (police) will remain the default in-person response. When law enforcement responds, people in crisis often end up in jails, in emergency departments, or worse; they are harmed or killed during the encounter. Resulting trauma also adds to the likelihood of dying by suicide. As recently reported in the Washington Post, since 2015, 23% of those killed by police had a mental illness, and 24% were Black[[5]](#footnote-1). A comprehensive, culturally aligned crisis response system is critical to advancing equity as these tragic outcomes are more likely to be experienced by communities of color and LBGT+ people. Suicide is the second leading cause of death for youth ages 10-24, and LBGT+ youth are four times more likely to attempt suicide than their peers,[[6]](#endnote-5) while Black youth die by suicide at twice the rate white youth.[[7]](#endnote-6)

MHA recommends the committee enact *The Behavioral Health Crisis Services Expansion Act* (S. 1902/ HR 5611) to ensure the development of crisis standards and the coverage of crisis services in Medicare and private insurance. S.1902 and other federal initiatives are urgently required to help build out and sustainably fund culturally appropriate community responses to all who are feeling suicidal and experiencing mental health crises. MHA further recommends that the Committee require CMS to issue guidance that would facilitate states developing robust crisis systems and provide technical assistance to states.

1. **Ensure access to medications by protecting and reinforcing the value of the six protected classes policy under Part D and establish a standardized electronic prior authorization response system in Medicaid managed care, similar to requirements under Medicare.**

MHA and its affiliates around the country have seen that mental health medications are highly individualized and access to the specific medication that works for a particular individual is critical to recovery and wellness. The six protected classes policy provides patients with mental illnesses access to the appropriate, FDA-approved therapies prescribed by their physician to manage their condition. This access to treatment is essential to any well-functioning mental health service delivery system. This policy provides significant additional protections for many other Americans living with complex chronic diseases such as cancer, HIV/AIDS, and epilepsy who suffer from disproportionately high rates of mental illness.

In addition, MHA urges the Committee to recognize the burdens that prior authorization requirements place on individuals and their physicians. Individuals with mental health conditions struggle to find in-network providers, and one of the barriers for providers is burdensome prior authorization requirements. These procedures also often result in a significant delay that frustrates individuals and families. CMS has issued a regulation requiring Part D sponsors to comply with standards for electronic prior authorization beginning in February of 2021. Medicaid managed care and Exchange plans should have the same requirements. The Committee should direct CMS to require Medicaid managed care and ACA exchange plans to comply with similar requirements and should work with Senate colleagues to ensure private plans also provide better access to effective medications and promote recovery for individuals with mental health conditions. In addition, the Committee should work with colleagues to enact *The Safe Step Act* (S. 464) to reform practices that require individuals to fail on multiple medications before they can access the one that they and their providers believe will be most effective, and to create timely, clear, and transparent processes to request exceptions from such policies.

***Ensuring Parity***

1. **Extend parity protections to fee for service Medicaid programs. fee for service and Medicare Advantage Plans in the Medicare program and Tricare**

MHA joined the October 13, 2021 joint letter from the Coalition to Stop Opioid Overdoes and the Mental Health Liaison Group to the Senate Finance Committee, noting:

Congress must no longer accept the status quo in which the more than 60 million older adults and individuals with disabilities enrolled in Medicare have among the worst coverage of mental health and substance use disorder services in the country. Additionally, more than 20 million Americans in traditional Medicaid have no protections under the Federal Parity Act and are frequently subjected to discriminatory state plans that offer inferior mental health and substance use disorder coverage. Furthermore, TRICARE’s nearly 10 million enrollees do not have full rights under the Federal Parity Act. Therefore, we urge you to make parity core to your efforts to address the ongoing mental health and addiction crisis facing our country…

1. **Strengthen federal network adequacy requirements across HHS-regulated plans (such as wait times, providers taking new patients, and providers billing for a minimum number of patients to avoid phantom networks) in accordance with The Bipartisan Policy Center Task Force on Integrated Care Recommendations**

In every community and across all health plans, individuals and families cannot access in-network mental health services. It is not possible to achieve parity without addressing this fundamental lack of access to mental healthcare. The Committee should include the network adequacy recommendation of the BPC Task Force in Integrated care and require CMS to strengthen federal network adequacy standards across all HHS-regulated plans. This effort would focus on adding performance standards such as wait times, providers taking new patients, and providers seeing a minimal number of patients within a time period (to address phantom networks). MHA recommends adding federal requirements across all HHS-regulated plans, including Medicaid managed care, Medicare Advantage plans, and Marketplace plans.

***Expanding Telehealth***

Given the extreme workforce shortages in mental health, expanding telehealth services is critical to increasing access to care, broadening the reach of existing health care providers, reducing service gaps, and providing more choices to individuals in need of help. MHA urges increased coverage, reimbursement, and extension of flexibilities extended to patients during the COVID-19 Public Health Emergency, especially payment parity, audio-only coverage, and removal of in-person requirements with a reliance on shared decision-making about modalities.

MHA supports the following policies and bills:

1. **Remove in-person requirements for telehealth and defer to shared decision-making by enacting the *Telemental Health Care Access Act of 2021* (S.2061/H.R. 4058)**

MHA urges the Committee to remove the statutory requirement that Medicare beneficiaries be seen in person within six months of being treated for mental and behavioral health services through telehealth. We believe the current statutory restriction on tele-mental health access through in-person requirements undercuts the current and very well received flexibility and access afforded by tele-mental health, even under the relaxed timeline of 12 months for subsequent visits included in the Final Physician Fee Schedule Rule.

These requirements fail to recognize the severity of workforce shortages that require reliance on mental health providers many hours away and across state lines. In addition, access to care for older adults, individuals with transportation, mobility, and geographic challenges will be significantly compromised if this in-person requirement is retained. Importantly, this requirement is not imposed on substance use telehealth services. Instead, Congress should defer to shared decision-making between the provider and individual on where to meet – online or in-person - and the frequency and need for in-person visits. MHA recognizes and supports the availability of in-person services when needed or preferred and believes that this should be a decision between the clinician and individual. MHA supports The *Telemental Health Care Access Act of 2021* (S.2061/H.R. 4058), removing the statutory requirement that Medicare beneficiaries be seen in person and deferring to shared decision-making so that individuals can get the care they need.

1. **Ensure parity in payment to continue access to telemental health by enacting the *Tele-Mental Health Improvement Act* (S.660/H.R.2264)**

MHA is very concerned that mental health providers are already paid inadequate rates. Any reduction in rates will lead to decreased access, and providers will revert to in-person care, depriving people of choice of settings. Accordingly, MHA urges Congress to enact the *Tele-Mental Health Improvement Act* (S.660/H.R.2264) which requires parity in coverage of mental health and substance use disorder services to individuals with private insurance, whether conducted in-person or through telehealth.

***Improving Access for Children and Young People***

1. **Include a comprehensive demonstration program for integrated care for youth in all youth-serving settings, such as pediatricians, schools, and community programs**

MHA recommends the implementation of a Medicaid demonstration program to achieve the goals of integrating mental health more seamlessly and enhancing delivery within local communities. After conversations with Senate Finance Committee staff, MHA drafted the attached language, patterned off of the Medicaid demonstration for the substance use disorder workforce in the SUPPORT Act, with technical assistance from the Center for Law and Social Policy (CLaSP) and Zero To Three. This policy would support states to plan, implement, and sustain payment and delivery systems that expand access to integrated children’s mental health care in the settings that are most convenient to them (with a focus on primary care and schools). The policy allows states the flexibility to integrate mental health services in a way that fits their Medicaid program and meets the needs of their beneficiaries, but with clear guidelines on quality and sustainability. To incentivize states to take up this demonstration, the policy offers planning grants and enhanced federal matching funds for the specific infrastructure and integrated services targeted by the policy.

1. **Require CMS to issue updated guidance for school-based mental health services in Medicaid**

Schools are critical settings for providing mental healthcare to children and youth. Providing services in schools eliminates the family burdens of making appointments, transportation, time off from work, and other barriers to care. Mental Health America recently issued its [2022 State of Mental Health Report](https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf) (p. 37), highlighting data showing that increasing access to school-based mental health services reduces disparities and improves access to care for students of color.

One of the most significant barriers to offering sustainable mental health programs in school stems from two guidance documents issued over twenty years ago by the Centers for Medicare and Medicaid. In February 2021, MHA was one of the fifty national education, mental health, disability, pediatric health, and child welfare-focused organizations that [wrote to the Centers for Medicare and Medicaid Services (CMS)](https://aasa.org/uploadedFiles/Policy_and_Advocacy/Resources/Letter%20to%20CMS%20on%20Updating%20School%20Based%20Medicaid%20Guidance.pdf), asking the agency to work directly with states and stakeholders to update the 1997 [Medicaid School Health Technical Assistance Guide](https://www.hhs.gov/guidance/document/medicaid-and-school-health-technical-assistance-guide) and the 2003 [Administrative Claiming Guide](https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf). This diverse collection of stakeholder groups believes that updating these documents is long overdue and is a critical first step in providing the guidance school districts need to correctly bill Medicaid for services, particularly mental health services, provided to children enrolled in Medicaid and enable more equitable access to Medicaid services for children in school.

The letter provides great detail on the areas that should be addressed by the updated guidance, including:

* Sharing best practices and state examples for how Medicaid has increased the availability of school-based mental and behavioral health services, including expanding and streamlining the types of reimbursable providers and services; improving care coordination and partnerships with community-based mental and behavioral health services; and, opportunities to allow for reimbursement of more early-intervention and prevention services, as well as building trauma-informed schools and preventing and treating substance use disorders.
* Encouraging the use of telehealth services. The CMS guidance documents currently in effect predate telehealth as a modality for delivering school-based services. It is critically important to address reimbursing effective and consistent application of telehealth services to Medicaid eligible children and making that guidance permanent especially given that this modality is a particularly effective option for enhancing mental health supports and services for students.
* Promoting the expansion of school-based Medicaid programs. Building on the success of the 13 states that have expanded their school-based Medicaid programs since the release of the 2014 State Medicaid Director letter on free care, CMS should update all relevant guidance and provide best practices for expanding state programs to include all Medicaid-enrolled students and to cover all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services in schools.
* Coordinating with the US Department of Education (ED) to help ED, states, and other stakeholders remove barriers to full participation in school-based Medicaid programs, such as addressing the administrative and documentation challenges of obtaining a separate parental consent requirement to bill Medicaid. Better coordination could also support states in including school psychologists and other school-based providers who are credentialed by state education agencies in becoming Medicaid-eligible providers.
* Clarifying how states could use a uniform, cost-based reimbursement methodology that would ensure districts of all sizes can be reimbursed by Medicaid for meeting the healthcare needs of their students regardless of their administrative capacity and student population. By publicizing an existing option of how CMS has permitted States to use a time study methodology to provide interim payments to schools and cost settlements in lieu of fee-for-service and transactional billing to dramatically reduce the administrative burden on school district personnel, this would encourage other States to consider this approach and greatly encourage districts to utilize Medicaid to fund mental health services for students. By leveraging an existing and proven process for Medicaid claiming that ensures strong accountability measures are still in place, it would also reduce the burden on State Medicaid Agencies and insurance companies to manage and respond to a high volume of Medicaid transactions from districts.
* Mitigating the burden to meet Third-Party Liability requirements. Medicaid is the payer of first resort in the school setting. This obligation to verify Third Party Liability means that district personnel must, in some circumstances, reach out to insurance companies and determine if they would pay for Medicaid-covered services that districts will provide to students regardless of whether they are reimbursed. The insurance companies invariably deny payment for services that districts believe are necessary to support student achievement. Since the liability of payment by Medicaid precedes that of the districts, it is an unnecessary and wasteful process to require determining third party liability of other insurers in order to process Medicaid claims
* Clarifying the role that other Medicaid stakeholders, including Medicaid-managed care organizations, community mental health centers, health care delivery systems, and others can play in the delivery of school-based health services and how they may seek reimbursement. The current capitated payment methods for MCOs and transactional billing requirements for schools are incompatible and create barriers to collaboration between districts and MCOs. Other constraints, such as credentialing and licensure of providers, complicate collaboration as well. Providing states with the flexibility to do away with transactional billing for school-based Medicaid reimbursement would facilitate collaboration between MCOs and school districts that would benefit both and bring improved and more efficient health-related services to school children. School districts could leverage providers that are employed by MCOs. MCOs would be able to deploy providers into school districts, thus alleviating some of the shortage of providers in schools. It would also encourage improvements in care coordination and determinants of health outcomes by incentivizing school districts and MCOs to partner with each other.
* Strengthening the role of school-based health centers, including providing additional guidance on the impact of prior authorization policies and Medicaid MCO contracting agreements on reimbursement.

It has been over nine months since stakeholders made this request with no action from HHS. Congress should mandate that CMS issue updated guidance and address these specific issues in the guidance.

**c. Advance equity in mental health services for youth**

The US mental health system is not exempt from perpetuating racism and failing to equitably reach and meet the mental health needs of individuals who are Black, Indigenous, and People of Color (BIPOC). For example, people who are African American or Black have historically been subjected to more severe diagnoses than their white counterparts, and BIPOC individuals have also been pathologized when they objected to racism and indignities that they faced.

In 2019, the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) National Survey on Drug Use and Health (NSDUH) found that 35% fewer adults who identified as Black or African American with any mental illness received services in the past year than those who identified as White (32.9% vs 50.3%). The 2019 Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey found that almost 50% more youth identifying as Black or African American reported attempting suicide compared to youth that identified as White (11.8% vs 7.9%), while NSDUH data indicates that Black adolescents have less access to depression care than white adolescents – 36% of Black youth with major depressive episodes received access to mental health care compared to 50% of White youth.

Given the alarming disparities in both suicide and access to services, especially for youth, the Congressional Black Caucus issued the report, [Ring the Alarm: The Crisis of Black Youth Suicide in America](https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf). The recommendations of the report were included in S.1795/H.R.1495, *the Pursuing Equity in Mental Health Act*, to build outreach programs that reduce stigma, and develop a training program for providers to effectively manage bias and reduce disparities in access to and delivery of mental health care for Black and brown youth.

MHA urges the Committee to work with colleagues on the HELP committee to enact the *Pursuing Equity in Mental Health Act*. This legislation is especially designed to meet the needs of youth of color early on to prevent suicide and self-harm as well as promote a trauma-informed response to underserved populations that experience bias and discrimination in health care.

Thank you for the opportunity to comment. We welcome the opportunity to work with you on further development of legislative proposals and can be reached at mgiliberti@mhanational.org.

Sincerely,

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Mary Giliberti

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   <https://www.thetrevorproject.org/research-briefs/estimate-of-how-often-lgbtq-youth-attempt-suicide-in-the-u-s> [↑](#endnote-ref-4)
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