Partnership to End Addiction

November 1, 2021

The Honorable Ron Wyden
Chairman, U.S. Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member, U.S. Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo,

Thank you for your attention to the issue of mental health and substance use disorders and your initiation of a bipartisan process to examine behavioral health care needs, as well as the opportunity to provide comment on how Congress can help address these challenges and improve access to mental health and addiction care.

Partnership to End Addiction is a national nonprofit uniquely positioned to reach, engage and help families impacted by addiction. With decades of experience in research, direct service, communications and partnership-building, we provide families with personalized support and resources – while mobilizing policymakers, researchers and health care professionals to better address addiction systemically on a national scale.

We strongly agree that evidence-based solutions are needed to strengthen the workforce; increase integration, coordination, and access to care; ensure parity; expand telehealth; and improve access to behavioral health for children and young people. Below, please find policy recommendations and responses to some of the specific questions you outlined in your letter in each of these categories.

Strengthening the workforce

Reimbursement

Increased reimbursement rates are needed to encourage greater behavioral health care provider participation in Medicare, Medicaid, and insurance offered on the ACA marketplace. Currently, reimbursement rates are insufficient to cover the cost of care, leading many providers not to participate in insurance networks, greatly limiting the affordability and accessibility of care. Raising the rates in Medicare could serve as a catalyst for increased rates in other insurance products, which often use Medicare as a benchmark. Low reimbursement rates for behavioral health services may also be a parity violation. A report from Milliman highlights the disparities in provider reimbursement for behavioral health versus physical health, and a report we authored with Legal Action Center also

highlights this issue as it pertains to inadequate provider networks.

Training

Another policy that would help strengthen the behavioral health workforce is integrating training on mental health and substance use disorders into the curricula for all health professionals. The Medication Access and Training Expansion (MATE) Act (S. 2235) would help ensure that DEA-registered prescribers receive baseline training on addiction, and we encourage Congress to pass this bill. However, such training should ultimately also include other health care providers that are not DEA-registered prescribers so that providers at every point in the health care system have the basic knowledge to identify and treat addiction (or refer to treatment). We also support passage of CARA 3.0 (S. 987), which also has several provisions that could help address workforce training needs.

Increasing integration, coordination, and access to care

CCBHCs

Increasing integration of care is critical to enhancing access, and federal payment policies that support integration are needed. Certified Community Behavioral Health Clinics (CCBHCs), for example, ensure access to integrated, evidence-based mental health and addiction services, and the model is sustainably funded through Medicaid in some states. However, only 10 states are included in this demonstration program, while many other states continue to be grant funded. Congress should expand the program to ensure sustainable Medicaid funding for the integrated care clinics in all states, such as through the Excellence in Mental Health and Addiction Treatment Act (S. 2069).

Wraparound/care coordination services

Similarly, state pilot programs that provide Medicaid reimbursement for wraparound and care coordination services should be expanded. A report by the Technical Assistance Collaborative demonstrates how some states are providing wraparound clinical and support services alongside their coverage of medications for addiction treatment (MAT) in Medicaid, explaining that such benefit designs for team-based MAT care models provide a pathway for primary care providers to offer sustainable, high-quality, evidence-based treatment. Such models must also include improved reimbursement rates, which, as explained above, are currently insufficient. Increasing reimbursement rates can enable hiring and expansion of services offered through an integrated team-based model in which prescribers prescribe medications while nurses, behavioral health professionals, care coordinators, and other professionals provide counseling, case management, care coordination, and other wraparound support services.

Crisis intervention

Crisis intervention models like CAHOOTS can help connect people to care and wraparound services by ensuring that individuals experiencing a mental health or substance use crisis are referred or linked to the health care system, with a full continuum of needed health and social services, rather than to the criminal justice system, where such services are lacking. The CAHOOTS Act (S. 764) and Mental Health Justice Act (S. 515), among other proposed legislation, would provide funding to expand such programs locally. Additional policies are crucial for ensuring sustained funding for such programs, including the option for states to provide community-based mobile crisis intervention services in Medicaid through the American Rescue Plan, as well as the enhanced federal matching for such

services in Medicaid and the Community Mental Health Block Grant set-aside for crisis care proposed in the Build Back Better Act and FY 2022 appropriations bills.

Crisis intervention programs can also help to reduce police violence and promote racial justice by having trained behavioral health professionals, rather than police, respond to relevant crisis calls. Police are not adequately trained or prepared to appropriately respond to behavioral health crises. This has led to people with mental illness and addiction becoming victims of fatal police shootings. Police response to mental health crises can be especially damaging in Black communities and other communities of color, which have been disproportionately impacted by punitive drug laws.

Reentry coordination

In addition to providing integrated care services to try to prevent people with mental health and substance use disorders from entering the criminal justice system, coordination is also needed to ensure coverage and linkage to care for those leaving incarceration. Proposed legislation including the Medicaid Reentry Act (S. 285) would help improve the transition to care for those reentering the community from incarceration by ensuring continuity in insurance coverage so that individuals are immediately able to access mental health and addiction care in the community upon release.

Ensuring parity between behavioral and physical health care

Parity compliance reporting and enforcement

To improve oversight and enforcement of parity laws and better understand shortfalls in compliance, Congress must ensure the strong implementation of the parity reporting requirement included in last year's Consolidated Appropriations Act. The legislation requires plans to provide parity analyses upon request from the Departments of Labor, Health and Human Services, or Treasury, as well as plan participants. We examined similar state reporting requirements in our report on parity compliance standards and believe that such requirements are an important step toward increased parity compliance and transparency. However, Congress should additionally require routine reporting by plans, rather than only upon request. Congress should also provide more resources to the regulators at the Department of Labor (as well as HHS and Treasury) so that they are able to adequately implement and enforce the reporting requirements. The Parity Enforcement Act introduced in the House (H.R. 1364) would also help by providing the Department of Labor with authority to investigate and levy monetary penalties against health insurers and plan sponsors that offer health plans that violate the Mental Health Parity and Addiction Equity Act (MHPAEA). This authority has also been proposed in the reconciliation proposal. Additionally, the Parity Implementation Assistance Act (S. 1962) would help states better enforce parity by authorizing grants to support their oversight of plans' compliance with parity requirements and incentivize the collection and review of insurers' comparative analyses.

Congress should require more transparency about the Centers for Medicare and Medicaid Services' (CMS) parity enforcement activities.

Medical necessity criteria

Wit v. United Behavioral Health set an important standard requiring health plans to utilize medical necessity criteria that reflect generally accepted standards of care when making coverage determinations for behavioral health benefits. As outlined in our report, many states have imposed requirements on health plans to use specific medical necessity criteria and evidence-based level of

care assessment tools in medical necessity determinations. Congress should adopt a federal standard on medical necessity criteria for plans under its jurisdiction based on the generally accepted standards of care set out in *Wit* to ensure that such criteria are parity-compliant and do not unnecessarily restrict access to behavioral health benefits. Congress should also designate an evidence-based, clinically reviewed patient level of care assessment tool to promote fidelity and standardization in health plans' application of the medical necessity criteria. Federal regulators should also conduct oversight of the medical necessity criteria used by health plans and ensure that the criteria used and applied by plans comply with MHPAEA's requirements.

Network adequacy

Another payor practice that limits access to care is inadequate plan networks. This issue is particularly acute for consumers with behavioral health care needs. According to research, consumers utilize out-of-network services for behavioral health care at significantly higher rates than for other medical services. There is tremendous variation in how network adequacy is defined. Our report on network adequacy explored the use of quantitative metrics to define and monitor network adequacy. The federal government requires health plans under its jurisdiction to establish adequate networks, but it only defines network adequacy in Medicare Advantage plans, where CMS establishes maximum travel time/distance standards based on provider type and geographical region and minimum facility- and provider-to-beneficiary ratios. CMS has established specific metrics for behavioral health providers, including geographic standards for psychiatrists and inpatient psychiatric facilities and provider-enrollee ratios for psychiatry. For qualified health plans and Medicaid managed care plans, the federal government has deferred to state standards. The federal government could take a stronger role in defining and monitoring network adequacy for plans under its jurisdiction.

Prior authorization requirements

Another payor practice that creates a barrier to care for patients with behavioral health needs is prior authorization requirements. While a common practice, such requirements are not clinically appropriate for substance use disorder services. We examined state requirements for health plans to limit or restrict the use of prior authorization, and the federal government can similarly prohibit the practice for plans under its jurisdiction.

Extend parity protections

To improve access to care and prevent discriminatory practices in Medicare and Medicaid, Congress should extend the requirements of MHPAEA to Medicare and Medicaid fee-for-services plans, which are currently not included. As shared in a letter by more than 60 behavioral health groups through the Coalition to Stop Opioid Overdose and the Mental Health Liaison Group in response to this request for information, discriminatory coverage of behavioral health services continues in Medicare and Medicaid due to the lack of parity protections. Medicare's particularly inadequate and discriminatory coverage for mental health and substance use disorder treatment is especially problematic because the program serves as a benchmark for other forms of health coverage, which are replicating Medicare's limited coverage of services, disparate reimbursement rates, and treatment limits.

In addition to Medicare and Medicaid fee-for-service exemptions, MHPAEA also includes opt-out options for state and local government plans. Congress should eliminate these opt-outs entirely to ensure that city and state employees are afforded essential parity protection.

Furthering the use of telehealth

With substance use treatment difficult for many to access, regardless of the pandemic, Congress should make permanent the COVID-19 flexibilities for behavioral health care, specifically those that allow the prescribing of buprenorphine and methadone without in-person visits and that allow expanded use of take-home doses. Many individuals in need of treatment cannot easily access these medications due to a lack of available providers in their area. Allowing treatment to be prescribed via telehealth can help eliminate the transportation, employment, child care, stigma, and other barriers that may prevent people from being able to participate in in-person treatment. Allowing audio-only services can help limit disparities caused by limited access to smartphones and broadband internet services, as well as limited digital literacy.

However, we do not support the expanded tele-prescribing flexibilities for all Schedule III and IV substances, as proposed in the Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act (S. 340), as this would include benzodiazepines. Overdose deaths involving benzodiazepines have been increasing, and benzodiazepines are particularly dangerous when combined with opioids. In-person visits may help reduce risky prescribing of benzodiazepines, and the expanded flexibilities should therefore be more specifically targeted at medications for the treatment of addiction.

Additionally, the abrupt removal of COVID-19 public health emergency flexibilities on interstate reciprocity in telehealth is leading to sudden terminations of care for patients who have been seeing a provider in another state via telehealth. While we recognize that this may largely be a state regulatory issue, Congress can make these exceptions permanent in Medicare and should take other action to try to minimize harm to patients in other insurance programs by, for example, extending these flexibilities at least temporarily beyond the end of the public health emergency to give patients, providers, and states time to find other solutions to prevent abrupt loss of access to care, as suggested in several bills already introduced in Congress. Further, mandating reciprocity in Medicare, as Congress has already done for physicians in the Veterans Affairs system, would likely encourage states to adopt legislation on reciprocity that would also affect patients with other forms of insurance.

Improving access to behavioral health care for children and young people

Pediatricians

In addition to the workforce recommendations outlined above, which would also pertain to the youth behavioral health care workforce, ensuring all pediatricians, specifically, receive training on behavioral health could help address the provider shortage. Pediatricians should be trained in substance use disorder risks so they can help educate parents on risk and protective factors and conduct screening, early intervention and referral to treatment during routine wellness visits.

School-based mental health

A unique opportunity for integrating care and expanding access to behavioral health care for children lies in schools. Congress should aim to increase school mental health programs, including through bills such as the Mental Health Services for Students Act (S. 1841), Pursuing Equity in Mental Health Act (S. 1795), and the Suicide Training and Awareness Nationally Delivered for Universal Prevention (STANDUP) Act (S. 1543), among others.

Earlier and broader approach to prevention

Congress should also help facilitate an earlier and broader approach to substance use prevention. Research led by the National Institute on Drug Abuse on social determinants and adverse childhood experiences demonstrates that we need to adopt a broader approach to prevention that enhances traditional substance use prevention interventions. This new approach requires better coordination and collaboration between substance use prevention and other fields that promote child health and resilience, as well as structural changes that facilitate healthy and stable families. As described in our blog published by *Health Affairs*, there are a number of policy initiatives to improve family stability and security and child health and resilience that Congress has recently undertaken in COVID-19-related legislation or is currently exploring in the Build Back Better Act. While these policy changes are seemingly outside the realm of substance use, they are critically important for prevention and will also reduce the risk for other negative mental and behavioral health outcomes that have the same risk and protective factors as substance use. Congress should include reporting requirements in grants and programs funded through policies to address family stability and child resilience to monitor and evaluate the longer-term impact on youth substance use and addiction risk and other mental and behavioral health outcomes. This data will help establish an evidence base for expanding traditional substance use prevention efforts to include social determinants of risk and protection. Establishing an evidence base for this type of earlier and broader approach to prevention is important for better directing our efforts in the future, by smartly dedicating our limited resources to interventions with the greatest promise of helping kids avoid substance use and addiction. It also will help to break down long-standing silos and encourage collaboration between the field of substance use and the many other fields that have deep expertise in promoting healthy childhood development.

Family support services

Similarly, in addition to broadly supporting families to improve youth wellbeing, directly providing support to families of those struggling with substance use is critical to improve outcomes. To do this, we encourage the Senate to pass the Family Support Services for Addiction Act (S. 485), which would establish a grant program for community organizations that provide support to families of individuals struggling with substance use.

Thank you again for the opportunity to respond to your questions and provide comments and for your commitment to improving access to behavioral health care. We would be happy to answer any additional questions or provide additional information to assist in your work.

Sincerely,

Partnership to End Addiction