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# THE COVID–19 PANDEMIC AND BEYOND: IMPROVING MENTAL HEALTH AND ADDICTION SERVICES IN OUR COMMUNITIES

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

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# THE COVID–19 PANDEMIC AND BEYOND: IMPROVING MENTAL HEALTH AND ADDICTION SERVICES IN OUR COMMUNITIES

**WEDNESDAY, MAY 12, 2021**

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
*Washington, DC.*

The hearing was convened, pursuant to notice, at 3 p.m., via Webex, in Room SD–215, Dirksen Senate Office Building, Hon. Debbie Stabenow (chair of the committee) presiding.

Present: Senators Cardin, Whitehouse, Hassan, Cortez Masto, Thune, Burr, Toomey, Cassidy, and Daines.

Also present: Democratic staff: Alex Graf, Legislative Advisor for Senator Stabenow. Republican staff: Rachel Green, Health Care Policy Advisor for Senator Daines; and Stuart Portman, Senior Health Policy Advisor.

## OPENING STATEMENT OF HON. DEBBIE STABENOW, A U.S. SENATOR FROM MICHIGAN, CHAIR, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator STABENOW. Well, good afternoon. It is my pleasure to call this hearing of the Finance Subcommittee on Health Care to order. And I am so pleased to be here during Mental Health Month talking about the urgent need to improve behavioral health-care services in our communities. And I am really pleased to be here as well with Ranking Member Daines. I am so glad you are my partner on this subcommittee, and I think there are a lot of great things that we can do on this subject, and others as well.

Everyone affected by mental illness or substance abuse disorders should be able to get the help they need so they can live a healthy and fulfilling life, period. And the good news is, we can make this a reality.

Before the pandemic, nearly one in five Americans had some form of mental illness, although fewer than half received treatment. This lack of support was even worse in the communities of color.

The pandemic has made things worse and exposed the weaknesses in the way we pay for behavioral health care in this country. In January, 41 percent of American adults reported that they were struggling with anxiety or depression. That is up from 11 percent before the pandemic. And more than one in four young people have reported having suicidal thoughts.

Meanwhile, overdose deaths have surged during the pandemic. The CDC reported that more than 87,000 Americans died of drug overdoses during the 12-month period that ended last September. That was the most deaths in any year since the opioid epidemic began in the 1990s.

And long after the pandemic ebbs, these behavioral health needs are going to continue, and that is why we are here today talking about these issues. We need to finally treat health care above the neck the same way we treat health care below the neck. And the good news is, we are making progress.

I have worked with my friend Senator Roy Blunt and so many people on the committee to create the Certified Community Behavioral Health Clinics program, now fully operational in 10 States, with over 300 startup grants bringing services to people in 41 States now.

We have a structure that allows clinics to truly meet the needs of their communities. This has been a tremendous success in a short amount of time, and it is the model for the future, I believe. These clinics are required to provide comprehensive services, including 24/7, 365 mobile crisis team services, immediate screening and risk assessment, and easy access to care. They see everyone who walks in the door. They have tailored care for active duty military and our veterans, care coordination with primary care providers, and coordination with law enforcement.

The results are stunning. According to HHS numbers included in the budget request last year, people who received services through what we call CCBHCs had 63 percent fewer emergency department visits for behavioral health. A lot of times folks are just sitting in the emergency room, maybe an officer with them, with no behavioral health services available.

We have seen 60 percent less time spent in jails by people who really needed health services, and law enforcement now has other opportunities and places where they can work with people to get people the care they need rather than sitting in jail. And we saw a 40.7-percent decrease in homelessness—so important.

And today the National Council for Mental Wellbeing, which was previously the National Council for Behavioral Health, released a new CCBHC impact report with similarly stunning results. They found that more than half of these clinics offer same-day services, and nearly all of them offer treatment within a week.

Compare that to the average wait time of 48 days nationally. And they are serving thousands of new people. Ninety-five percent of CCBHCs have engaged in promising new practices in collaboration with law enforcement and our criminal justice agencies.

This month, Senator Blunt and I, hopefully joined by all of you, will be introducing legislation giving every State in the country the option of participating in this fully successful program.

It will ensure that behavioral health care clinics are reimbursed for services in the same way we fund Federally Qualified Health Centers. We can get this done, and we can bring community care to millions of Americans who need it.

So I am going to thank our wonderful witnesses who are with us today virtually. We have colleagues who are here with us in the Finance Committee room, and others who are with us virtually as

well. And so many of my colleagues have focused on this issue and care so much about it—I am so grateful—whether it is what I am talking about with CCBHCs, or the importance of telehealth, crisis supports, coordination with law enforcement and schools, and so many other ways to address mental health and substance abuse. It is all very important, and I really look forward to working with each of you.

Now I would like to turn to Senator Daines.

[The prepared statement of Senator Stabenow appears in the appendix.]

## OPENING STATEMENT OF HON. STEVE DAINES, A U.S. SENATOR FROM MONTANA

Senator DAINES. Madam Chair, thank you. I am really glad to be here with you today for the first subcommittee hearing of the year. It is also great to have a fellow Montanan joining us today. We will get into a more formal introduction in a bit, but a warm welcome to Lenette. I am glad you could be here with us today.

May is Mental Health Awareness Month, an issue at the top of my mind and many others following a year of isolation for Montanans and Americans across the country. In fact last year, due to COVID restrictions, Montanans and Americans were forced to stay home. We saw family-owned and small businesses shutter; workers struggling; family members isolated from loved ones; and schools closing, directly impacting our Nation's youngest and brightest.

Through no fault of their own, hardworking Montanans and Americans across the country lost their jobs, leaving them wondering how they are going to keep a roof over their families' heads, and food on the table. Instead of socializing and learning with their friends in classrooms, students were stuck behind computer screens. Symptoms of anxiety and depression are on the rise.

In fact, one survey states that more than half of the adults reported that worry or stress related to the pandemic was having a negative effect on their mental health. As we all know, mental health issues were a problem before the pandemic. In fact, it is estimated that nearly one in five American adults had some form of mental illness, but fewer than half of those adults received treatment in 2019.

Since the pandemic, lockdowns, economic hardships, and social isolation have only helped to intensify what we already knew, and that is, we need mental health services in our communities, and we need to make this a priority.

The pandemic has also helped expose and magnify the flaws in our mental health system. Sadly, in 2020 suicide was the 10th leading cause of death, and drug overdose deaths hit a record high. In Montana we are, unfortunately, not immune to these devastating statistics. We are fourth in the Nation for suicides. We are first in the Nation per capita for children being placed in foster care, most often due to a parent's drug or alcohol use. And we are witnessing a disturbing increase in meth-related violent crime.

It is clear that more needs to be done to support individuals and families struggling with addiction or mental illness. We are fortunate in Montana to be home to treatment facilities like Rimrock, which I have had the opportunity and the privilege of visiting sev-

eral times over the years. In fact, I even had the opportunity to bring Vice President Pence and his wife Karen to show them firsthand the great work the organization does for Montanans struggling with addiction and mental health issues.

In fact, one visit I will never forget. I had the chance to meet with a few moms who were receiving substance abuse treatment. I had just become a grandfather. I was overwhelmed with emotion to see the little ones there with these moms struggling with these addiction issues. But there I saw hope, and I saw struggle, and I saw commitment, and so much love that the Montana moms had for their children. Because at Rimrock, thanks to a bill that I had led in the Senate and was signed into law by President Trump, moms who are working to get back on their feet are able to stay with their children. Let me tell you, that means the world to these moms. It gives them a reason, a very important reason, to get better.

Treatment centers like Rimrock make a world of difference in our communities, and they are more important now than ever before as we come out of this pandemic. And after a year of lockdowns and closures, we are finally starting to see light at the end of the tunnel. And thanks to the leadership of our new Governor Greg Gianforte, life in Montana is on its way to getting back to normal.

We have vaccinated over 350,000 Montanans and have led the Nation in vaccine administration. We are now open for business in Montanan, and we are open for school. We are incentivizing getting back to work versus staying at home, something I believe is also important for mental health, because I believe there is dignity in work.

But the reality is that there will likely be long-lasting impacts of the pandemic, particularly on mental health. We must aim to meet the challenges of today, and prepare for the increased needs that this pandemic has created. So I am very committed to working with my colleague Senator Stabenow towards that goal.

And again, I appreciate our witnesses being here today offering their advice and their expertise on such a very important topic.

Thank you, Madam Chair.

Senator STABENOW. Thank you so much.

[The prepared statement of Senator Daines appears in the appendix.]

Senator STABENOW. We will now introduce our witnesses, and I would like to start by inviting Senator Burr to introduce a great witness from North Carolina.

Senator BURR. Madam Chair, thank you very much for having this hearing, but more importantly for the opportunity to introduce Victor Armstrong from Charlotte, NC, a constituent of mine.

I am proud to say Mr. Armstrong has both decades of experience with behavioral health, and strong North Carolina roots. Mr. Armstrong currently serves as the North Carolina Department of Health and Human Services Director of Mental Health, Developmental Disabilities, and Substance Abuse.

He began serving in this capacity in March 2020, taking the directorship at a critical time for behavioral health care. COVID–19 was beginning to upend society as we knew it, causing economic

and social turmoil that has had extraordinary impacts on mental health and addiction.

Prior to assuming his current role, Mr. Armstrong was the vice president of behavioral health with Atrium Health Care, where he was responsible for operations at Atrium's largest behavioral health hospital. He currently serves on the board of directors of the American Foundation for Suicide Prevention, North Carolina. And he previously served as board chair of the North Carolina chapter of the National Alliance of Mental Health.

Mr. Armstrong, thank you for your service, for your willingness to be here today, and for the challenging times we continue to go through, both in North Carolina and across the country. I look forward to your testimony, and I thank the chair.

Senator STABENOW. Thank you very much.

I would now like to turn to Senator Cortez Masto, who I know has placed these issues at the very, very top of her issues that she is working on and leading on in Nevada. And so I will turn to you, Senator.

Senator CORTEZ MASTO. Madam Chair and Vice Chairman Daines, thank you for holding this important hearing. I am honored to introduce Dr. Stephanie Woodard, the Senior Advisor on Behavioral Health for Nevada's Department of Health and Human Services.

In that capacity, she manages the planning, policy, and funding for our State's substance use disorder and mental health programming. In addition to her deep knowledge of our behavioral health system, Dr. Woodard also brings clinical expertise as a front-line practitioner. She is a licensed psychologist whose body of work has focused on behavioral health integration, co-occurring disorders, and mindfulness-based treatments.

I am especially pleased to have Dr. Woodard here to speak to her great leadership in standing at Nevada's nine Certified Community Behavioral Health Clinics, or CCBHCs, that Senator Stabenow has been so instrumental in building here at the Federal level.

My State has been particularly hard hit by this pandemic. The twin public health and economic crises have taken a toll on the mental health of Nevada families. And, Dr. Woodard, I am glad to have you here today to share your experience and insight on how we can better serve families across the country as we emerge from the pandemic.

I look forward to your testimony.

Senator STABENOW. Thank you so much. And I am going to turn it back over now to Ranking Member Daines to introduce a great person from Montana.

Senator DAINES. Well, thank you, Chair Stabenow. She is a great person from Montana. I am very pleased to introduce and welcome Lenette Kosovich to the committee. Lenette serves as the CEO of Rimrock Foundation in Billings, MT, which is the largest behavioral health organization in the State, providing substance abuse treatment and mental health services.

She has been in this role for over a decade and is well-versed on the complexities of providing mental health and addiction services. I was with her when she hosted Vice President Pence in fact, when she had a chance to show him what they were doing to help these

moms there. She is a trusted advocate in Montana and works every day to improve the lives of Montanans in need of substance use and mental health assistance.

I am glad my colleagues and others here today will get to hear her experiences firsthand. So, thanks for joining us today, Lenette. It is great to have you here.

Senator STABENOW. Well, thanks so much. And last, but absolutely not least, I would like to introduce Malkia Newman, who is a team supervisor for the CNS Healthcare Anti-Stigma Program in Michigan. I have known Malkia for many years, and she is a leading advocate, not just in Michigan but nationwide, for individuals with mental health and substance abuse issues.

She is a peer educator, developing and leading programs in our State, and sharing her expertise around the country. She is also an ordained minister at New Birth International Church in Pontiac, MI, and she is a board member of the Oakland Community Health Network and has served several terms as board chair and vice chair. You know, I could go on and on, but let me just say in summary, she is a voice for so many people struggling with mental illness and substance use disorders. And she is working hard every day to make people's lives better.

So I am so grateful that you are with us, Ms. Newman. Thank you so much for participating today.

So let me start first—and we will ask each of our witnesses to speak for 5 minutes, and we certainly welcome any other supplemental information you want to share in writing with the committee as well.

But, Mr. Armstrong, we will start with you. Welcome.

**STATEMENT OF VICTOR ARMSTRONG, MSW, DIRECTOR, DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, RALEIGH, NC**

Mr. ARMSTRONG. Good afternoon. Thank you, Chair Stabenow, Ranking Member Daines, and honorable members of the committee, for the opportunity to testify about North Carolina's approach to equity in community behavioral health services.

My name is Victor Armstrong. I am the Director of North Carolina's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. I am a social worker, a husband, and a father to three black boys. I am a mental health advocate, and I am the son of a preacher, born and raised in rural North Carolina—Plymouth, to be specific—but I now reside in Charlotte, NC.

I share all of this because I am the sum of all of these things. This will no doubt create a perception for who I am based not only on what I have just shared, but also based on your lived experiences and mine.

Much as you today will interact as tradition and formality dictate, in many ways our mental health and substance use system has worked the same way until COVID–19 and social injustice rocked our Nation.

Unfortunately, it is a system that has not been practiced nor been funded through a lens of equity. The lens of equity is about

the intersectionality of race, culture, and ethnicity in addition to living with mental health and substance abuse challenges.

It is about being black and living with a serious mental illness. It is about being Latino and living with intellectual disabilities and with traumatic brain injuries. It is about being an American Indian and living with a substance abuse disorder. It is about being an Asian or trans person, struggling with an anxiety disorder exacerbated by the discrimination that often accompanies mental illness, the bigotry that is perpetrated toward trans Americans, and the increasing rates of violence against Asian Americans.

We cannot ignore how a person of color enters the behavioral health system. People of color often do not have access to outpatient services within their communities. This makes it more likely that they are introduced to the behavioral system when they are in a state of crisis, and more likely to enter the system via the back of a police car or an acute care emergency department, neither of which is conducive to good clinical outcomes, and neither of which is likely to foster positive relationships with the mental health system.

Systemic racism and bias, both explicit and implicit, are multilayered and seep into every crevice of society. This includes our mental health and substance use care, but we can change that if you are willing to help to reform our system.

We know that inequity exists. It is our moral responsibility to address that inequity by leaning into equity. Every decision that we make as clinicians, policy-makers, or simply as agents of change, either leans into creating a more equitable system or perpetuates our existing problem of inequity.

We can address the issue of access by supporting the creation of more mental health resources in communities of color and underserved ZIP codes. We can create more community-based resources that provide access to upstream treatment.

One way that communities are doing this is through the Certified Community Behavioral Health Clinic, or CCBHC, model. CCBHCs are required to provide comprehensive, timely, and culturally competent services to anyone in their communities. One CCBHC here in North Carolina—Monarch—has embedded a peer support specialist with the EMS team that responds to opioid overdoses. The peer stays with that person through the trip to the hospital and helps to connect them to community treatment upon release, making sure that that person does not get lost on the road to recovery in the community.

We support the CCBHC model and appreciate any funding to increase CCBHCs. We can support efforts to build a workforce that mirrors the population it serves. In North Carolina we have roughly 4,000 trained certified peer specialists representing black, white, Latino, Asian, and American Indians, with only about 1,600 individuals gainfully employed.

We need to utilize the peer workforce and pay them a living wage. We need to partner with Historically Black Colleges and Universities to build a multicultural workforce. We need to partner with clinicians of color and provide them access to government grants and contracts. We need to partner with the faith-based orga-

nizations, and we need to fund studies that consider the nuances of race, culture, and ethnicity and the impact on mental wellness.

Further, we need to better understand the impact of systemic racism and complex trauma experienced by people of color. In North Carolina, it has taken intentionality to mitigate the effects of the COVID–19 pandemic, particularly the disproportionate impact of the virus on black and brown communities.

As the North Carolina Department of Health and Human Services sought to intervene, we recognized that without incorporating trusted voices who represent the individuals we seek to assist, we would lack credibility, and full engagement would be difficult if not impossible.

Historically marginalized communities, those marginalized by race, ethnicity, or diagnosis, are simply looking for a collaborative partner who will value their expertise and life experience. We have the resources to build a more equitable system. If we do not build equity into our mental health and substance abuse programs and practices, we will ultimately fail the most powerless and vulnerable.

I will leave you with one final thought. Mental health and substance use transcends barriers, divides, and differences. People from all walks of life are dying every day from suicide or overdose. Mental health and substance abuse do not see race, culture, or ethnicity. The same cannot be said of our treatment systems. It is time that we fix our system to serve the diverse communities in our Nation. Thank you for your time.

[The prepared statement of Mr. Armstrong appears in the appendix.]

Senator STABENOW. Thank you so much for that very, very important testimony.

We will now turn to Stephanie Woodard. We appreciate very much, Dr. Woodard, your being with us.

**STATEMENT OF STEPHANIE WOODARD, Psy.D., SENIOR ADVISOR, DIVISION OF PUBLIC AND BEHAVIORAL HEALTH, NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES, CARSON CITY, NV**

Dr. WOODARD. Thank you, Senator Stabenow, Ranking Member Daines, and members of the committee.

My name is Stephanie Woodard, and I am a licensed psychologist and serve as the Department of Health and Human Services' Senior Advisor on Behavioral Health. I also serve on the board at the National Association of State Mental Health Program Directors.

I am humbled and honored to have the opportunity to testify before you today to discuss how the COVID–19 pandemic has highlighted the critical role of crisis services and Certified Community Behavioral Health Clinics, as well as underscored the importance of Federal spending strategies to support the States as they look to build sustainable standards of care.

National guidelines by the NASMHPD, the Substance Abuse Mental Health Services Administration, and the National Council have been and continue to be invaluable resources as Nevada develops our crisis continuum of care. A coordinated crisis continuum of care ensures that when individuals are in crisis, they have some-

one to talk to, someone to respond, somewhere to go, and that the system is rooted in effective practices.

Crisis services should be available to anyone, anywhere, any time, regardless of insurance status. It is this cascade of care that provides appropriate community-based response to a behavioral health crisis, and is essential in saving lives.

With the implementation of 988 coming in July of 2022, the time to act is now. During COVID, Nevada has seen an influx of calls and texts through our Lifeline, but also the acuity and urgency of those calls have increased. And while we have huge Federal grant funds to enhance staffing to meet the increased demand, we are still faced with the limitations of the current system. 988 presents challenges to States to ensure call centers are sufficiently staffed to respond timely to people who are reaching out in crisis.

With 80 to 90 percent of callers having their immediate needs addressed by the call, the call center will need to have technology to deploy mobile crisis teams, ensure individuals have access to needed stabilization services, and interoperability with 911.

We remain hopeful that sustainability will be possible with pending 988 State legislation and through Medicaid. Overutilization of the 911 emergency response system with EMS and law enforcement has resulted in inappropriate and costly use of public safety and health-care resources.

Mobile crisis teams offer an alternative response to individuals and families in crisis, allowing for stabilization in the community. By providing alternative destinations for individuals in crisis, Crisis Stabilization Centers divert patients away from costly emergency room visits and unnecessary inpatient hospitalizations. Together, these services result in cost savings across criminal justice, law enforcement, and health care.

We thank Chairman Wyden and Senator Cortez Masto for the inclusion of Medicaid crisis care funding in the American Rescue Plan. Within Nevada, a new Medicaid rate for Crisis Stabilization Centers is expected to result in a cost savings to Nevada over the long term. The recent infusion of Federal funds is necessary for the development of this essential infrastructure. However, it is insufficient for long-term sustainability.

To bring the entire crisis continuum to scale, Nevada, along with other States, will need guidance from the Centers for Medicare and Medicaid services to ensure these services are sustainable into the future. For States to be successful in rising to the challenge 988 presents, coordination between SAMHSA and CMS is recommended by the Medicaid and CHIP Payment Access Commission, or MACPAC. It will be essential.

Nevada was fortunate to be selected to participate in the CCBHC demonstration grant in 2018. And over the course of the demonstration, CCBHCs had increased access to critical safety net behavioral health services, while lowering cost of care and improving outcomes.

The success of the CCBHCs can be measured by the relationships the clinics have within their communities, collaboration with law enforcement for community-based crisis intervention services, expansion of services into schools, comprehensive case management and peer recovery support to better address social determinants of

health, and increased engagement in care. Additionally, the cost-based reimbursement has enhanced their ability to recruit and retain qualified behavioral health professionals.

Nevada's CCBHCs were able to pivot quickly during the pandemic to expand telehealth services, resulting in high rates in the continuity of care. We would also like to express our gratitude to Senator Stabenow, Senator Blunt, the National Council, and Nevada's Governor Sisolak, who have supported the CCBHC model and expanded the demonstration to 2022.

Since 2018, we have made significant investment in the CCBHCs through our mental health block grant, and continue to support the CCBHC expansion grant.

Thank you for your time, and I am happy to answer any questions that you may have.

[The prepared statement of Dr. Woodard appears in the appendix.]

Senator STABENOW. Thank you so much. We are really appreciative that you are with us.

Lenette Kosovich—we would appreciate Ms. Kosovich sharing her testimony.

**STATEMENT OF LENETTE KOSOVICH, R.N., MHA, CHIEF EXECUTIVE OFFICER, RIMROCK FOUNDATION, BILLINGS, MT**

Ms. KOSOVICH. Senator Stabenow, Senator Daines, and members of the committee, thank you for inviting me to talk about one of the most complex and far-reaching issues facing Montana and our Nation.

My name is Lenette Kosovich. I am the CEO of Rimrock Foundation, the largest behavioral health-care facility in Montana, and we are one that provides the full continuum of services, including peer support and detoxification, inpatient residential, outpatient, and mental health treatment. And we have extended treatment for 12 months or longer, as Senator Daines said, for women with their children as they recover. We also have a reentry program for those recently released from incarceration.

We serve seven treatment courts, including a Family Drug Court, a Veteran Court, and recently an Indian Child Welfare Act Family Recovery Court. And all in all, we see nearly 2,000 clients a year.

There is no doubt that COVID has exacerbated an already complex problem. Before COVID, substance use disorder and mental illness were already the top health needs in our county and our State.

We have had a methamphetamine-fueled increase in violent crime, and we have also had a burgeoning child welfare system where four out of every five cases involved parental drug use. And over the last 5 or 6 years, our clients are considerably more compromised than even a decade ago. Along with serious illicit substance use disorder, patients most likely have mental health disorders, and they are accompanied by one or two comorbidities like hypertension or diabetes. And it has become the norm for us to have a 25-year-old patient in our care who has already received a heart valve replacement due to endocarditis resulting from IV drug use.

So, enter COVID. Alcohol consumption, drug use, and mental illnesses have increased. Our referrals have gone up 40 percent in 11 months. The calls to our State suicide hotline have doubled. And unfortunately, violent crime in our county has increased nearly 70 percent. And one thing we know for certain is that drugs have played a part in all of this.

COVID complicated and delayed service delivery. The quarantine and social distancing that we needed to do really reduced the space we had to provide services by about a third. And many of our industry partners suspended their services, or even closed. And so our wait list has increased.

With physical space at a premium, COVID accelerated the adoption of telehealth tenfold. And with that came incredible pressure. iPads were needed for all, except it was hard to get iPads in some cases. Group therapy via telehealth, except Johnny's Internet wasn't that reliable in some parts of Montana. Family week via Zoom is great, except Suzy's mom didn't have a computer.

So training and new admission policies, new safety protocols; every part of our industry was stretched to the max. But the worst challenge of COVID for me was workforce. Before COVID, the workforce shortage was severe. Wait times for positive COVID results made the problem much worse. And when I don't sleep at night, it is often because I am worried about the number of my employees pulling a double shift on the brink of a mental breakdown themselves.

History teaches us—we have talked about this—that the mental health impact of a catastrophic event such as a pandemic will far outlast the physical impact. So I, as well as you, are probably buckled in for a bumpy road. Fortunately, we do believe there is hope on the horizon with the expansion of the Certified Community Behavioral Health Clinics.

Rimrock in Billings, and two other organizations in Montana, were recently granted CCBHC expansion pilots. In the active CCBHC sites, this innovative model of care has dramatically increased access to mental health and substance use disorder treatment. And it has been proven to address the pain points, just as I have shared, and I am looking forward to some of the same outcomes that were highlighted already by Senator Stabenow that were recently released in an impact study by the National Council for Mental Wellbeing.

We must increase the number of clients that are served. There is no doubt about that. And we see that a CCBHC model does increase the number that are available to serve.

Wait times are another issue that is always at the top of our mind, and we know that 84 percent of clients in this model are seen within a week. Investing in the workforce—this is an enhanced reinforcement model that allows States to have the funds for us to hire more people to the clinic. And then, making the crisis service supports available to all.

Delivery of services in the community, not just in facilities, and the innovation and the collaboration with criminal justice, community services, helping to divert people from crisis—from emergency rooms and jails—and getting them into the appropriate level of care is a must.

Senator Stabenow, Senator Daines, and the committee, there is not one constituent whose life has not been impacted by substance use disorder or mental illness. And there is not one of our economies that also has not had negative impact. And we can do better. And the CCBHC model does do better, and I am very encouraged and continue to urge you to support these models throughout the States.

Thank you for inviting me to speak on this issue, and I am open to answering any questions also.

[The prepared statement of Ms. Kosovich appears in the appendix.]

Senator STABENOW. Well, thank you so much.

And again, last but not least, Malkia Newman. Ms. Newman, we welcome you. It is wonderful to have a chance to see you again, even if it is only virtually.

**STATEMENT OF MALKIA NEWMAN, TEAM SUPERVISOR, CNS HEALTHCARE ANTI-STIGMA PROGRAM, WATERFORD, MI**

Ms. NEWMAN. [Sings a song.]

Good afternoon, members of the U.S. Senate, staff, and guests. I am very honored to be asked to give testimony to this distinguished body today. I want to especially thank Health Care Chairwoman Debbie Stabenow and Ranking Member Steve Daines for convening this vitally important discussion today.

My name is Malkia Newman, and I am living proof that the services and support that are available through our community mental health system work. I am not naive to the fact that many areas need to be improved, but I know that my life would not be the amazing life that I am living now had I not received treatment for bipolar disorder almost 20 years ago.

I am a survivor of childhood sexual trauma, as well as a survivor of intergenerational trauma, a sad legacy of slavery and discrimination. I wrestled with suicidal thoughts, had difficulties maintaining relationships or employment. My daughter Tracie—I call her my miracle—she was my reason for living when all hope was gone.

Mental health conditions are prevalent in my family. The treatment and hospitalizations that my brother Ronnie endured, who had schizophrenia, terrified me, which made it harder for me to ask for help until there was no other option available.

Fast forward 20 years. I have 15 years of continuous employment with CNS Healthcare's Anti-Stigma Program. I have been a homeowner for 9 years. And on June 5th, my husband Dubrae and I will celebrate our 15-year wedding anniversary. I have reconciled with my family, and I serve proudly as an ordained minister at my Church, New Birth International. My list of community service awards and recognitions is long.

I am living proof, I am an advocate, and I am proud to speak on behalf of those who have not yet found their voice. It is vitally important that we not just continue to offer behavioral health treatment, but that we prepare for the increased need that the pandemic has created.

We need more qualified providers—doctors, nurses, therapists, and other support personnel, especially Peer Support Specialists—people with lived experience and expertise in the mental health

field who can encourage and educate people receiving services in a richer way than the other professionals can.

We need to compensate our professionals at every level to make sure that we have qualified, culturally and linguistically competent people meeting the needs of people no matter what their background.

The Certified Community Behavioral Health Clinics, the CCBHCs, have made it easier for people to access services regardless of if they have insurance or not, which in the past has created a huge barrier for people needing help.

Integration of physical and mental health has been a topic of discussion for many years. Integration is needed to help people with mental health disorders live longer, healthier lives, but the focus has shifted from people getting whole health treatment from head to toe, to an argument about who will fund and administer the dollars associated with the treatment.

I believe that the people served, and their loved ones, should have a role in shaping what health care should be, as people with intimate knowledge of what works and what does not. Advisory groups can and should be involved at every level of program development, implementation, and evaluation. The finished product would be more efficient and cost-effective as well.

It is my prayer and hope that we will not rush to get back to "normal" at the expense of programs and systems that work.

Thank you for this time of testimony, and I am available to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Newman appears in the appendix.]

Senator STABENOW. Well, thank you so much, Malkia. It is wonderful to see you again, and I so appreciate your courage and your work in Michigan.

We will now turn to questions. And let me start by first saying that there are so many things that we need to do in this area, but fundamentally for me, and the work that Senator Blunt and I have done, is to basically say we should fund mental health and substance use disorders as health care—health care. And yet we fund Federally Qualified Health Centers in a permanent way, fully reimbursing for the cost of services, and in the area of mental health, of course, and substance use, as you know, we do not. We basically have done it traditionally through grants. And when the grant runs out, the service is gone.

So that is the whole point of CCBHCs: to move to what we know works in the community. So right now we have wonderful support for fully expanding across the country the opportunity to fully fund health care that is above the neck. In fact, we have 22 members of the Finance Committee now who have at least the start-up grants in their State. There are 10 States that are fully funded as health care, and we want to expand that.

But I would like to ask each of you a question relating to CCBHCs as we move forward with the next legislation we will be offering soon.

Ms. Kosovich, you were awarded a CCBHC expansion grant earlier this year, and I understand you are going live next month. I wondered if you might just speak a little bit more about the kind

of services that you are going to be able to provide in the community as a result of the new funding, and what it would mean to take the next steps to be fully funded like health centers are.

Ms. KOSOVICH. Certainly. Thank you for the question. We have already implemented one of the components, and that is the PACT team, which is the Program for Assertive Community Treatment.

This is about taking care of people where they are in the community. Again, they are not necessarily coming to a facility. They are being served at their house, at a coffee shop, sometimes we take them for a ride in their car, or in our car. And we have found already some amazing results from that.

Our local health-care organizations are talking about how that has reduced ER visits already. We are a huge proponent of peer supports, and we have been using those also with our PACT, and with our other treatment services.

And one of the things probably most important to our county right now is crisis services. We have had a plethora of crime over the last 6 weeks, devastating crime, like I said earlier in my testimony, methamphetamine-fueled. And for us to be able to get to a crisis before it comes to the level that there might be loss of life, is so important for us.

So those are some of the things that we are most excited about bringing forward.

Senator STABENOW. Thank you so much. I appreciate it.

And, Dr. Woodard, I know that you were the lead for the State of Nevada in putting together the CCBHC planning grants, and one of the 10 States that are receiving the full funding now, reimbursement and prospective payment for staffing and so on.

So I wonder if you could talk a little bit about what this program has meant for communities in the State and what services you are providing that you were not able to provide before you had the stability of this funding?

Dr. WOODARD. Thank you for the question, Senator Stabenow. CCBHCs actually have accelerated a lot of momentum related to implementing evidence-based practices, as well as ensuring that communities have a full continuum of care that is available to them.

So one of the basic premises around CCBHCs is being able to provide services in the community, moving outside of the four walls, and ensuring that individuals, whether it be children, adolescents, or adults and families, have access to the care that they need in the most timely way.

Crisis services have expanded the opportunity for individuals who need immediate services to be able to receive those services, whether it is within the clinic or out in the community. Partnerships with law enforcement have also encouraged more individuals to be interfaced with crisis services versus going to the emergency room or to jails.

The access to services, especially during COVID, has been incredibly important. We have been able to see continued care that has been throughout COVID. We actually did not see a big decrease in access to care through our CCBHCs. So the comprehensive array of services that is available, was, and continues to be available dur-

ing COVID, was really critical in ensuring that individuals had timely access to services.

Through some of the evidence-based practices—I heard PACT be mentioned before—making sure that assertive community treatment is available in our communities has also been very important. It is really critical to ensure that people have the opportunity to remain in their communities, and are supported with wrap-around services in order to continue to remain stable.

We also have focused a lot on transitions of care. So as individuals are moving from inpatient psychiatry back into the community, or as they are moving at the continuum of care, the CCBHCs are able to support that individual wherever they move throughout the system so that they have a home, a behavioral health home, which will allow them to continue to repeat those services over the long term.

It is really the continuity of care and the continuum of care that CCBHCs have provided that have had, I think, some of the greatest results in the communities where CCBHCs are. We also know that our CCBHCs were not previously community mental health clinics. The vast majority, actually eight of the nine, had started out as substance abuse and disorder treatment providers. These providers had a lot of work to do in order for them to be able to meet the demands and the rigors of the CCBHC model, and in partnering with the States they are able to achieve what I think are some pretty phenomenal achievements in being able to build the expansion of services necessary to meet the CCBHC certification criteria.

We have one FQHC, and that dually certified FQHC is also working through what it means to have the dual certification for the FQHC and the CCBHC. But we have leaned in very hard into the CCBHC model, investing mental health block grant dollars to expand the CCBHC even outside of the expansion grants, because we have seen that the value these Certified Community Behavioral Health Clinics bring to our communities is worth the investment.

Senator STABENOW. Well, thank you so much.

I am going to turn now to Senator Hassan, and thanks, Senator Daines. For the audience, we are in the middle of votes, so we are running back and forth to vote and coming back. Senator Daines voted and is now back, but I know Senator Hassan is going to go vote in a moment. So I am going to turn it over to Senator Hassan, who is certainly a passionate advocate and certainly understands all of these issues, and we are so glad to have your voice in the U.S. Senate.

Senator HASSAN. Thank you so much, Senator Stabenow. And thank you to the ranking member for his courtesy in letting me go first.

I have a question for Dr. Woodard. Even before the COVID–19 pandemic, our health-care system was grappling with an unprecedented workforce shortage. Today, as more and more Americans are struggling to access mental health and substance use disorder treatment services, it is critical that Congress ensures robust support for the behavioral health workforce.

That is why I reintroduced bipartisan legislation with Senator Collins that creates 1,000 new medical residency positions focused

on addiction medicine at teaching hospitals in New Hampshire, Maine, and all across the country.

Dr. Woodard, can you please speak to the existing mental and behavioral health-care workforce shortage that we are facing? And what steps should Congress take to provide support for these providers in the coming years?

Dr. WOODARD. Thank you for the question. Nevada actually has a very significant workforce shortage in the majority of our State, about 14 counties that experienced severe workforce shortages.

One hundred percent of Nevadans actually live in a workforce shortage area. So workforce shortages are something that we have prioritized as a State for quite some time. And what we have seen is, when we have been able to track the pipeline for behavioral health providers, it includes reaching down to the K–12 programs and beginning to build opportunities for specialization and introduction into careers in the behavioral health-care system, as well as in the broader health-care system.

Being able to track individuals and how students really engage in education around health care and behavioral health care is one of the greatest strategies that we can use—so, ensuring that we have some opportunity to build capacity within our K–12 system and to begin to introduce careers and then, once individuals are engaged in education, making sure that the cost of education is not so great that it keeps people who are very capable and motivated in being part of the workforce from actually engaging in education.

So we want to encourage individuals to go into careers, especially in the behavioral health field, without fear of being saddled with overwhelming student debt when they get out. Certainly loan repayment programs—and from a Federal level, loan repayment programs are very helpful in encouraging individuals to move into these critical health-care fields, knowing that the risk for financial burden in the future can be limited.

Also the opportunity is there to build residencies and internships within States so that people who are moving through the professional training path can remain in the communities that they wish to live and serve in so that they do not have to travel to other communities in other States to receive the enriched experience, education, and training necessary to move into the professional field.

And it is also looking to stratify the behavioral health workforce. You know, one of the greatest workforce multipliers that we have seen in Nevada is the introduction of the Peer Recovery Support Services. Community health-care workers and Peer Recovery Supports really help to build upon a foundation of a strong behavioral health care delivery system and really do serve as a workforce multiplier.

So an opportunity to continue to build those professions as well, can certainly help to offset some of the workforce shortages that we see in the behavioral health-care field.

Senator HASSAN. Thank you very much.

I have one more question to Director Armstrong. The dramatic expansion of telehealth during the pandemic has increased access to mental health services for many Americans. But rural residents, low-income individuals, and communities of color have faced

unique hurdles accessing the technology needed to get mental health telehealth services.

Moving forward, Congress has to work to address the remaining inequities that limit access to mental health telehealth services for underserved communities.

Director, how can Congress work to expand access to mental health services through telehealth for rural areas, low-income individuals, and communities of color?

Mr. ARMSTRONG. Thank you for that question. I think there are a number of things that we can do.

First of all, we do need to expand broadband access in our rural communities. We here in North Carolina have a number of people in our most rural communities who do not have adequate broadband access. So that is one of the things that we have to address.

But one of the other things that I think we have to look at is, while access to telehealth has been a huge advantage during the COVID–19 pandemic because it has allowed us to continue to provide services to people who otherwise would not have been able to have access, the other thing that I think we have the ability to do and that we could use support and funding for is that we have done, over the years, a decent job of integrating behavioral health into primary care, and primary care into behavioral health. With the expansion of telehealth, it also gives us an ability to expand into communities where people live, work, and play. In addressing the social determinants of health, that is our primary goal.

And by that, I give an example of looking at, particularly in some of these rural communities where people may not have access at home, why can we not incorporate telehealth and behavioral health into the faith-based community, into the YMCAs, into the community centers?

So one of the things I think Congress can look at is, how do we provide more resources to expand and partner differently than we have in the past? This also helps us to address some of the issues around access to care for communities of color. In many of the communities that have socioeconomic challenges, access to those services is not available in their communities. And if we want to address those access issues, we can do that by expanding telehealth, by relaxing some of the restrictions around utilizing telehealth, and by allowing funding that allows organizations and State systems to partner more easily with communities.

Part of our challenge oftentimes is that the funding that we receive—while we greatly appreciate the Federal funding—is often restricted in how we can use it. Oftentimes we can only use the funding for individuals who are severely mentally ill, or children who have severe emotional disturbances. And what would allow us to utilize those services more easily would be if we were able to use it for more prevention, and be able to use that telehealth service to reach people before they reach that point of crisis.

Senator HASSAN. Thank you. Thank you very much. And thank you, Madam Chair and Ranking Member, for your indulgence. And now I am going to vote.

Senator STABENOW. Yes, please do. And thank you.

Now, Ranking Member Daines.

Senator DAINES. Right. Thank you, Chair Stabenow.

In Montana, meth—and it's Mexican meth—is taking a devastating toll on our communities. It has contributed to an increase in violent crimes across our State. In fact, a few weeks ago when I was on our southern border, I heard directly from Border Patrol agents of the need to secure the southern border to stop the flow of illegal drugs into our country, and in this case into Montana, as well as directly into our State.

In fact, I spoke with the Cascade County sheriff recently who told me they have Mexican cartel members who have been incarcerated in the county jail there in Great Falls.

Ms. Kosovich, could you speak a bit about how Rimrock is working to support those in need of behavioral health services? And importantly, what might Congress or the Biden administration do to help combat meth use and crime?

Ms. KOSOVICH. It is—thank you for the question, Senator Daines. It is one of the most concerning things that we see here. And like I said earlier, the amount of crime that we're seeing resultant of meth use is seriously out of control.

I had the honor to work with Kurt Alme, who was our former U.S. Attorney General for Montana for the last 3 years, and we talked very deeply about where this meth is coming from. And he said unequivocally we know there are five different Mexican cartels that are using I–90 all the way up to Montana. They have foregone the use of the middle man. They are selling directly.

So there are a couple of things that I think would really help. One, it is a supply and demand issue. Let's take away the demand through treatment. Let's make sure that we get to those folks who have been suffering with meth addiction and get them on the road to recovery.

One of the challenges we know with meth is, it really does change some brain chemistry. And it takes a while for a person to have the clarity to even engage deeply in treatment when they have been on meth.

One of the things that I would like to see is funding for longer-term treatment for meth itself, meth addiction itself, so we have that opportunity of time to get the brain to start healing and reduce some of the cravings and those things that make them want to continue to go out and seek and feed their addiction.

So I think that that is one thing. If we have the funding for longer-term meth use, let's also just cut off the supply and get people treated so we do not have these cartels on this highway-to-high coming up I–90.

Senator DAINES. Thanks, Ms. Kosovich. In Montana and across the country, we do not have a job shortage; we have a labor shortage. Businesses across Montana, as I drive around the State, I see their struggles to find workers. In fact, when you drive across our State, you see a lot of "Now Hiring" or "Help Wanted" signs. Some Montana businesses in fact are being forced to close because they cannot find enough workers.

Ms. Kosovich, in your experience, is there a correlation between employment, working, and mental health?

Ms. KOSOVICH. There absolutely is. I mean, we look at it as one of the social determinants of health. Your overall well-being—there is data that shows it will be better if you are employed.

A couple of weeks ago we actually partnered—the Billings Chamber of Commerce partnered with the U.S. Chamber of Commerce and gave a seminar to employers across Montana talking about drug use in the work environment. How do you recognize it? What do you do about it? Because, like you said, we need everybody who wants to work and is available to work to work so we can start addressing this shortage.

I felt it was very helpful. There were some great questions. I think that there are some strategies that are going to be coming out of both the Montana Chamber of Commerce and the U.S. Chamber of Commerce to directly address this issue, to make sure that we have everybody out there who wants to work working.

It absolutely is a direct correlate of the social determinant of care.

Senator DAINES. So experts said, as you did in your testimony, that we have not even reached the peak need for behavioral health services as a result of the COVID–19 pandemic. In fact, local leaders in Montana say we will not see the peak negative health effect until probably 18 to 24 months after this public health emergency.

As discussed earlier, we are already facing workforce shortages across Montana, including in the mental health and behavioral health space.

Ms. Kosovich, how do we ensure that we are better equipped to serve those in need when we have not even seen the full effects of the pandemic on mental health? I will also ask Ms. Newman to respond to that question.

Ms. KOSOVICH. It is a horrifying question to answer. We are competing, with mental health worker wages, with every industry there is. We have been historically paid poorly, or low, and it is mainly because of the reimbursement levels. I believe the CCBHC model really will give us a leg up to be able to be competitive to attract that talent and the skill set that we need to sustain a hardy behavioral health service.

I think there is hope on the horizon because of the CCBHC and the enhanced reimbursement.

Senator DAINES. Thank you.

Ms. Newman, do you have a thought on that question? Then I've got to yield back my time; I'm over.

Ms. NEWMAN. Yes, I do have a thought on that question. My work on the Anti-Stigma team is to address the negative connotation that is associated with mental health in general. And sometimes when we speak to audiences, they do not always understand what it is like living with a mental health condition, and that you do not have to be fearful.

We speak to nursing students. We speak to psychiatric students. We go into colleges. And we have a chance for them to meet us on this side of graduation. And many times when they have had a chance to interact with us and see that we are not cutters and slashers, and that we will not con them, people are more inclined to want to go into mental health as a profession because the stigma has been taken away, that negative connotation has been taken away. I think that is one of the areas that we definitely need to do more work in: the way we speak about mental health, the way we speak about people who receive mental health treatment. We

are not junkies. We are not frequent fliers. We are not bipolar. We are people who have conditions that are treated successfully and live very successful lives, and we need to highlight that more so that people know that this is an honorable profession and it is one that you may want to pursue.

Senator DAINES. Thank you, Ms. Newman.

Ms. NEWMAN. Thank you for the question.

Senator STABENOW. Thank you very much, Senator Daines.

I believe Senator Cortez Masto is back with us.

Senator CORTEZ MASTO. I am; thank you to the chairwoman. I apologize. I have two committee hearings going at the same time.

But let me start with Dr. Woodard. One of the most concerning patterns that we have seen emerge from the pandemic is the relative spike in behavioral health cases that present in our emergency rooms. That worries me, and I think it worries many of us, because it could suggest that we are seeing more severe cases. But I am also concerned that the ER may not be the best place for many of these cases.

So, Dr. Woodard, can you talk about the importance of providing the right care in the right setting?

Dr. WOODARD. Thank you for the question. We have seen that, on any given day, pre-COVID, we had 90 individuals waiting in our emergency rooms for inpatient hospitalization.

In an effort to try to resolve this, we have looked to see what in our community is missing. Is there an opportunity for us to do a better job of aiding individuals where they are at, with the issues that they are bringing forward? And what we have realized is that we have some pretty critically significant gaps in our communities to be able to address some of those most immediate needs.

As I had mentioned in some of my testimony before, we really believe that building out the 988 system is critical to helping individuals on the other end of the phone—who can answer that call 24 hours a day, 7 days a week—to be able to address whatever their needs are.

And what we see from some of the data is, approximately 80 to 90 percent of individuals who call the crisis line are able to have their issues resolved, at least resolved to a point where they can get maybe a same-day or a next-day appointment. Without that critical service, an individual may, in a time of desperation, go to the emergency room to present for treatment.

We also recognize that mobile crisis teams are an essential component to getting services to an individual in the community where they are at when they need the service. Our Children's Mobile Crisis Team works with families 24 hours a day, 7 days a week, to be able to go into the home, meet with the family, help to deescalate the crisis. And more often than not, that is a diversion from the emergency room. Parents and families who are struggling with no other options most likely will seek care in an emergency room.

What we also see is that crisis stabilization—so that alternative destination, that alternative front door—is very important so, instead of having people go to the emergency rooms, which are providing critical emergency medical services, we have a place for people to be able to go that is welcoming that can serve them in a way that they need to be served by providing screening and assessment

in behavioral health services. A large peer workforce incorporated into those Crisis Stabilization Centers helps individuals really strategize and problem-solve. And when we have seen this model work, we see that actually relatively few individuals who were touched by these systems end up needing that higher level of care for inpatient psychiatry.

So overall, we believe that it is all solutions. It is 988, it is Mobile Crisis, and it is Crisis Stabilization Services in our community that will make the greatest difference in helping to keep individuals from needing care in the emergency room.

Senator CORTEZ MASTO. Oh, I could not agree more. And that is why I so appreciate Chairwoman Stabenow for having this hearing today, and all the good work that she has done on this issue in addressing mental health in our communities—and Senator Blunt as well.

I am working with Senator Cornyn on a bill that seeks to better integrate behavioral health crisis services, including those provided by the CCBHCs, and health planning, and to really put crisis services on par with physical health care.

So, thank you for your comments, and for the panel members. Thank you so much.

Ms. Newman, thank you for sharing your story. I believe strongly that community leaders like you who have experienced some of life's toughest challenges will be key to helping us meet the country's mental and behavioral health needs moving forward.

Can you talk a little bit about the benefits of peer support when they are provided as part of a patient's care plan?

Ms. NEWMAN. One of the greatest benefits of peer support is when you are in crisis and you are talking to a peer, you do not have to explain. Some things you cannot even put into words. We connect on a level that is really deep.

I will give you an example. A young lady called me a couple of weeks ago and started to share with me why she was suicidal. And she had three children. Two of her sons had been murdered. One of them died in her arms, screaming, "Mama, help me!"

She was going through a divorce, and she saw both of her parents take their last breath. I started crying with her on the phone, but I also told her any one of those things would be enough to put somebody on the brink, but you must be a very special person; you are surviving all of that.

I was able to help her see her situation in a different light. Even though all those things were horrible things that happened, and sad, she still came away from the conversation with hope, because she did not want to die, and I recognized that. She did not want to die. She just wanted the pain to stop and for somebody to be able to say, "I hear. You are hurt. I hear that you need help." And she was in treatment within 4 days of that phone call. I reached out to our CCBHC and got her an intake within days.

So when you talk to a peer, it is like a warm fuzzy blanket. You do not have to explain. You do not have to be ashamed. You do not have to feel like you are less than because you are struggling. Peers do amazing work, amazing work. I love my job. If I did not get paid to do what I do, I would still do it.

Thank you for the question.

Senator CORTEZ MASTO. Oh, thank you. I agree with you. I have learned the benefits of peer support and peer counseling. It just really makes the difference that I have seen. So thank you. Thank you to all the panelists.

Senator STABENOW. Thank you so much, Senator Cortez Masto. I just want to say "amen" to Malkia. Thank you so much. We are so proud of you in Michigan and for all that you do to help people reach out to get the help they need, and the recovery they need. So we are so grateful that you are part of what is happening in Michigan to help people.

At this point, I am going to have to leave to go vote on the floor. There are actually a couple of votes. And so, we are at a point where I am going to turn the gavel—we have a bipartisan hearing going on. I am turning the gavel over and trusting Senator Daines to wrap up the meeting.

He has one other question he wants to ask. I have 50 I could ask, and certainly I will continue to work with all of you because there is so much to do, and we are so grateful, and we are excited about moving forward to the next step to be able to make CCBHCs available to every State, the full funding, treating health care above the neck, funding it the same as health care below the neck. And so we are excited about moving forward with all of you to get that done.

But at this point, I will turn to Senator Daines. And he will wrap up the hearing, and we will follow up with questions for everyone. But we appreciate you. Mental Health Month is this month, and let's all reach out to tell our own stories and then move forward together to make things better.

Thank you.

Senator Daines?

Senator DAINES [presiding]. Senator Stabenow, thanks for your help and your leadership. And I think the American people would like to see more of this. We are literally sharing a gavel. So thank you. I will be down to join the vote here in just a minute. So thank you.

I do have one more question, Ms. Kosovich, that relates to stigma associated with seeking mental health treatment. If your neighbor can recognize your truck or a vehicle outside a treatment facility, you might not be comfortable seeking help.

With Montana in the top five States with the highest suicide rate, sadly, this seriously concerns me. That is why I think it is important that we look for ways to increase access to mental health treatment and really think outside the box when it comes to increasing access, including using mental health telehealth services.

Ms. Kosovich, do you think it is important for individuals to have access to mental health services outside of the traditional brick and mortar doctor's office?

Ms. KOSOVICH. I absolutely do believe so, and thanks for that question. You know, we have been doing telehealth before COVID. COVID forced us to do it better and look at different access points for everything. And I would go as far as saying there are other applications for telehealth too, when we are talking about the crisis continuum and how we are going to serve that.

We have some very promising pilots going on with tablets, with our law enforcement, that they are out in the road and they can actually connect somebody in mental health crisis with the appropriate level of care, either a peer or a counselor, whatever it may be.

So the applications are just so profound. And it should not be contained just to a mere facility. We do have some people who have done a lot better on telehealth during COVID, especially people who have anxiety disorders. We also have a contingency, if they really want to have that face-to-face, but I think finally we have the opportunity to have both.

And one comment on stigma. I remember when I was a little girl and my mom would have a coffee klatch, and I could hear them whispering about the neighbor who had "cancer." They whispered the word "cancer." And I thought it was something so bad, and we know how far we have come over the years in treatment of cancer.

And if we just would stop whispering about "mental health" and "addiction" and people who—I am so proud of this panel talking about their own stories. Maybe stopping that whisper will be the impetus for us to stop the stigma. And that would be my encouragement for everybody who has a story and can tell it; we might get there some day.

Senator DAINES. Well, thank you, Ms. Kosovich. And thanks to the panel today. I share your gratitude, Ms. Kosovich. This has been a great panel, and I appreciate the expertise, the passion, and the compassion that we saw today from our witnesses.

This concludes the subcommittee hearing. We have up to 7 days if changes need to be made to the record. But without any further Senators here seeking to question, this subcommittee is now adjourned.

[Whereupon, at 4:15 p.m., the hearing was concluded.]

# APPENDIX

## ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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PREPARED STATEMENT OF VICTOR ARMSTRONG, MSW, DIRECTOR, DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good afternoon. Thank you, Chair Stabenow, Ranking Member Daines, and the honorable members of the committee, for the opportunity to testify on North Carolina's approach to ensuring equity in community behavioral health services.

My name is Victor Armstrong. I am the Director of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. I am a social worker, a husband, and a father to three black boys. I am a mental health advocate, and I am the son of a preacher, born and raised in rural North Carolina—Plymouth to be specific—though I now reside in Charlotte, NC. I share all of this because I am the sum of all these things. This will no doubt create a perception of who I am, based not only on what I have just shared, but also based on both your lived experience and mine. Much as you today will interact as tradition and formality dictate, in many ways our mental health and substance use system has worked the same way. Unfortunately, it is a system that has not been practiced nor been funded through a lens of equity.

The lens of equity is about the intersectionality of race, culture, and ethnicity, in addition to living with mental health and substance use challenges. It is about being black and living with a serious mental illness. It is about being Latino and living with intellectual disabilities or traumatic brain injury. It is about being American Indian and living with a substance use disorder. It is about being an Asian or trans person struggling with an anxiety disorder exacerbated by the discrimination that often accompanies mental illness, the bigotry that is perpetrated toward trans Americans, and the increasing rates of violence against Asian Americans.

We cannot ignore how a person of color enters the behavioral health system. People of color often do not have access to outpatient services within their communities. This makes it more likely that they are introduced to the behavioral health system when they are in a state of "crisis" and more likely to enter the system via the back of a police car or an acute care emergency department, neither of which is conducive to good clinical outcomes, and neither of which is likely to foster a positive relationship with the mental health system.

Systemic racism and bias, both explicit and implicit, are multilayered and seep into every crevice of society. This includes our mental health and substance use care, but we can change that if you are willing to help to reform our system. When we know that inequities exist, it is our moral responsibility to address those inequities by leaning into equity. Every decision that we make as clinicians, policymakers, or simply as agents of change, either leans into creating a more equitable system or perpetuates our existing problem of inequity.

We can address the issue of access by supporting the creation of more mental health resources in communities of color and underserved ZIP codes. We can create more community-based resources that provide access to upstream treatment.

One way that communities are doing this is through the Certified Community Behavioral Health Clinic, or CCBHC, model. CCBHCs are required to provide comprehensive, timely, and culturally competent services to everyone in their communities. One CCBHC here in North Carolina—Monarch—has embedded a Peer Support Specialist with the EMS team that responds to opioid overdoses. The peer stays

with that person through the trip to the hospital and helps to connect them to community treatment upon release, making sure that the person does not get lost on the road to recovery in the community. We support the CCBHC model and appreciate any funding to increase CCBHCs.

We can support efforts to build a workforce that mirrors the populations served. In North Carolina, we have roughly 4,000 trained Certified Peer Specialists, representing blacks, whites, Latinos, Asians, and American Indians, with only about 1,600 individuals gainfully employed. We need to utilize the peer workforce and pay them a living wage. We need to partner with Historically Black Colleges and Universities (HBCUs) to build a multicultural workforce. We need to partner with clinicians of color and provide them access to government grants and contracts. We need to partner with faith-based organizations, and we need to fund studies that consider the nuances of race, culture, and ethnicity and the impact on mental wellness. Further, we need to better understand the impact of systemic racism and complex trauma experienced by people of color.

In North Carolina, it has taken intentionality to mitigate the effects of the COVID–19 pandemic, particularly the disproportionate impact of the virus on black and brown communities. As the North Carolina Department of Health and Human Services sought to intervene, we recognized that without incorporating trusted voices who represent the individuals that we seek to assist, we will lack credibility, and full engagement will be difficult, if not impossible. Historically marginalized communities—whether marginalized due to race, ethnicity, or diagnosis—are simply looking for a collaborative partner who will value their expertise and life experience. We have the resources to build a more equitable system. If we do not build equity into our mental health and substance use programs and practices, we will ultimately fail the most powerless and vulnerable.

I will leave you with one final thought: mental health and substance use transcends barriers, divides, and differences. People from all walks of life are dying every day from suicide or overdose. Mental health and substance use do not see race, culture, or ethnicity. The same cannot be said of our treatment system. It is time that we fix our system to serve the diverse communities in our Nation. Thank you for your time.

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PREPARED STATEMENT OF HON. STEVE DAINES,
A U.S. SENATOR FROM MONTANA

Thank you, Madam Chairwoman. I'm glad to be with you hosting our first subcommittee hearing of the year. It's also great to have a fellow Montanan join us today. We'll get into a more formal introduction in a bit, but welcome, Lenette. I'm glad you could be here.

May is Mental Health Awareness Month—an issue at the top of my mind and many others following a year of isolation for Montanans and Americans across the country. Last year due to COVID restrictions, Montanans and Americans were forced to stay home—we saw family-owned and small businesses shutter; workers struggle; family members isolated from their loved ones; and schools close, directly impacting our Nation's youngest and brightest.

Through no fault of their own, hardworking Montanans and Americans across the country lost their jobs—leaving them wondering how they were going to keep a roof over their families' heads and food on the table. Instead of socializing and learning with their friends in classrooms, students were stuck behind computer screens. Symptoms of anxiety and depression are on the rise.

In fact, in one survey, more than half of adults reported that worry or stress related to the pandemic was having a negative effect on their mental health. As we all know, mental health issues were a problem before the pandemic. In fact, it's estimated that nearly one in five American adults had some form of mental illness, but fewer than half of those adults received treatment in 2019.

Since the pandemic, lockdowns, economic hardships, and social isolation have only helped intensify what we already knew: we need mental health services in our communities, and we need to make them a priority. The pandemic has also helped expose and magnify the flaws in our mental health system.

In 2020, suicide was the tenth leading cause of death, and drug overdose deaths hit a record high. In Montana, we are unfortunately not immune to these devastating statistics. We are fourth in the Nation for suicides and first in the Nation

per capita for children placed in foster care—most often due to a parent's drug or alcohol use. And we are witnessing a disturbing increase in meth-related violent crime.

It is clear that more needs to be done to support individuals and families struggling with addiction or mental illness. We are fortunate in Montana to be home to treatment facilities like Rimrock, which I've had the privilege of visiting several times over the years. I even had the opportunity to bring Vice President Pence to show him firsthand the great work the organization does for Montanans struggling with addiction and mental health issues.

One visit I will never forget, I had the chance to meet with a few moms who were receiving substance use treatment. I had just become a grandfather. I was overwhelmed with emotion. There I saw devotion, struggle, commitment, and so much love that the Montana moms had for their children.

Because at Rimrock, thanks to a bill I led in the Senate, which was signed into law by President Trump, moms who are working to get back on their feet are able to stay with their children. Let me tell you, this means the world to these moms. Treatment centers like Rimrock make a world of difference in our communities, and they are more important now than ever as we come out of this pandemic.

After a year of lockdowns and closures, we are finally seeing a light at the end of the tunnel. Thanks to the leadership of our new Governor, Greg Gianforte, life in Montana is on its way to being back to normal. We've vaccinated over 350,000 Montanans and have led the Nation in vaccine administration.

Montana is now open for business. We are open for school. We are incentivizing getting back to work versus staying home—something I believe is also important for mental health, because I believe there is dignity in working. But the reality is that there will likely be long-lasting impacts of the pandemic, particularly on mental health. We must aim to meet the challenges of today and prepare for the increased need that this pandemic has created.

I am committed to working with my colleague Senator Stabenow toward that goal.

Again, I appreciate our witnesses being here today and offering their advice and expertise on such an important topic.

Thank you, Madam Chairwoman.

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PREPARED STATEMENT OF LENETTE KOSOVICH, R.N., MHA,
CHIEF EXECUTIVE OFFICER, RIMROCK FOUNDATION

Senator Stabenow, Senator Daines, and members of the committee, thank you for inviting me to talk about one of the most complex and far-reaching issues facing Montana and our Nation. My name is Lenette Kosovich. I'm the CEO of Rimrock Foundation, the largest behavioral health care facility in Montana. We provide a full continuum of services, including peer support, medical detoxification, inpatient, residential, and outpatient treatment. We have extended treatment—12 months or longer, for mothers with their children, *and* those recently released from incarceration. We serve seven treatment courts, including Family Drug Court, Veteran Court, and Indian Child Welfare Act Family Recovery Court. All in all, we see nearly 2,000 clients a year.

There is no doubt that COVID has exacerbated an already complex problem. Before COVID:

- Substance use disorders and mental illness were already the top *health* needs in our county.
- We had a methamphetamine-fueled increase in violent crime, and a burgeoning child welfare system where *four out of every five* cases involved drugs or alcohol.
- Over the last 5 or 6 years, our clients are considerably more compromised than a decade ago. Along with serious illicit substance use disorders, patients most likely have mental health issues accompanied by 1 or 2 comorbidities, like hypertension or diabetes.
    - It has become the norm to have 25-year-old patients in our care who have already received a heart valve replacement due to endocarditis resulting from IV drug use.

Enter COVID.

(1) Alcohol consumption, drug use, and mental illness are **up.**
- Our referrals are up **forty percent**.
- Calls to our State suicide hotline have **doubled**.
- Violent crime in our county has increased nearly **70 percent** in the past 12 months. One thing is certain: drugs played a role.

(2) While increasing the need, COVID complicated and delayed service delivery.
- Quarantine and social distance needs reduced the space we have to provide treatment by about one third. Many of our industry partners suspended services, so waitlists increased.
- With physical space at a premium, COVID accelerated adoption of telehealth tenfold. With that acceleration came incredible pressure. iPad needed for all—except you couldn't get iPad. Group therapy via telehealth, except Johnny's Internet doesn't work. Family week via Zoom—great, except Suzy's mom doesn't have a computer. Training, new admit policies, new safety protocols. . . . **Every** part of our industry was stretched to the max.
- But the worst challenge of COVID for me was workforce. Before COVID, the workforce shortage was severe. Wait times for COVID results and positives made the problem much worse. When I don't sleep at night, it is often because I am worried about the number of my employees pulling double shifts, on the brink of mental breakdown themselves.

History teaches us that the mental health impact of a catastrophic event, such as the pandemic, will far outlast the physical impact. So I am buckled in for a bumpy road.

Fortunately, there is hope on the horizon with the expansion of the Certified Community Behavioral Health Clinic model or CCBHC. Rimrock in Billings, and two other organizations in Montana, were recently granted a CCBHC expansion pilot.

In active CCBHC sites, this innovative model of care has dramatically increased access to mental health and substance use disorder treatment and been proven to address the pain points I just shared. I look forward to achieving outcomes like those highlighted in the recent impact study by The National Council for Mental Wellbeing. We **must**:

- Increase the number of clients served—according to The National Council, CCBHCs increased clients served by 17 percent.
- Decrease wait times for care—remarkably 84 percent of clients in a CCBHC are seen within 1 week.
- Invest in the workforce—there is an enhanced reimbursement with CCBHC which allows clinics to increase hiring.
- Make crisis services and supports available to all—CCBHCs deliver crisis support services in the community, not just in facilities. Innovative collaboration with criminal justice and community services help to divert people in crisis from emergency rooms and jails and get them to the appropriate level of care.
- Address health disparities—CCBHCs increase screening for unmet social needs that affect health, like housing or transportation. We improve care coordination and partnerships to address those needs.

Thanks to Federal and State investment, today 340 CCBHCs are operating in 40 States, Washington, DC, and Guam.

Senator Stabenow, Senator Daines, and the committee, there is not **one** of your constituents whose life has not been impacted by substance use disorder or mental illness. There is not **one** of your economies that has not suffered. We **can** do better, and the CCBHC model **does** do better. I unequivocally urge your continued support of the CCBHC model of care.

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## QUESTIONS SUBMITTED FOR THE RECORD TO LENETTE KOSOVICH, R.N., MHA

### QUESTION SUBMITTED BY HON. DEBBIE STABENOW

*Question.* What strategies have you used, or seen succeed around the country, to provide high-quality comprehensive services in rural communities? What is the role of mobile units?

Answer. Immediate access is necessary. Bringing the care to people with a mobile unit eliminates traditional access barriers. It helps increase compliance and carries with it a strong message that there are people who can help.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

*Question.* In your testimony, you describe how workforce shortages challenge your ability to care for your patients. My legislation with Senator Portman, CARA 3.0, would provide funding for training and employment for substance abuse professionals, including peer recovery specialists, and for dedicated retention efforts through SAMHSA and HRSA.

How would additional funding for workforce training and employment address the challenges you've identified?

Are there other workforce challenges beyond funding that we should address?

Answer. This is a complicated question to answer. Montana, as well as other States, is facing other challenges that are outside training and employment. We have a shortage of affordable housing and many people are willing to be employed but can't afford a place to live. Also, they may simply lack reliable transportation to get to their work or not have childcare.

*Question.* Your CCBHC offers same-day services, as does Newport Mental Health in Rhode Island.

How does your ability to offer same-day services help you better serve patients experiencing mental and behavioral health crises?

Answer. Access is everything. And immediate access is crucial in a behavioral health crisis. A true behavioral crisis may gradually subside with the passing of time (or conversely, end tragically). But the root cause of the crisis may not diminish and the likelihood of a reoccurrence of the crisis or one of a more elevated nature is great. The urgency of access in a timely manner is key to getting people on their way to wellness.

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PREPARED STATEMENT OF MALKIA NEWMAN, TEAM SUPERVISOR, CNS HEALTHCARE ANTI-STIGMA PROGRAM

"I was born by the river, in a little tent. Then I go to my brother, I say, brother, help me please. It's been too hard living, but I'm afraid to die. It's been a long, a long time coming, but I know, a change is gonna come, oh yes it will."

Good afternoon, members of the U.S. Senate, staff, and guests. I am very honored to be asked to give testimony to this distinguished body today. I want to especially thank Health Chairwoman Debbie Stabenow and Ranking Member Steve Daines for convening this vitally important discussion.

My name is Malkia Newman, and I am living proof that the services and supports that are available through our community mental health system work. I am not naive to the fact that there are many areas that need to be improved. But I know that that my life would not be the amazing life that I'm living now had I not received treatment for bipolar disorder almost 20 years ago.

I am a survivor of childhood sexual trauma, as well as a survivor of intergenerational trauma, a sad legacy of slavery and discrimination. I wrestled with suicidal thoughts, had difficulties maintaining relationships or employment. My daughter Tracie, who I call my miracle, was my reason for living when all hope was gone.

Mental health conditions are very prevalent in my family. The treatments and hospitalizations that my brother Ronnie endured, who had schizophrenia, terrified me, which made it harder for me to ask for help until there was no other option available.

Fast forward 20 years. I have 15 years of continuous employment with CNS Healthcare's Anti-Stigma Program, I've been a homeowner for 9 years, and on June 5th my husband Dubrae and I will celebrate our 15th wedding anniversary. I have reconciled with my family, and I serve as an ordained minister at my church, New Birth International of Pontiac, MI. My list of community service awards and recognitions is long. I have provided a copy of my resume to the subcommittee.

I am living proof, I am an advocate, and I am proud to speak on behalf of those who have not yet found their voice. It is vitally important that we not just continue to offer behavioral treatment, but that we prepare for the increased need that the pandemic has created. We need more qualified providers, doctors, nurses, therapists, and other support personnel, especially Peer Support Specialists, persons with lived experience and expertise in the mental health field who can encourage and educate

people receiving services in a richer way than other professionals can. We need to compensate our professionals at every level, to make sure that we have qualified, culturally, and linguistically competent people meeting the needs of people, no matter what their background.

The Certified Community Behavioral Health Clinics, CCBHCs, have made it easier for people to access services regardless of if they have insurance or not, which in the past created a huge barrier to people needing help.

Integration of physical and mental health has been a topic of discussion for many years. Integration is needed to help people with mental health disorders live longer, healthier lives, but the focus has shifted from people getting whole health treatment from head to toe to an argument about who will administer the dollars associated with the treatment. I believe that people served, and their loved ones, should have a role in shaping what health care should be, as people with intimate knowledge of what works and what doesn't. Advisory groups can and should be involved at every level of program development, implementation, and evaluation. The finished product would be more efficient and cost-effective as well.

It is my prayer and hope that we will not rush to get back to "normal" at the expense of programs and systems that work.

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## QUESTIONS SUBMITTED FOR THE RECORD TO MALKIA NEWMAN

### QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

*Question.* CNS Healthcare, where you serve as team supervisor of the Anti-Stigma Program, has received a CCBHC expansion grant. What has that meant for your work?

Answer. It has made it much easier to refer the people that I meet in the community that are looking for help to CNS no matter where they live or their ability to pay. They don't always have the insurance necessary or sometimes they don't have any insurance at all. The safety net that CCBHC provides takes the guesswork out of the equation. It has made so many more families happier and healthier in every way.

*Question.* I think the work you and your team do as Peer Support Specialists is incredibly important and effective. We talk a lot about strategies to address stigma and break down the barriers to seeking treatment, but I think what sometimes is underappreciated is the fact that people like you are out in communities doing that right now.

What strategies do you use to help people get the treatment they need? What types of services and connections do you provide to help people recover?

Answer. I have a great working relationship with our intake staff, they are good at following up on all the people I refer to the agency. They did such a great job with me when I came in as a person in desperate need of help, that I have peace of mind when I send someone else in to get the lifesaving treatment that I was able to get way back in 2004!

When people see us in the community, whether it's in a virtual format or in person, they can see what a difference treatment has made in our lives. We're open and honest about our experiences, that it doesn't matter how far they have gone, there are places where people can go and get the treatment and support necessary to help turn their lives around.

We also make our presentations as entertaining as possible so that people can hear our message. We want people to see that we're not weird or unnatural, we have the same challenges, we've found a healthy way to move past the stigma that has held us captive in the past. Truth really does free you from misconceptions and stereotypes that limit the kind of life you can have, no matter your age, race, culture, religion. We love to bust stigmas with truth.

My role is more that of providing education, and hope. There aren't many situations that we can't identify with, and in doing so let people know, you still have an opportunity to live a life worth living by taking advantage of the services and supports that our CCBHC provides. The ability to access services without going through the uncertainty of who's going to pick up the tab so to speak, and letting the system do what it was designed to do. Help those with insurance and the ability to pay and having to extra funds available to help those who aren't as fortunate.

I am living proof that there is a life worth living after receiving a mental health diagnosis!

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QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

*Question.* In your testimony, you describe how workforce shortages challenge your ability to care for your patients. My legislation with Senator Portman, CARA 3.0, would provide funding for training and employment for substance abuse professionals, including peer recovery specialists, and for dedicated retention efforts through SAMHSA and HRSA.

How would additional funding for workforce training and employment address the challenges you've identified?

Answer. Ability to fully implement team-based care approach (holistic approach to care with teams comprised of Case Managers, Therapists, Peer Recovery Coaches, Peer Support Specialists, and Nurse Practitioners).

Ability to offer competitive salaries for limited licensed and fully licensed staff.

Ability to offer a good salary/wage for peers reflective of the importance and value of hiring persons with lived experiences and the significant positive contributions they make for those served and the team overall. Would also allow for ability to hire more peers to enhance offerings.

Ability for more staff to be trained, receive support/monitoring/supervision towards substance use disorder credentialing (*i.e.,* development plans) and more supervision time overall to increase the number of staff obtaining substance use disorder credentialing.

*Question.* Are there other workforce challenges beyond funding that we should address?

Answer. We need credentialing across health plans to be consistent. Current limitations limit mental health professionals from providing services they are trained to provide (*i.e.,* significant limitations for Licensed Professional Counselor and Limited License Psychologist).

Need for CCBHCs to have consistent policies/practices regardless of what county individuals are seeking care from. Additionally, established clinical care pathways with recommended guidelines are needed similar to FQHCs to ensure continuity of care and remove barriers.

*Question.* Your CCBHC offers same-day services, as does Newport Mental Health in Rhode Island.

How does your ability to offer same-day services help you better serve patients experiencing mental and behavioral health crises?

Answer. It increases our ability to engage individuals immediately with no delays and to provide an expedited response when persons are seeking help. Same-day services also reduce occurrences of emergency department visits for mental health/behavioral health circumstances and provides services through less restrictive, community-based means.

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PREPARED STATEMENT OF HON. DEBBIE STABENOW,
A U.S. SENATOR FROM MICHIGAN

I call this hearing of the Finance Subcommittee on Health Care to order.

I'm so pleased to be here, during Mental Health Month, talking about the urgent need to improve behavioral health-care services in our communities.

Ranking Member Daines, it is great to have you as my new partner on this subcommittee, and I know we can do a lot of great work on this issue, and many others.

Mental Health Month is when we raise awareness, take on stigma, celebrate triumphs, and make sure no one feels alone. Everyone affected by mental illness or substance use disorders should be able to get the help they need so they can live a healthy and fulfilling life—period. We can make this a reality!

This issue is personal to so many of us. It affected my own father.

Before the pandemic, nearly one in five Americans had some form of mental illness, yet fewer than half received treatment. This lack of support is even worse in our communities of color.

Our overworked and underfunded health-care system was already leaving millions of Americans without the treatment they need. The pandemic has made things worse and exposed the weaknesses in the way we pay for behavioral health care in this country.

In January, 41 percent of American adults reported that they were struggling with anxiety and depression. That's up from 11 percent before the pandemic. And more than one in four young people have reported having suicidal thoughts. Meanwhile, overdose deaths have surged during the pandemic.

The CDC reported that more than 87,000 Americans died of drug overdoses during the 12-month period that ended in September—the most deaths in any year since the opioid epidemic began in the 1990s. And long after the pandemic ebbs, these behavioral health issues will linger. We need to finally treat health care above the neck the way we treat health care below the neck. The need has never been more urgent.

The good news is that we are making progress. I've worked with my friend Senator Roy Blunt and many of you to create and expand the Certified Community Behavioral Health Clinics program.

Now fully operational in 10 States with startup grants bringing the program to 41 States, we have a structure that allows clinics to truly meet the needs of their communities. This has been a tremendous success, and is the model for the future.

These clinics are required to provide comprehensive services including 24/7/365 Mobile Crisis Team services; immediate screening and risk assessment; easy access to care—they see everyone who walks in the door; tailored care for active-duty military and veterans; care coordination with primary care providers; and coordination with law enforcement.

The results are stunning. According to HHS numbers included in the budget request last year, people who received services at CCBHCs had 63.2 percent fewer emergency department visits for behavioral health issues, spent 60.3 percent less time in jails, and saw a 40.7-percent decrease in homelessness

And today, the National Council for Mental Wellbeing (previously the National Council for Behavioral Health) released a new CCBHC impact report with similarly stunning results:

- More than half of CCBHCs offer same-day services, and nearly all of them offer treatment within a week. Compare that to the average wait time of 48 days nationwide—and they are serving thousands of new clients.
- CCBHC funding created an average of 41 new jobs per clinic.
- Ninety-five percent of CCBHCs have engaged in promising new practices in collaboration with law enforcement or criminal justice agencies.

This month, Senator Blunt and I—hopefully joined by all of you on this subcommittee—will be introducing legislation giving every State in the country the option of participating in the full program. It will ensure that behavioral health care clinics are paid in the same way we pay Federally Qualified Health Centers (FQHCs).

We can get this done and bring quality community-based care to millions of Americans who need it.

Thank you to our fantastic witnesses for being here today. I look forward to hearing from you and know we will have a great bipartisan discussion.

So many of my colleagues are focused on this issue, and whether it is CCBHCs, telehealth, crisis supports, coordination with law enforcement, schools, and many other issues, I look forward to working with you.

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PREPARED STATEMENT OF STEPHANIE WOODARD, PSY.D., SENIOR ADVISOR, DIVISION OF PUBLIC AND BEHAVIORAL HEALTH, NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator Stabenow, Ranking Member Daines, and members of the committee, my name is Stephanie Woodard. I am a licensed psychologist and serve as the Nevada

Department of Health and Human Services' Senior Advisor on Behavioral Health. I also serve on the board for the National Association of State Mental Health Program Directors and the Nevada Board of Psychological Examiners.

I am humbled and honored to have the opportunity to testify before you today to discuss how the COVID–19 pandemic has highlighted the critical role of crisis services and Certified Community Behavioral Health Clinics and our opportunities to build strong, resilient communities throughout the recovery.

Inadequate access to critical behavioral health infrastructure has long contributed to Nevada's struggles to address the behavioral health needs of the population. Nevada's vast geography combined with workforce shortages, insufficient access to critical health and behavioral health resources, and high rates of uninsured and underinsured have been amplified during the pandemic and contributed to the disproportionate impacts of COVID–19 across communities in our state.

When compared to previous years, in 2020 Nevadans experienced higher rates of depression and anxiety. Emergency room admissions for overdose, suicide attempt, and suicide ideation all increased over the course of last year resulting in the highest number of admissions in the past decade. While overall deaths by suicide decreased, the suicide rate rose 25 percent in youth and young adults age 8 to 24. Additionally, opioid-related overdose deaths increased 44 percent with synthetic opioid overdose deaths accounting for more than 50 percent of the overdose fatalities in Nevada. These data underscore the urgent need to address substance use, mental illness, and suicide, they help us to understand the magnitude of suffering occurring in our neighbors, co-workers, children, friends, and family members, and they provide an imperative to act.

Informed by the body of knowledge on disaster behavioral health, Nevada's COVID–19 Disaster Behavioral Health Response and Recovery Plan, established in May of 2020, used a population health model focused on promotion, prevention, early intervention, continuity of behavioral health care, and access to recovery supports. Our Certified Community Behavioral Health Clinics, suicide prevention crisis hotline, mobile crisis teams, and crisis stabilization centers provided the necessary foundation for Nevada's plan.

### NEVADA'S COMPREHENSIVE CRISIS CONTINUUM OF CARE

National guidelines developed by the NASMHPD, SAMHSA, and the National Council were valuable tools as we developed a coordinated crisis continuum of care. Essentially, a coordinated system of crisis care ensures that when individuals are in crisis, they have someone to talk to, someone to respond, somewhere to go and the services and supports are based on best practices. These guidelines have been the road map for the crisis system in Nevada statewide, and regionally, over the past 3 years.

Nevada completed assets and gaps mapping in July 2020 and found significant gaps in the capabilities across continuum of care, however, knowing the gaps in the system has led to strategic use of Federal funding through CMS and SAMHSA to respond to community needs for crisis services.

### CRISIS CALL HUBS/CARE TRAFFIC CONTROL

Crisis Support Services of Nevada is part of the National Suicide Prevention Hotline, meaning no call goes unanswered. Through grant funds we have been able to increase staffing on the crisis line to increase in-state answer volume, decrease wait times for callers, and begin to ready the system for 988 in July of 2022. Nevada has pending legislation to establish a fee and a fund to support the implementation of 988 by July 2022.

### MOBILE CRISIS SERVICES

Ultimately, overutilization of emergency services within EMS and law enforcement has resulted in costly use of critical public safety resources with lengthy wait-times and a mismatch of intervention to support the individual. COVID–19 grant funding has been used to divert children and families away from emergency rooms through the expansion of children's mobile crisis teams. We plan to further this work with the new supplemental funding through the American Rescue Plan Supplemental Block Grant funding and the enhanced FMAP through Medicaid to sustain more mobile crisis teams across the State.

CRISIS STABILIZATION CENTERS

Prior to COVID–19, on any given day an average of 90 people would be waiting in an emergency room for an inpatient psychiatric bed, the vast majority of whom were underinsured or uninsured. We expanded funding for uncompensated care to 24/7 crisis stabilization centers through Federal grant funding in order to provide an alternative destination for individuals in crisis and diverted from emergency rooms.

Statewide expansion of mobile crisis teams and crisis stabilization centers is planned with new supplemental funding through the American Rescue Plan Supplemental Block Grant and enhanced FMAP for sustainability for mobile crisis. A new Medicaid rate for crisis stabilization centers is expected to result in cost saving to Nevada over the long term. The recent infusion of Federal funding is necessary in the development of essential infrastructure; however, it is insufficient for long-term sustainability. To bring the entire crisis continuum to scale, Nevada, along with other States, will need guidance from CMS to ensure these services are sustainable into the future. For States to be successful in rising to the challenges 988 presents, collaboration between SAMHSA and CMS, as recommended by the Medicaid and CHIP Payment Access Commission (MACPAC), will be essential.

Nevada established Certified Community Behavioral Health Clinics through the SAMHSA CCBHC planning grant in 2016 and the demonstration grant in 2018. Nevada's investment in CCBHCs through the demonstration grant, mental health block grant funding, and the CCBHC expansion grant has resulted in nine CCBHCs under the Medicaid State plan.

Over the course of the demonstration, CCBHCs have increased access to critical safety net behavioral health services including 24/7 crisis services, while lowering costs of care and improving outcomes. CCBHCs' success can also be measured by the relationships the clinics have with the communities they serve. Collaboration with law enforcement for community-based crisis intervention has reduced unnecessary incarceration and emergency room visits. Expansion of services into schools has increased access to care for students with behavioral health needs. Comprehensive case management and peer recovery supports better address social determinants of health and increase engagement in care. Cost-based reimbursement has enhanced their ability to recruit and retain qualified behavioral health professionals in competitive job markets despite workforce shortages across all regions of our State.

In addition, while many behavioral health providers experienced significant challenges in maintaining operations over the past year, Nevada's CCBHCs were able to pivot quickly to expand telehealth services and offer hybrid services to individuals for in-person care. We anticipate continued CCBHC continued success and look forward to onboarding an additional four CCBHCs under the most recent SAMHSA expansion grant.

Nevada expresses our gratitude to Senator Stabenow, Senator Blunt, the National Council, and countless others who have supported the CCBHC model and expanded the demonstration until 2022.

OPPORTUNITIES AND SOLUTIONS

Collaboration between SAMHSA and CMS, as recommended by the Medicaid and CHIP Payment Access Commission (MACPAC), will be essential for States to fully leverage Medicaid to sustain the crisis continuum of care.

Looking ahead, we would encourage SAMHSA to work closely with State mental health program directors as they administer the expansion grants. CCBHC certification requires State time and resources and is essential in ensuring all clinics qualifying as CCBHCs meet the rigorous certification criteria.

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## QUESTIONS SUBMITTED FOR THE RECORD TO STEPHANIE WOODARD, PSY.D.

### QUESTION SUBMITTED BY HON. DEBBIE STABENOW

*Question.* We've seen a huge expansion of telehealth services during the pandemic, particularly in behavioral health care. We hope that COVID cases continue to go down, and in-person care becomes safer, but I think we all agree telehealth is an important option.

As providers in your State scaled up their telehealth services, what have you seen work well? What needs to happen to improve these services going forward?

Answer. Nevada experienced a profound and rapid transition to telehealth services following the declaration of the COVID–19 public health emergency in March of 2020. Several factors facilitated this rapid transition, including allowing our subgrant recipients to amend subawards to allow for the purchase of telehealth equipment, Centers for Medicare and Medicaid allowing for telephonic-only services, and clear communication with providers on policy changes to allow for telehealth services and information on how to properly bill for services. We have heard from providers that the vast majority, if not all, behavioral health services were offered both in-person and through telehealth during 2020 and early 2021. As restrictions are lifted and more providers are moving to greater availability of in-person services, most providers anticipate a significant percentage of services to still be provided via telehealth. Following the first 6 months of the pandemic, we conducted a study of Medicaid recipients initiating and receiving behavioral health services in-person and through telehealth the 12 months prior to March 2020 compared to March–August of 2020. This study found that the year prior to COVID, only 29 percent of new behavioral health patients initiated care via telehealth, whereas from March through August 2020, 41 percent of new behavioral health patient initiated care by telehealth. The study also found that for patients who were engaged in behavioral health care prior to the pandemic, the majority of those patient continued with care despite the public health crisis as much of their care continued either in-person or via telehealth. In Nevada ongoing discussions around the merits of telehealth expansion have promoted debate over issues such as payment parity for telehealth or telephonic services versus in-person care. Many patient advocates have expressed concern that, gone unchecked, telehealth services that do not have enough evidence to substantiate their efficacy or effectiveness is commensurate with in-person care may be offered to vulnerable populations or that patients may not have freedom of choice to receive care by the modality of their choosing. Dialogue with national thought leaders on these and other issues has underscored the need for continued evaluation of telehealth practices and policies to ensure equity in access, patient rights, medical necessity, and ethical decision making are a taken into careful consideration at Federal and State levels.

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QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

*Question.* Reforming how individuals experiencing mental and behavioral health crises are treated requires working with a broad coalition of stakeholders at the State and local levels, such as health departments, behavioral health providers, and law enforcement.

Are there any jurisdictions in your State successfully coordinating various State and local stakeholders? What best practices have they developed?

Answer. Yes, Nevada has several regional and local coalitions of stakeholders who convene around behavioral health issues, including crisis services. Nevada established Regional Behavioral Health Policy Boards (RBHPB) during the 2017 legislative session and further expanded upon that work in 2019 (NRS433.429). The Regional Behavioral Health Policy Boards are supported by the Department of Health and Human Services (DHHS) to convene stakeholders monthly in each region to address issues around behavioral health, including crisis. The RBHPB have diverse memberships, including legislative representation and members who represent law enforcement, community-based organizations, the criminal justice system, providers of residential substance use disorder treatment, social services, public health, psychology or psychiatry, payers of health care, and individuals with lived experience. The duties of the RBHPB include but are not limited to advising the Department on the behavioral health needs of children and adults in the region, planning to address the needs and improve access to services, addressing gaps within the region, priorities for allocating funding for behavioral health services, promoting improvements in care, and collecting and reporting behavioral health data. The RBHPBs and coordinators of the boards have been instrumental in assessing the assets and gaps within each region's crisis continuum. Beginning in 2018, the RBHPBs have been engaged in ongoing mapping, planning, and prioritizing of crisis services with their region. In 2020, in collaboration with Regional Behavioral Health Coordinators, stakeholders within each region supported the completion of assets and gaps mapping, and prioritized activities to develop the crisis continuum. A summary of

this work can be found here: *https://socialent.com/2020/06/nevada-crisis-response-system-virtual-summit/*.

Additionally, Nevada also convenes Regional Children's Mental Health Consortia (RCMHC), which were established by statute in 2001 (NRS433b.333). The RCMHC are supported by DHHS to engage regional stakeholders in developing long-term strategic plans for children's mental health services and supports. The RCMHC have diverse membership, including representation from State children's mental health services, child welfare, State Medicaid, school districts, juvenile justice, providers of behavioral health care and foster care, parents of children with severe emotional disturbance, and providers of substance use prevention services. The long-term strategic plans for mental health service and support for children includes active engagement of families whose children have severe emotional disturbance, ensures the mental health system is flexible and offers timely access to affordable care, emphasizes screening and early identification, offers services in the least restrictive environment, and must be responsive to the cultural and gender-based differences and special needs of children. Nevada's RCMHC are strong advocates for crisis services to be designed for children, youth, and families to access with the goal of offering assessment and stabilization supports in-home with wrap-around services, respite, and parenting support. Current planning for 988, mobile crisis, and crisis stabilization services includes the design and implementation for a children's system of care with the RCMHC as critical partners in this work.

*Question.* How can the Federal Government promote better coordination of funding, training, and resources among stakeholders responding to behavioral and mental health crises?

Answer. Nevada strives to support better coordination of funding, training, and resources among stakeholders. However, this work requires an intentional approach to ensuring timely, clear communication, transparent processes to determine allocation of funding, and dissemination of best practices through training and technical assistance, and resources. We have recognized the need to not only continue to engage traditional stakeholders in the development of the crisis continuum, but we have also recognized the need to reach stakeholders across different sectors and individuals within disproportionality impacted communities. We have begun to use an approach called Community Based Participatory Research to engage community members in meaningful dialogue to gather information needed to design the crisis system with the community in mind. We would encourage the Federal Government to consider the necessary time for convening stakeholders in meaningful inquiry around the needs and assets in their communities when developing plans when infusing dollars into States to address behavioral health crisis. Nevada is grateful for the additional funding through the block grants for crisis services, however, the timeline for the plans for the funding is very aggressive and does not necessarily allow for the time needed for the meaningful engagement of the community in designing the plan for the allocation of funding. We would encourage the consideration of sufficient time for States to plan for the use of this funding to ensure the projects that are funded are developed to have the greatest impact and have the opportunities for sustainability once the funding ends.

*Question.* One of the primary challenges I hear from Rhode Island providers is that the current funding streams for crisis intervention and mental and behavioral health services are not consistent. This can lead to funding cliffs that force States to scramble to come up with money or programs to end.

How have cities and States created sustainable funding for these programs?

Answer. Sustainability of programming is a primary consideration in planning for the use of the funding offered to States for crisis services. All States want the ability to give careful consideration of the use of the funding to limit the risks of funding cliffs to occur. When programs are built in communities without sustainability plans, there is incredible risk that harm can come to those communities when the grants funding ends and programming must be dismantled and discontinued. Nevada is fortunate for the passage of Senate Bill 390 (SB390; *https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8095/Text*) during the 2021 legislative session which was enabled by the National Suicide Prevention Designation Act of 2020 being signed into Federal law in October 2020. Several States have initiated similar legislation under the Federal frame which allows States to establish a fee on telecommunications and a fund for that fee to support the necessary expansion of the crisis system for 988 implementation. States have had varying levels of success in passing such laws. In SB390, we were able to establish a cap for the fee at .35 per line/month. The law also established funding Nevada will receive as a re-

sult of opioid settlement litigations as a possible additional funding sources for the 988 and crisis system. While these investments will assist the State in long-term financing options for the crisis system we are working to establish with the new allocation of block grant funding, Nevada also realizes we must constantly evaluate the system as it is implemented to identify any possible funding cliff that could arise without sufficient funds to continue the services. The Medicaid payment enhancements through the American Rescue Plan and existing Medicaid authority are sources of possible sustainability that Nevada plans to evaluate. We are encouraged by the promise of increased collaboration across Federal Health and Human Services agencies to support States in exploring the options to use Medicaid to support sustainability of crisis services. Nevada anticipates the need for technical assistance to understand and plan for the use of Medicaid options in our sustainability planning.

*Question.* What can the Federal Government do to help other jurisdictions do the same?

Answer. Technical assistance from HHS agencies to States to plan for sustainability through Medicaid would assist States in exploring the possible long-term options for maintaining crisis services. In addition, States would benefit from the expressed allowance of the use of block grant dollars to be used more flexibly within their State to invest in additional technical assistance and support to develop changes to the Medicaid State plans, applications for Medicaid waivers, building out the data and technology infrastructure needed to implement programs through Medicaid State agencies. This type of flexibility would support States in successfully leveraging Medicaid as a viable source of sustainability for crisis services. Without such flexibility in funding, it may be challenging for some States to move from concept to implementation within Medicaid.

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QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

*Question.* The COVID–19 pandemic has had a dramatic effect on our Nation's public health. Recent data from the Centers for Disease Control and Prevention (CDC) demonstrates that overdose deaths reached an all-time high between October 2019 and September 2020.[1] Moreover, improper opioid prescribing and substance misuse has had substantial effect on Medicaid enrollees living in Appalachian counties. The OIG recently found that Medicaid enrollees across the Appalachian region are even more at risk of opioid misuse and overdoes than prior to the pandemic.[2]

While the pandemic exacerbated the Nation's opioid crisis, issues with how State Medicaid programs identify overdose victims and connect them to treatment predate the pandemic. One study found that less than one in three Medicaid-enrolled adolescents who experienced an opioid-related overdose received any treatment whatsoever.[3] The trends are similar for adult Medicaid beneficiaries—approximately 60 percent of those who suffered a nonfatal overdose between 2007 and 2013 among a sample of enrollees received another legal opioid prescription within six months of the event.[4]

For these reasons, Senator Manchin and I recently introduced the Improving Medicaid Programs' Response to Overdose Victims and Enhancing (IMPROVE) Addiction Care Act (S. 1575) to address this information gap. Among its provisions, the IMPROVE Addiction Care Act would require State Medicaid programs to make efforts to connect Medicaid enrollees to treatment after a nonfatal overdose and ensure that prescribers are alerted of a patient's previous, nonfatal opioid overdose, as well as fatal overdose.

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[1] "12 Month-Ending Provisional Number of Drug Overdose Deaths," Centers for Disease Control and Prevention, *https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#selection_specific_states_jurisdictions.*

[2] U.S. Department of Health and Human Services Office of Inspector General, "Opioids in Medicaid: Concerns About Opioid Use Among Beneficiaries in Six Appalachian States," December 2020, *https://oig.hhs.gov/oei/reports/OEI-05-19-00410.pdf.*

[3] Rachel Alinsky, Bonnie Zima, Jonathan Rodean, et al., "Receipt of Addiction Treatment After Opioid Overdose Among Medicaid-Enrolled Adolescents and Young Adults," *JAMA Pediatrics,* January 6, 2020, *https://jamanetwork.com/journals/jamapediatrics/article-abstract/2758103.*

[4] Winfred Frazier, Gerald Cochran, Wei-Hsuan Lo-Ciganic, et al., "Medication-Assisted Treatment and Opioid Use Before and After Overdose in Pennsylvania Medicaid," *JAMA,* August 22, 2019, *https://jamanetwork.com/journals/jama/fullarticle/2649173.*

Can you describe the barriers or fragmentation that occurs in the Medicaid program that may be allowing prescribers to subsequently prescribe an opioid to an overdose victim?

Answer. Nevada established statutory requirements for prescribing controlled substances in 2017 through the Controlled Substance Abuse Prevention Act through Assembly Bill 474. Among the many provisions within the State statute is the requirement for providers register with the Prescription Drug Monitoring Program (PDMP) if they have a license to prescribe controlled substances, check the PDMP, assess for patient risk for misuse, addiction and overdose, and obtain informed consent from the patient. Since this legislation's implementation we have seen a 40-percent decrease in the rate of opioid prescriptions per 100 people, with the most significant decrease occurring in initial prescriptions. In that same time period, Nevada had a 68-percent reduction in the co-prescribing of opioids and benzodiazepines. Overdose deaths related to prescription drugs have also decreased since 2017, while overdose rates from synthetic opioids have increased to now account for over 50 percent of opioid overdoses. Fragmentation occurs when data on overdoses is not available to prescribers prior to initiating or continuing a prescription for an opioid medication. Nevada has long contemplated a adding a flag in the PDMP to alert prescribers of an overdose for their consideration and evaluation of risk for prescribing and subsequent overdose however, we have not yet instituted such a warning system. Within the Medicaid program, it would be possible to match data between a patient who has survived a non-fatal overdose to provide such information to a prescribed for consideration, but such a data matching process does not currently exist.

*Question.* What factors or indicators are you aware of that have been associated with increased risk for overdose deaths?

Answer. The number of opioid-related overdose deaths in Nevada decreased from 437 in 2010 to 374 in 2019, in large part due to the deaths associated with prescription opioids decreasing. The rate per 100,000 Nevada residents for opioid-related overdose deaths decreased by 4 percent from 16.2 to 15.4 from 2010 to 2020. Roughly 85 percent of all benzodiazepine-related overdose deaths in Nevada also involve opioids while roughly 30 percent of all opioid-related overdose deaths also involve benzodiazepines. The co-prescribing of benzodiazepines is widely recognized as a risk factor for overdose death. Other risk factors include risk of misuse and addiction, dosage, patient risk factors including age and co-morbid medical conditions, and previous overdoses. The Nevada Controlled Substance Abuse Prevention Act of 2017 addresses many of these risk factors through prescribing protocols while maintaining the prescriber-patient relationship and supporting prescribers' clinical decision-making.

*Question.* Do States have the capability to implement a mechanism to identify a Medicaid enrollee who has suffered a nonfatal overdose? Can you discuss the challenges that a predominately fee-for-service State versus managed care State may encounter?

Answer. Nevada is able to collect and report data on non-fatal overdoses through both billing and claims records or through mandated reporting from hospitals to the Department of Health and Human Services. Through rigorous evaluation, Nevada has determined that billing and claims data can be used to identify beneficiaries who have survived a non-fatal overdose; however, claim lags create some issues around timely notification to prescribers. Data matching from the mandated reporting may be more timely, however data matching to the Medicaid databases for medical and pharmacy to trace back to the prescribing provider(s) of record may cause a delay.

Either approach is feasible in Nevada, though consideration would need to be given to accuracy and timeliness of the information to determine which process would be most efficient. While we cannot speak to other States experiences with fee-for-service or managed care, Nevada does operate Medicaid programs in both systems.

We anticipate Managed Medicaid may experience less challenges in data matching and timely notification to prescribers because of the closed system they operate within. Fee-for-service Medicaid may pose more challenging because of the multiple data sets that would need to be used for matching and likely cause a delay in prescriber notification.

# COMMUNICATIONS

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The American College of Physicians (ACP) is pleased to submit this statement and offer our views on how to improve mental health and addiction services during and after the COVID–19 pandemic. We greatly appreciate that Senators Stabenow and Daines have convened this hearing, "The COVID–19 Pandemic and Beyond: Improving Mental Health and Addiction Services in Our Communities." Thank you for your commitment to ensuring that clinicians have the opportunity to share their views about the response to the public health emergency (PHE) caused by COVID–19 including how we can use the lessons learned during the PHE caused by COVID–19 to improve mental health and increase access to addiction services. Through the experiences of its physicians on the frontlines of furnishing primary care during the COVID–19 pandemic, ACP would like to share its input and recommendations surrounding COVID–19 and mental health and addiction services, including integrating primary care and behavioral health, expanding the available tools to treat mental health, substance use disorders (SUDs), and increasing the physician workforce.

The American College of Physicians is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID–19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

**The Pandemic Increased Demand for Mental Health and Addiction Services**

Recently, the U.S. Government Accountability Office (GAO) released a report, Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID–19 Pandemic. The purpose of the report was to determine if the need for and access to mental health and addiction services varied as the availability to care diminished during the PHE caused by COVID–19. The report showed several concerning trends. The Centers for Disease Control and Prevention (CDC) found that 38 percent of individuals surveyed reported symptoms of anxiety or depression from April 2020 to February 2021. This was a 27 percent increase from 2019 for the same time period. CDC data found that emergency department visits for overdoses was 26 percent higher and suicide attempts were 36 percent higher for the time period of mid-March through mid-October 2020 when compared to that period during 2019. The Substance Abuse and Mental Health Services Administration (SAMHSA) found that in September 2020 opioid deaths in certain sections of the United States increased anywhere from 25 to 50 percent when compared to the same time during 2019. SAMHSA data also showed that contacts by individuals to the Disaster Distress Helpline increased during the PHE in 2020 over comparable timeframes in 2019. For example, between March and August 2020, calls hit a high in April 2020 at almost 10,000 calls, which is an 890 percent increase over April 2019. In August 2020, a survey conducted by the National Council for Behavioral Health (NCBH), found that over half of their member organizations had an increase in demand for their services in the three-month period before the survey. A February 2021 follow-up survey by NCBH discovered that the demand for services had increased by 67

percent.[1] Clearly, the U.S. population has experienced a sharp increase in mental health issues and SUDs during the COVID–19 pandemic.

**Mental Health and Addiction Services Workforce Shortage Made Worse by the COVID–19 Pandemic**

Meanwhile, persistent mental health and addiction services workforce shortages from before the pandemic only worsened during the PHE caused by COVID–19. Before the pandemic, the Health Resources and Services Administration (HRSA) found that by 2025, shortages of seven different types of mental health clinicians were anticipated, with shortages of 10,000 and above in some clinician fields of practice. In September 2020, HRSA designated over 5,700 mental health provider shortage areas with 119 million people living in one of these areas. HRSA estimated that available mental health clinicians in these areas were only adequate enough to meet 27 percent of the need for services.[2] SAMHSA reported that due to a combination of reasons, including laying off staff and the closure of clinicians offices that could not sustain themselves financially, led to a decrease in access. In February 2021, NCBH reported that member organizations had decreased staff and services because of the pandemic caused by COVID–19, including 27 percent laying off staff and 23 percent furloughing staff, resulting in 68 percent of member organizations canceling, rescheduling, or turning away patients.[3] Not unexpectedly, the demand for mental health and addiction services rapidly increased during the PHE caused by COVID–19 while at the same time access to these services diminished.

**Integrate Primary Care and Behavioral Health**

ACP strongly supports the integration of behavioral health care into primary care and encourages its members to address behavioral health issues within the limits of their competencies and resources. Accordingly, ACP supports using the primary care setting as the springboard for addressing both physical and behavioral health care. The basis for using the primary care setting to integrate behavioral health is consistent with the concept of "whole-person" care, which is a foundational element of primary care delivery. It recognizes that physical and behavioral health conditions are intermingled: many physical health conditions have behavioral health consequences, and many behavioral health conditions are linked to increased risk for physical illnesses. In addition, the primary care practice is currently the entry point and the most common source of care for most persons with behavioral health issues—it is already the de facto center for this care. The degree of medical practice integration can vary, from basic coordination between a primary care physician and behavioral health clinicians, to collocation with a behavioral health clinician practicing in close proximity to the primary care physician, to a truly integrated care approach in which all aspects of care delivered in the primary care setting recognize both the physical and behavioral perspective. For example, the patient-centered medical home (PCMH) has been proposed as an appropriate model to address the integration of primary and behavioral care, highlighting its emphasis on primary care, care coordination, and delivery of care by a team of professionals. The Affordable Care Act incentivized the development of Medicaid health homes, which promote addressing behavioral health issues in the primary care setting. Evidence also shows opportunities in the primary care setting not only to address current behavioral health conditions but also to serve as a platform to promote prevention in at-risk patients or populations and address behavioral health conditions before symptoms can occur in patients.[4]

ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health-care professionals work to remove payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the

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[1] U.S. Government Accountability Office. (2021) *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID–19 Pandemic.* GAO–21–437R. *https://www.gao.gov/assets/gao-21-437r.pdf.*

[2] U.S. Government Accountability Office. (2021) *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID–19 Pandemic.* GAO–21–437R, *https://www.gao.gov/assets/gao-21-437r.pdf.*

[3] U.S. Government Accountability Office. (2021) *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID–19 Pandemic.* GAO–21–437R. *https://www.gao.gov/assets/gao-21-437r.pdf.*

[4] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.*

practice infrastructure required to effectively provide such care. The barriers to seamless integration of behavioral and primary care are both administrative and financial. Behavioral and physical health-care clinicians have a long history of operating in different care silos. The artificial separation of behavioral and physical health care is reflected in many ways. For example, primary care physicians generally lack extensive clinical training in behavioral health, and traditional medical and mental health training models and practice environments are substantially different, which may lead to cultural clashes if they are not thoughtfully integrated.[5]

Even though there are challenges, the evidence shows that integrating behavioral health and primary care leads to improved mental health outcomes, improved physical health, improved quality of life, and lower costs. The available research evidence, while limited, does support the efficacy of this approach.[6] The Behavioral Health Integration (BHI) Collaborative, in which ACP participates, has found that benefits of integration can include promoting long-term value, improved patient satisfaction, and reducing the stigma of mental health issues and SUD.[7] Primary care physicians also support integrated care and report that the integrated care model encourages better communication and coordination among behavioral health and primary care physicians and reduces mental health stigma.[8]

Accordingly, Congress can and should take action to encourage primary care and behavioral health integration. Congress could establish grant programs with adequate funding to incentivize primary care uptake of the various integrated care models. These grants could help defray costs of establishing and delivering integrated primary and behavioral health services. These costs can include but are not limited to, hiring additional staff such as behavioral health managers, contracts with other needed health-care clinicians such as psychiatrist consultants and behavioral health managers, and purchasing or upgrading software and other resources to provide new services such as more coordinated care. Congress could also encourage additional payment models that potentially facilitate integrated care including bundling payments, partial and full capitation, and even fee-for-service. For example, additional fee-for-service payment codes could be aligned to incentivize integration by establishing payment for behavioral health—primary care consultations, multidiscipline care plan development, and related activities.[9]

ACP also strongly supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting and Congress should prioritize research in this area. Although a review of the current literature supports the efficacy of the integration of behavioral health care in the primary care setting, it is limited and filled with many gaps. Substantial research is needed to focus on the efficacy of various models of integration, as well as the diagnostic and treatment interventions most appropriate for use in these models. The following additional factors should be considered within research efforts: specific conditions addressed, populations involved (such as child vs. adult), funding structures, personnel employed, and resources available to the participating prac-

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[5] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.*

[6] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.*

[7] Behavioral Health Integration Collaborative. Behavioral Health Integration Compendium. American Medical Association, 2020. *https://www.ama-assn.org/system/files/2020-12/bhi-compendium.pdf.*

[8] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.*

[9] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.*

tices.[10] Federal research agencies, such as the Agency for Healthcare Research and Quality (AHRQ) are well suited to study the best ways of integrating behavioral health care in the primary care setting and Congress should provide the resources to enable this type of care.

**Improve Mental Health Parity with Increased Federal Oversight and Enforcement**

One of the barriers to true integrated primary and behavioral health care are the likely instances of noncompliance by insurance plans with mental and SUD coverage parity required by federal law. While the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity for mental health and SUD coverage, state and federal oversight and compliance efforts have been uneven. Unfortunately, according to the GAO, the true nature of the problem of noncompliance with MHPAEA is not well known.[11] While noncompliance violations have been reported, these complaints were relatively small in number and not considered a true snapshot of the magnitude of noncompliance. While the GAO found that insurance-plan compliance with federal parity law was key to coverage parity, federal agencies are only aware of a small number of patient complaints and discovered violations of coverage parity law. In addition, the GAO found that when federal agencies did engage in compliance reviews for coverage parity that there was a high rate of insurance plan violations. This frequency, the GAO determined, could indicate that insurance-plan noncompliance with mental health and SUD coverage parity law could be a common occurrence.[12] In response, the GAO recommended that the federal government should determine whether current targeted oversight of compliance efforts are sufficient and effective and then develop better ways in which to enforce MHPAEA as well as attain greater oversight authority if needed.[13] ACP strongly recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that remain barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws, including oversight and compliance efforts by federal and state agencies.[14]

**Make Naloxone More Available to Prevent Overdoses**

ACP supports funding to distribute naloxone to individuals with opioid use disorder to prevent overdose deaths and train law enforcement and emergency medical personnel in its use. A 2019 CDC report found that not all individuals in need of naloxone are receiving it due to prescribing and dispensing variations across the country. The CDC recommended actions to improve naloxone access such as reducing patient insurance copays, enhancing clinician training and education, and focusing allocation, especially to rural areas.[15] Legal protections (that is, Good Samaritan laws) should continue to be established or refined to encourage use of naloxone and the reporting of opioid overdoses in instances where an individual's life is in danger. A GAO review found that overall state Good Samaritan laws helped in reducing deaths by overdose and that states that enacted such laws have lower rates of opioid overdose deaths when compared to before the law's enactment or to states without

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[10] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.*

[11] U.S. Government Accountability Office. (2019) *Mental Health and Substance Use, State and Federal Oversight of Compliance with Parity Requirements Varies.* GAO–20–150. *https://www.gao.gov/assets/gao-20-150.pdf*

[12] U.S. Government Accountability Office. (2019) *Mental Health and Substance Use, State and Federal Oversight of Compliance with Parity Requirements Varies.* GAO–20–150. *https://www.gao.gov/assets/gao-20-150.pdf.*

[13] U.S. Government Accountability Office. (2019) *Mental Health and Substance Use, State and Federal Oversight of Compliance with Parity Requirements Varies.* GAO–20–150. *https://www.gao.gov/assets/gao-20-150.pdf.*

[14] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.*

[15] Life-Saving Naloxone from Pharmacies, More dispensing needed despite progress. CDC Vital Signs. Centers for Disease Control and Prevention, August 2019. *https://www.cdc.gov/vitalsigns/naloxone/index.html.*

these laws at all.[16] Physician standing orders to permit pharmacies to provide naloxone to eligible individuals without a prescription should be explored. Insurance and cost related barriers that limit access to naloxone should also be addressed. As the need for naloxone has grown, so has its price. In response, government representatives and private sector entities have partnered to make bulk purchases of naloxone at substantial discounts for state and local jurisdictions fighting the opioid epidemic. These and other efforts must be accelerated to ensure that naloxone continues to reach those in need.[17]

**Expand Medication-Assisted Treatment (MAT) for Physicians**

In order to expand access to medication-assisted treatment (MAT) of opioid use disorders, improved training in the treatment of substance use disorders is necessary, including for buprenorphine-based treatment. Pre- and post-buprenorphine training support and education tools and resources should be made available and widely disseminated to assist physicians in their treatment efforts. Physician support initiatives, such as mentor programs, shadowing experienced providers, and telemedicine, can help improve education and support efforts around substance use treatment.[18] In addition, continued efforts are needed to remove barriers or administrative burdens for physicians to fully take advantage of using MAT to treat their patients, such as eliminating burdensome prior authorization requirements. These roadblocks can delay or deny needed treatment that utilize already approved medications in the course of MAT to treat SUDs. Several states have already taken action to eliminate or reduce prior authorization requirements for MAT and Congress should explore legislative options on the federal level.[19]

**Establish a National Prescription Drug Monitoring Program (PDMP)**

ACP reiterates its support for the establishment of a national Prescription Drug Monitoring Program (PDMP). Until such a program is implemented, ACP supports efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting program. The College strongly urges prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) before writing and filling prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to ensure confidentiality and privacy. In addition to a national PDMP, ACP strongly encourages Congress to be helpful in this area by requiring efforts to facilitate the use of PDMPs, such as by linking information with electronic medical records and permitting other members of the health-care team to consult PDMPs.[20]

**Conduct Research to Implement Effective Public Health Interventions**

ACP believes more federal research is needed. The effectiveness of public health interventions to combat substance use disorders and associated health problems should be studied further. Public health-based substance use disorder interventions, such as syringe exchange programs (SEPs) and safe injection sites that connect the user with effective treatment programs should be explored and tested. Risky injection drug use habits, such as needle sharing, contribute to the spread of HIV, hepatitis C virus, and other blood-borne pathogens. Several SEPs have shown the potential to reduce the spread of these diseases. Indeed, the federal government has al-

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[16] U.S. Government Accountability Office. (2020) Drug Misuse, Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects. *https://www.gao.gov/assets/gao-21-248.pdf.*

[17] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953.*

[18] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953.*

[19] American Medical Association. Opioid Task Force 2019 Progress Report. *https://www.end-opioid-epidemic.org/wp-content/uploads/2019/06/AMA-Opioid-Task-Force-2019-Progress-Report-web-1.pdf.*

[20] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953.*

ready established and funded Syringe Services Programs (SSPs) through the CDC.[21] These community-based prevention programs have a track record of furnishing much-needed services, such as disposal of sterile syringes, vaccination, testing, infectious disease care, and most critically, SUD treatment.[22] These programs may also connect individuals with other health and social services, as well as referrals to SUD treatment, as mentioned above, prevention supplies, and health screenings. As the opioid epidemic continues to increase the number of people who inject drugs, federal and state funding should be directed to communities to prevent the spread of blood-borne diseases, such as HIV infection and hepatitis C, as well as connect people to social and health-care services that can provide necessary assistance. Because safe injection facilities have not been extensively tested in the United States, state and local health officials need the resources to conduct pilot tests prior to any possible full implementation.[23]

**Ensure Adequate Physician Workforce to Integrate Behavioral Health and Primary Care**

ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting. Cross-discipline training is needed to prepare behavioral health and primary care physicians to effectively integrate their respective specialties. Primary care physicians need to be trained to screen, manage, and treat common behavioral health conditions, and behavioral health providers need to be trained to understand care for common medical needs. Both sectors need to overcome the operational and cultural barriers that prevent seamless integration. A report from the SAMHSA–HRSA Center for Integrated Health Solutions cited inadequate skills for integrated practices and reluctance to change practice patterns.[24]

The workforce of professionals qualified to treat behavioral health and substance use disorders should be expanded. ACP supports policies to increase the professional workforce engaged in treatment of behavior health and substance use disorders. Loan forgiveness programs, mentoring initiatives, and increased payment may encourage more individuals to train and practice as behavioral health professionals.[25]

Primary care physicians, including internal medicine specialists, continue to serve on the frontlines of patient care during this pandemic with increasing demands placed on them. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health-care professionals providing care for all communities, including for racial and ethnic communities historically underserved and disenfranchised.[26] According to the Association of American Medical Colleges (AAMC), before the Coronavirus crisis, estimates were that there would be a shortage of 21,400 to 55,200 primary care physicians by 2033. In addition, the federal government determined that an additional 14,900 primary care physicians and 6,894 psychiatrists were needed *in 2018* to provide services that would have eliminated a HPSA designation for areas with primary care and mental

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[21] Centers for Disease Control and Prevention. Syringe Services Programs (SSPs) Funding. Accessed at *https://www.cdc.gov/ssp/ssp-funding.html.*

[22] Centers for Disease Control and Prevention. Syringe Services Programs (SSPs) Safety and Effectiveness Summary. Accessed at *https://www.cdc.gov/ssp/syringe-services-programs-summary.html.*

[23] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953.*

[24] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.*

[25] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953.*

[26] Serchen J, Doherty R, Hewett-Abbott G, Atiq O, Hilden D; Health and Public Policy Committee of the American College of Physicians. Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk: A Position Paper of the American College of Physicians. Philadelphia: American College of Physicians; 2021. *https://www.acponline.org/acp_policy/policies/understanding_discrimination_affecting_health_and_health_care_persons_populations_highest_risk_2021.pdf.*

health shortages.[27] Now, with the closure of many physician practices and near-retirement physicians not returning to the workforce due to COVID–19, it is even more imperative to assist those clinicians serving on the frontlines and increasing the number of future physicians in the pipeline.

For example, many residents and medical students are playing a critical role in responding to the COVID–19 crisis all while they carry an average debt of over $200,000. In addition, international medical graduates (IMGs) are currently serving on the frontlines of the U.S. health-care system, both under J–1 training and H–1B work visas and in other forms. These physicians serve an integral role in the delivery of health care in the United States. IMGs help to meet a critical workforce need by providing health care for underserved populations in the United States. They are often more willing than their U.S. medical graduate counterparts to practice in remote, rural areas and in poor underserved urban areas. More must be done to support their vital role in health-care delivery in the United States.

ACP supports several pieces of legislation from the 116th Congress that should be reintroduced as well as legislation recently introduced that should be passed in the current 117th Congress to assist medical graduates and the overall physician workforce as well as address the mental and behavioral health needs of physicians themselves.

- *The Resident Education Deferred Interest Act* (H.R. 1554, 116th Congress) would make it possible for residents to defer interest on their loans.
- *The Conrad State 30 and Physician Access Reauthorization Act* (S. 948, 116th Congress) and *the Healthcare Workforce Resilience Act* (S. 3599, 116th Congress), would help with medical student loan forgiveness and support IMGs and their families by temporarily easing immigration-related restrictions so IMGs and other critical health-care workers can enter the U.S. to train in internal medicine residency programs, assist in the fight against COVID–19, and provide a pathway to permanent residency status.
- *The Student Loan Forgiveness for Frontline Health Workers Act* (H.R. 2418, 117th Congress) would assist frontline clinicians as they provide care during the pandemic.
- *The Dr. Lorna Breen Health Care Provider Protection Act* (H.R. 1667/S. 610, 117th Congress) is an important proposal because it aims to prevent and reduce incidences of suicide, mental health conditions, substance use disorders, and long-term stress, sometimes referred to as "burnout" among physicians themselves. Through grants, education, and awareness campaigns, the legislation will help reduce stigma and identify resources for health-care clinicians seeking assistance. The legislation also supports research on health-care professional mental and behavioral health, including the effect of the COVID–19 pandemic. View ACP's letter of support to the House and Senate for H.R. 1667 and S. 610.

In addition, ACP was encouraged that bipartisan congressional leaders worked together last year to provide 1,000 new Medicare-supported Graduate Medical Education (GME) positions in the Consolidated Appropriations Act, 2021 (H.R. 133)—the first increase of its kind in nearly 25 years—and that some of those new slots will be prioritized for hospitals that serve Health Professional Shortage Areas (HPSAs).

- ACP now calls on Congress to pass the *Resident Physician Reduction Shortage Act of 2021* (H.R. 2256/S. 834, 117th Congress) which would provide 14,000 new GME positions over seven years, or 2,000 per year to build on the 1,000 new GME slots mentioned above.
- Congress should also pass the *Opioid Workforce Act of 2021* (S. 1483, 117th Congress). This bill would provide Medicare funding for 1,000 more GME positions over five years in hospitals that already have established, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

ACP also supports other physician and clinician workforce programs and we strongly supported providing $800 million for the National Health Service Corps (NHSC) and $330 million to expand the number of Teaching Health Centers (THC) Graduate Medical Education (GME) sites nationwide and increase the per resident allocation that were enacted in the American Rescue Plan (ARP) Act, H.R. 1319. Indeed, a recent study appearing in the *Annals of Internal Medicine* showed that in counties

[27] Prepared for the AAMC by IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. Association of American Medical Colleges, June 2020. *https://www.aamc.org/media/45976/download.*

with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy.[28] Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed in order to furnish primary care, behavioral health, and SUD services. Enhanced investments in programs such as the NHSC and THCGME that increase the physician workforce should be sustained after the pandemic caused by COVID–19 has come to an end.

**Conclusion**

We commend you and your colleagues for working in a bipartisan fashion to examine any lessons learned about treating mental health and addiction services during the COVID–19 pandemic to improve health outcomes and to develop legislative proposals to combat not only the ongoing Coronavirus crisis—but to address any issues caused by the current pandemic as well as future pandemics. We wish to assist in the Finance Committee's efforts in this area by offering our input and suggestions about ways that Congress and federal health departments and agencies can intervene through evidence-based policies both now and beyond the PHE. Thank you for consideration of our recommendations that are offered in the spirit of providing the necessary support to physicians and their patients going forward. Please contact Brian Buckley, Senior Associate, Legislative Affairs, by phone at (202) 261–4543 or via email at bbuckley@acponline.org with any further questions or if you need additional information.

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AMERICAN PHARMACISTS ASSOCIATION

Chairwoman Stabenow, Ranking Member Daines, and Members of the Committee, the American Pharmacists Association (APhA) is pleased to submit the following Statement for the Record for the U.S. Senate Finance Subcommittee on Health Care Hearing, "The COVID–19 Pandemic and Beyond: Improving Mental Health and Addiction Services in Our Communities."

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA thanks the Committee for holding this important hearing on improving mental health and substance use disorder (SUD) and opioid use disorder (OUD) services. Unfortunately, the COVID–19 pandemic has exacerbated the drug overdose crisis. According to the Centers for Disease Control and Prevention (CDC), during the period October 2019 through September 2020, there were more than 87,000 overdose deaths—a record high.[1] Clearly, additional steps need to be taken to address this crisis.

Pharmacists are important providers on the patient's health care team and play a critical role in caring for patients with acute and chronic pain and/or OUD including prescribing medications, as authorized; medication management; administering; dispensing; and educating patients about opioid and non-opioid pain medications, as well as talking to patients about nonpharmacologic therapies. Pharmacists also provide services focused on screening for mental health conditions and work with other members of the patient's team to manage medications used in the treatment of mental health conditions.

Pharmacists have more medication-related education and training than any other health care professional. As medication experts, pharmacists are uniquely qualified to provide opioid stewardship and medication management services including comprehensive medication management, dose optimization, appropriate tapering of opioids and other pain medications, and education on safe storage and disposal

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[28] Sanjay Basu, M.D., Ph.D.; Russell S. Phillips, M.D.; Seth A. Berkowitz, M.D., MPH. Estimated Effect on Life Expectancy of Alleviating Primary Care Shortages in the United States. *Ann Intern Med.* 2021. *https://www.acpjournals.org/doi/pdf/10.7326/M20-7381.*

[1] CDC National Center for Health Statistics. 12 Month-ending Provisional Number of Drug Overdose Deaths, based on data available for analysis on 4/4/2021, available at: *https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.*

methods. In addition, pharmacists aid opioid overdose reversal efforts by furnishing naloxone and training patients and community members on its use.

In order to increase access to pharmacist-provided patient care services for patients with mental health conditions, SUD, and OUD, APhA urges Congress to pass the following legislation:

**S. 1362/H.R. 2759, the Pharmacy and Medically Underserved Areas Enhancement Act**

Despite the fact that many states and Medicaid programs are turning to pharmacists to increase access to health care, Medicare Part B does not cover many of the impactful and valuable patient care services pharmacists can provide. While over 90% of Americans live within 5 miles of a community pharmacy,[2] and pharmacists are also present in clinics and physician office practices, many of our nation's seniors are medically underserved. As proven during the COVID–19 pandemic, pharmacists are an underutilized and accessible health care resource who can positively affect beneficiaries' care and the entire Medicare program.

Accordingly, APhA strongly urges the Committee to include S. 1362, the Pharmacy and Medically Underserved Areas Enhancement Act, recently introduced by Committee members Charles Grassley (R–IA), Robert Casey (D–PA), and Sherrod Brown (D–OH), in the Committee's legislative package to allow pharmacists to deliver vital patient care services in medically underserved areas to help break down the barriers to achieving health care equity in this country, improve patient care, health outcomes, the impact of medications,[3] and consequently, lower health care costs and extend the viability of the Medicare program.

By recognizing pharmacists as providers under Medicare Part B, S. 1362 would enable Medicare patients in medically underserved communities to better access health care—including mental health, SUD, and OUD care—through state-licensed pharmacists practicing according to their own state's scope of practice. In medically underserved communities, pharmacists are often the closest health care professional and the most accessible outside normal business hours. The ongoing COVID–19 pandemic has further illustrated how difficult it is for patients living in medically underserved communities to access care and achieve optimal medication therapy outcomes. S. 1362 recognizes that pharmacists can play an integral role in addressing these longstanding disparities to help meet health equity goals [4] and ensure that our most vulnerable patients have access to the care they need. Helping patients receive the care they need, when they need it, is a common sense and bipartisan solution that will improve outcomes and reduce overall costs.

**S. 445/H.R. 1384, the Mainstreaming Addiction Treatment (MAT) Act**

Only 1 in 5 Americans with opioid use disorder receive buprenorphine.[5] The Department of Health and Human Services' (HHS) recent issuance of Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder [6] is a step in the right direction to increase patient access to buprenorphine, which has been proven to cut the risk of overdose death in half.[7] However, the Practice Guidelines exclude pharmacists—the most accessible healthcare providers—because pharmacists are statutorily ineligible to apply to the Substance Abuse and Mental

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[2] NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

[3] *See,* Avalere Health. Exploring Pharmacists' Role in a Changing Healthcare Environment. May 2014, available at: *http://avalere.com/expertise/life-sciences/insights/exploring-pharmacists-role-in-a-changing-healthcare-environment.* Also, *see,* Avalere Health. Developing Trends in Delivery and Reimbursement of Pharmacist Services. October 2015, available at: *http://avalere.com/expertise/managed-care/insights/new-analysis-identifies-factors-that-can-facilitate-broader-reimbursement-o.*

[4] The White House. Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. January 20, 2021, available at: *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.*

[5] Rebecca Haffajee, Ph.D., J.D., M.P.H. et al., Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment, 54 *Am. J. Prev. Med.* S230–42 (2019).

[6] HHS. Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder. 86 FR 22439. April 28, 2021, available at: *https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder.*

[7] National Academy of Sciences, Engineering, and Medicine. Consensus Study Report: Medications for Opioid Use Disorder Save Lives, Nat'l Acad. Press (2019), available at: *https://www.nap.edu/catalog/25310/medications-for-opioid-use-disorder-save-lives.*

Health Services Administration (SAMHSA) for a DATA 2000/X waiver[8] necessary to prescribe buprenorphine as medication-assisted treatment (MAT) for OUD.

Under certain states' scope of practice laws, pharmacists are eligible to prescribe Schedule III controlled substances but are unable to prescribe certain Schedule III medications, such as buprenorphine, because they are not eligible for a DATA waiver. When pharmacists partner with physicians and other healthcare providers to provide MAT, they streamline and improve care. Pharmacists' MAT-related services may include treatment plan development, patient communication, care coordination, and adherence monitoring and improvement activities, among others. Allowing pharmacists to prescribe buprenorphine according to their states' scope of practice laws will increase patients' access to MAT and help address treatment gaps.

Accordingly, APhA strongly urges the Committee to include S. 445, the Mainstreaming Addiction Treatment (MAT) Act, introduced by Committee member Maggie Hassan (D–NH) and Senator Lisa Murkowski (R–AK), in the Committee's legislative package to further expand the number of practitioners—including pharmacists—who are ready, willing, and able to prescribe buprenorphine to patients in their jurisdictions.

**Conclusion**

APhA would like to thank the Committee for holding this important hearing and for continuing to work with us by including S. 1362 and S. 445 in your legislative package to increase access to pharmacist-provided patient care services for patients with mental health conditions, substance use disorder, and opioid use disorder. Please contact Alicia Kerry J. Mica, Senior Lobbyist, at AMica@aphanet.org or by phone at (202) 429–7507 as a resource as you consider this legislation. Thank you again for the opportunity to provide comments on this important issue.

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**Statement of Katherine B. McGuire, Chief Advocacy Officer**

The American Psychological Association (APA) thanks the Subcommittee for the opportunity to offer evidence-based solutions to address the mental and behavioral health impact of the COVID–19 pandemic, which the nation will continue to confront long after the pandemic ends. APA is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology. APA has more than 122,000 members and affiliates who are clinicians, researchers, educators, consultants, and students.

As the U.S. Government Accountability Office (GAO) recently found, "longstanding unmet needs for behavioral health services" continue to persist and were in fact "worsened by new challenges associated with the COVID–19 pandemic" (GAO, March 31, 2021). Over the past year, the pandemic created "a cascade of societal challenges, including illness and death, prolonged social isolation, job loss, and reliance on remote work and online education" while also "cast[ing] a bright light on the destructive effects of health, educational, employment, legal, and criminal justice disparities and inequities." (American Psychological Association, August 2020). The results of APA's "Stress in America" survey series during this time tell a compelling story about the mental health impact of the pandemic on everyday Americans, particularly on communities of color and other underserved communities (American Psychological Association, 2021). This impact manifests in a highly individualized manner, which includes but is not limited to higher rates of emotions associated with prolonged stress, such as anxiety, stress and anger; unexpected fluctuations in weight; disruptions in sleep; and increased consumption of alcohol and dangerous substances.

Innovative solutions are urgently required if we are ever to meet the challenge of addressing the long-term mental health impact of this pandemic while remedying preexisting barriers to accessing these services. However, there is no "one size fits all" approach to addressing this crisis. This Subcommittee and its members have at their disposal an array of solutions, which we respectfully outline in this document.

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[8] 21 U.S.C. § 823(g)(2).

- **Support Permanent Expansions in Medicare Coverage of Certain Audio-Only Telehealth Services.** Congress' and CMS' decision to expand Medicare coverage of mental and behavioral services via telehealth—including those furnished via audio-only communication—prompted a long-overdue expansion of mental health services to many communities that traditionally lacked access to such services. Audio-only services in particular are a critical (and often the only) link to mental and behavioral health services for many individuals and communities that are less likely to have reliable access to technological training or broadband technology, such as older adults, individuals with disabilities, people in rural and frontier areas, lower-income families, and communities of color.

  We remain concerned, however, that this access expansion will abruptly end once the current public health emergency ends, and we hope members of the Subcommittee will help avoid this "access cliff" and permanently authorize Medicare to cover audio-only telehealth for mental, behavioral, and substance use disorder services. Additionally, while APA supports Congress's decision to eliminate certain site-of-service requirements on Medicare tele-mental health coverage in the year-end budget and COVID package, we are concerned that the new six-month in-person service requirement will inequitably limit access to services. Finally, we hope this Subcommittee will support a bipartisan bill co-sponsored by Chairwoman Stabenow, the Tele-Mental Health Improvement Act (S. 660), which will—both during and shortly after the pandemic—place coverage and reimbursement for mental health and substance use disorder services on the same footing as services provided in-person.

- **Support Innovative Approaches to Combating the Resurgent Opioid and Substance Use Disorder Crisis.** Despite Congress' commendable efforts to combat the opioid epidemic, the COVID–19 pandemic worsened rates of opioid and substance use. According to CDC data, over 88,000 individuals died due to a drug overdose between August 2019 and August 2020, an astounding 26.8% increase over the previous year (Ahmad, et. al. 2021). CDC data also shows that while opioids, and especially fentanyl, continue to account for the bulk of overdose deaths, the use of psychostimulants such as methamphetamine increased by 46% over the previous year (Volkow, 2021). The drug overdose crisis demands a strong public health response which meets individuals with substance use disorders where they are. The CAHOOTS Act (S. 764) introduced by Chairman Wyden embodies this approach, and we urge both its enactment and the adoption of mobile crisis intervention services by Medicaid programs nationwide.

  We urge the Subcommittee to advance similarly innovative approaches to this crisis, such as those outlined in: (1) the bipartisan Medicaid Reentry Act (S. 285), co-sponsored by Sen. Whitehouse, which allows inmates within 30 days of release to enroll in Medicaid to reduce the risk of relapse upon release; (2) Sen. Hassan's Mainstreaming Addiction Treatment Act (S. 445), which eliminates the unnecessary and counterproductive requirement that prescribing providers obtain a waiver from the Drug Enforcement Agency (DEA) before prescribing buprenorphine for the treatment of substance use disorders; (3) H.R. 2051, legislation introduced by Rep. Scott Peters to designate methamphetamine as an emerging drug threat; and (4) H.R. 2366, the "Support, Treatment, and Overdose Prevention of Fentanyl Act of 2021", introduced by Rep. Ann Kuster. We would like to especially highlight H.R. 2366's provisions that: (a) remove barriers to the establishment of contingency management programs, an evidence-based form of behavioral treatment developed by psychologists for treatment of methamphetamine, cocaine, and other substance use disorders (De Crescenzo, et. al., 2018); (b) fund grants to states, localities, and community-based programs for harm reduction programs; (c) remove the one-year waiting period for admission to maintenance treatment for opioid use disorders; and (d) request a study on the effectiveness of overdose prevention centers on reducing overdose deaths and improving access to effective treatment and recovery.

- **Support Increased Funding for Programs to Strengthen School-Based Mental Health Programs.** The pandemic continues to have an outsized impact on children and youth, with nearly a third of parents reporting that their child experienced some degree of harm to their emotional or mental health during the pandemic (Gallup, 2020). This population is of particular concern not only due to their higher overall vulnerability to stress, but also because of the increased risk they will experience adverse childhood experiences (ACEs) such as various forms of abuse, neglect, and household dysfunction.

One of the major disruptions in the lives of children and youth involve disruption in their daily school schedules, which often led to higher levels of social isolation. As schools are a key provider of mental and behavioral health services to children, the pandemic often cut off access to mental health services for many children (Nuamah, et. al., 2020). We hope members of the Subcommittee will consider a significant increase in funding for services under the Individuals with Disabilities in Education Act, Project AWARE, Title IV–A Student Support and Academic Enrichment Grants, and the Safe Schools National Activities Program, along with support for school-based health centers that provide an array of mental health services to Medicaid-eligible students and their families.

- **Expand Research in Social and Behavioral Science to Invest in Health Equity.** The COVID–19 pandemic both highlighted and exacerbated longstanding disparities in access to mental health services, particularly amongst individuals from communities of color. Psychological science continues to inform innovative solutions to combat challenges related to health equity including, for example, guidance on facilitating transparent and thoughtful conversations between community leaders and individuals to enable informed decisions about vaccine behaviors. As a critical first step in remedying these disparities, APA hopes members of the Subcommittee will support H.R. 1475, the Pursuing Equity in Mental Health Act, which is among the bills listed on the House suspension calendar this week. Among other provisions, this bill would authorize funding to support health equity research, build outreach programs to reduce the stigma of seeking mental health treatment, and develop a training program for providers.

  To develop more innovative approaches to health equity, we hope members of this Subcommittee will also support National Institutes of Health (NIH) and National Science Foundation (NSF) research in social and behavioral science, as well as increased funding for the health equity offices across HHS to enhance equity-focused emergency preparedness planning and response to future public health emergencies. Specifically, we hope that members of this Subcommittee will support a significant increase in funding for the NIH Office of Behavioral and Social Sciences Research, which has a critical role in coordinating trans-NIH initiatives examining the social and economic impact of the COVID–19 crisis including its effect on mental health. Understanding the disruption in work and schooling, the economic uncertainty, grief, stress, unhealthy coping mechanisms, and the mechanisms that convey risk and resilience will help policymakers improve their long-term response to the current pandemic.

- **Increase Funding for the Psychology Workforce Programs.** Among the most effective ways to expand access to services for those experiencing mental health challenges from the pandemic is to develop the psychology workforce to reach underserved and marginalized communities. Programs such as the Graduate Psychology Education (GPE) program and the Behavioral Health Workforce Education and Training (BHWET) Grant Program serve a critical role in expanding access to mental health services in traditionally underserved areas, while the Minority Fellowship Program (MFP) serves a dual function to both expand access to patients while increasing the racial and ethnic diversity of the workforce itself. We hope members of this Subcommittee will support increased funding for all these programs to help meet an expected increase in need for mental health services due to the public health and economic impact of the pandemic.

APA stands ready to assist the Subcommittee in finding impactful bipartisan solutions to address the mental health and substance use disorder impact of this pandemic. Please contact Andrew Strickland, J.D. at astrickland@apa.org if our association can serve as a resource.

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CENTER FOR FISCAL EQUITY
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**Statement of Michael G. Bindner**

Chairman Stabenow and Ranking Member Daines, thank you for the opportunity to submit these comments for the record to the Subcommittee.

Mental health care and addiction services have actually stood up rather well during the pandemic. Zoom, and similar platforms, have stepped in nicely to continue face to face care where needed. Phone appointments and video calls have also worked in family practice settings where medication management is the only task.

Managing my prescriptions and assisting my housemate in managing his contacts with his are much easier than a trip to our respective mental health providers.

Detox and rehabilitative services for alcohol and drug abuse are still active, although sometimes bringing in outside speakers is not possible if there are glitches in electronic media or in the event a facility is moving to a new location. This is the exception, not the rule.

In Montgomery County, housing of Drug Court clients has been moved from our Pre-Release Center to contracted half-way houses. The system has kept up with COVID.

Regular Twelve Step meetings are occurring remotely as well. Some new members have never been to an in-person meeting, although clubhouses and church basement meetings are now opening up and outdoor meetings (both masked and unmasked) have been occurring throughout the pandemic.

Coronavirus and SARS2 infections occurred in the recovery community even when meetings were not held in person. People have mostly gotten sick in other places. Last year, older members got sick. This year, it is our younger members who suffer from the second wave. Older members have not been ill, having already recovered.

For many, including me, the virus spreads by being sneezed on in private during the first phase of the illness, which occurs before the asymptotic phase and the more serious symptoms.

The first phase is largely attributed to seasonal allergies or bad colds. People die in the more serious phase because they expect it to go away as the first did. The CDC has either not detected this pattern or has not informed the nation of it, for whatever reason. This is more of a factor in causing death than masking ever was.

While I might have been infected at a public event last February, it is as or more likely that infection occurred as I was typing Comments for the Record at the local library or by having coffee or a meal or seeing a movie during that period. I infected

others during the first period. During the later part of the asymptotic period, no one I breathed on took ill.

There is one area of major concern that must be addressed, although I am not sure how we can go about it. During this crisis, before there was vaccine hesitancy, there was Zoom hesitancy. Some of our older members simply could not figure out or declined to use video calls to attend meetings.

I experienced this reticence myself, not wanting to download software to my phone that was unknown to me. In the beginning, I was also too ill to do much more than eat, be tired from eating, rest and then go back to bed. It was only the usual miracles experienced by those who are spiritually awake that had me download the software and attend a midnight meeting.

My housemate is not technically savvy. Without my help, and the use of my Chromebook, he would still be visiting his psychiatrist in person, where he would be taken into a room for a teleconference with his doctor.

He is a victim of the digital divide. It inhibits him (as well as the lack of a computer of his own) to seek English as a Second Language courses, which are free at Montgomery College (our local community college). His disability, which is matched by his lack of education and equipment hamper both his treatment and his ability to improve his skills.

This is where improvement is necessary. As I have stated in previous comments for the record, paying a stipend to undertake both computer and basic literacy training is an essential incentive to seek it. Such stipends should not count against his disability payments. If they did, they would be a disincentive toward learning. It is a conservative meme that poverty leads to self-improvement. Research has shown that the opposite is the case. It certainly is for him.

And yes, better broadband in some areas of the country would be helpful, although this would not solve the problem of digital illiteracy, especially among vulnerable populations. Most people have access to the Internet through their cable companies, although those that do not should be given free access paid for by higher cable fees.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

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EATING DISORDERS COALITION FOR RESEARCH, POLICY, AND ACTION
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*http://eatingdisorderscoalition.org/*

Chairwoman Stabenow, Ranking Member Daines and members of the U.S. Senate Committee on Finance, Subcommittee on Health Care, thank you for holding this important hearing entitled, "The COVID–19 Pandemic and Beyond: Improving Mental Health and Addiction Services in Our Communities" to ensure the nation has the services and supports in place to care for individuals across the nation with mental illness and addiction, including those with eating disorders.

The Eating Disorders Coalition for Research, Policy and Action (EDC) is a nonprofit organization comprised of patient and caregiver advocates, treatment providers, advocacy organizations, and academics, aimed to advance the recognition of eating disorders as a public health priority throughout the U.S. By promoting federal support for improved access to care, the EDC seeks to increase the resources available for education, prevention, and improved training, as well as for scientific research on the etiology, prevention, and treatment of eating disorders.

**As the number of new COVID–19 cases continues to decline, eating disorders diagnoses continue to climb. Research indicates a 30 percent increase in eating disorder diagnoses since March 2020 compared with data in previous years.**[1] EDC members, the **National Eating Disorders Association has seen a 53 percent increase in their call volume to their helpline since March 2020 and the Alliance for Eating Disorders Awareness has already served 7,000 individuals representing all 50 states and 32 countries and provided approximately 50,000 referrals for treatment since January 2021.**

[1] Tanner, Lindsay. (May 23, 2021). Pandemic has fueled eating disorders surge in teens, adults. Associated Press. Retrieved from: *https://apnews.com/article/coronavirus-pandemic-virus-lifestyle-eating-disorders-health-27c9d5680980b1452f7e512db4d9f825.*

This is just a sampling of the magnitude of services our coalition members are doing to support individuals and families in need. Despite this incredible work, we know there is still work to be done to improve the care for individuals with eating disorders.

Eating disorders are serious mental illnesses that affect 28.8 million Americans over the course of their lifetime.[2] They have the second highest mortality rate of any psychiatric illness, with one death occurring every 52 minutes as a direct result of an eating disorder.[3] **Without access to comprehensive treatment, eating disorders create great economic distress, costing the U.S. economy $64.7 billion annually with the federal government shouldering $17.7 billion of that cost.**[4] Ensuring comprehensive coverage for eating disorders treatment has the potential to mitigate disease progression or relapse into higher levels of treatment. **Without access and/or coverage to treatment, higher levels of eating disorders treatment cost the U.S. $29.3 million in emergency room visits and $209.7 million in inpatient hospitalizations annually.**[5]

**Eating disorder prevalence rates among the senior and disabled populations are similar to the general population at approximately 3 percent to 6 percent.**[6, 7] However, older Americans with eating disorders are particularly serious as chronic disorders or diseases may already compromise their health.[8] Inadequate nutrition as a result of their eating disorder can result in memory deficits; cognitive decline; decubitus ulcers; impaired healing of sores, wounds, or infections; and dizziness, disorientation, and falls, which can initiate a cascade of pathophysiological events leading to a 30 percent to 40 percent mortality rate.[9] **Tragically, 78 percent of deaths from anorexia nervosa occur in the elderly.**[10]

Prevention and early intervention are the best tools to prevent disease progression for those with mental illness or substance use disorders. Given the complexity of eating disorders, a multidisciplinary treatment team that includes a medical provider, psychiatrist, psychologist, and registered dietitian is considered to be the four key provider components for comprehensive eating disorders treatment. The exponential rise in eating disorders as a consequence of the pandemic further underscores the importance of early intervention.

**Unfortunately, Medicare does not provide outpatient coverage for medical nutrition therapy (MNT) for individuals with eating disorders.** This coverage only applies to beneficiaries that are diagnosed with diabetes or end stage renal disease. This lack of coverage leaves individuals susceptible to disease progression and in need of a higher, costlier level of treatment. According to the American Dietetic Association, nutritional therapy conducted by a registered professional is an "essential component" for the treatment of patients with anorexia nervosa, bulimia nervosa, and other eating disorders.[11] Research shows mental health interventions for eating disorders may not be successful if the underlying nutritional issues haven't been addressed first, since nutritional deficiency causes cognitive issues (*e.g.,* depression) that can impede recovery.[12] Nutrition counseling guides patients in identifying problematic behaviors and setting realistic and achievable nutrition related goals to support clients in making behavior changes. Nutrition education includes conversations about discrepancies between knowledge, beliefs and behaviors,

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[2] Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: *https://www.hsph.harvard.edu/striped/reporteconomic-costs-of-eating-disorders/*.

[3] *Ibid.*

[4] *Ibid.*

[5] *Ibid.*

[6] Peat, Christine; Peyerl, Naomi; and Muehlenkamp, Jennifer. (2010). Body Image and Eating Disorders in Older Adults: A Review. *The Journal of General Psychology,* 135:4, 343–358.

[7] Mangweth-Matzek B, Hoek HW. Epidemiology and treatment of eating disorders in men and women of middle and older age. *Curr Opin Psychiatry.* 2017;30(6):446–451. doi: 10.1097/YCO.0000000000000356.

[8] Peat, Christine; Peyerl, Naomi; and Muehlenkamp, Jennifer. (2010). Body Image and Eating Disorders in Older Adults: A Review. *The Journal of General Psychology,* 135:4, 343–358.

[9] Dudrick, Stanley. (2013). Older Clients and Eating Disorders. *Today's Dietitian,* 15:11, 44.

[10] Dudrick, S. (2014). Older clients and eating disorders. *Today's Dietitian,* 15(11), 44.

[11] Ozier, AD and Henry, BW. "Position of the American Dietetic Association: nutrition intervention in the treatment of eating disorders." NCBI/NLM/NIH. *https://www.ncbi.nlm.nih.gov/pubmed/21802573.*

[12] Rosen, David. (2010). Clinical Report—Identification and Management of Eating Disorders in Children and Adolescents. American Academy of Pediatrics, 126:6.

ultimately empowering the patient to normalize eating and make healthier decisions.[13]

Fortunately, Congress has legislation to address this gap in coverage with a bipartisan bill entitled, the Nutrition Counseling Aiding Recovery for Eating Disorders Act or the **Nutrition CARE Act (H.R. 1551/S. 584)** led by Senators Maggie Hassan (D–NH) and Lisa Murkowski (R–AK) and Representatives Judy Chu (D–CA–27), Jackie Walorski (R–IN–02) and Lisa Blunt Rochester (D–DE–AL). **The legislation would provide Medicare Part B coverage for medical nutrition therapy for beneficiaries diagnosed with an eating disorder at the same coverage levels beneficiaries with diabetes and end stage renal disease receive.**

This legislation is a small, critical step in ensuring the federal government is meeting the mental health needs of Americans across the lifespan. We urge the U.S. Senate Committee on Finance, Health Subcommittee to move this bill forward for consideration to the full committee as we work together to support the 2 to 2.5 million Medicare beneficiaries with eating disorders that could benefit from the Nutrition CARE Act.

Thank you for your consideration.

Sincerely,

Eating Disorders Coalition for Research, Policy and Action Members in Formation:

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|---|---|
| Academy for Eating Disorders | Reston, VA |
| Academy of Nutrition and Dietetics | Chicago, IL |
| Alliance for Eating Disorders Awareness | West Palm Beach, FL |
| Alsana: Eating Disorders Treatment and Recovery Centers | Ballwin, MO |
| Bannister Consultancy | Durham, NC |
| BE REAL USA | Chicago, IL |
| Cambridge Eating Disorder Center | Cambridge, MA |
| Center for Change | Orem, UT |
| Center for Discovery | Los Alamitos, CA |
| Eating Disorder Coalition of Iowa | Clive, IA |
| Eating Disorder Hope | Redmond, OR |
| Eating Recovery Center | Denver, CO |
| Farrington Specialty Centers | Fort Wayne, IN |
| Gail R. Schoenbach FREED Foundation | Warren, NJ |
| International Association of Eating Disorders Professionals | Pekin, IL |
| International Federation of Eating Disorders Dietitians | Dallas, TX |
| Laureate Eating Disorders Program | Tulsa, OK |
| Monte Nido and Affiliates | Miami, FL |
| Montecatini | Carlsbad, CA |
| Moonshadow's Spirit | Webster, NY |
| Multi-Service Eating Disorders Association | Newton, MA |
| National Eating Disorders Association | New York, NY |
| Park Nicollet Melrose Center | St. Louis Park, MN |
| Project HEAL | Brooklyn, NY |
| REDC Consortium | St. Paul, MN |
| Rogers Behavioral Health | Oconomowoc, WI |
| Rosewood Centers for Eating Disorders | Wickenburg, AZ |
| Stay Strong Virginia | Chesterfield, VA |
| Strategic Training Initiative for the Prevention of Eating Disorders | Boston, MA |
| SunCloud Health | Northbrook, IL |
| The Donahue Foundation | Richmond, VA |
| The Emily Program | St. Paul, MN |
| The National Association of Anorexia Nervosa and Associated Eating Disorders | Chicago, IL |

[13] Ruiz-Prieto, Inmaculada, Bolanos-Rios, Patricia and Jauregui-Lobera, Ignacio. (2013). Diet Choice in weight-restored patients with eating disorders; progressive autonomy by nutritional education. *Nurtricion Hospitlaria,* 28:5, 1725–1731.

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|---|---|
| The Renfrew Center | Pittsburgh, PA |
| Veritas Collaborative | Durham, NC |
| Walden Behavioral Care | Waltham, MA |
| WithAll | St. Louis Park, MN |
| Wrobel and Smith, PLLP | St. Paul, MN |

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HEALTHCARE LEADERSHIP COUNCIL
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Washington, DC 20001

May 11, 2021

The Honorable Debbie Stabenow
Chair
U.S. Senate
Committee on Finance
Subcommittee on Health Care
Washington, DC 20510

The Honorable Steve Daines
Ranking Member
U.S. Senate
Committee on Finance
Subcommittee on Health Care
Washington, DC 20510

Dear Chair Stabenow and Ranking Member Daines:

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing on, "The COVID–19 Pandemic and Beyond: Improving Mental Health and Addiction Services in Our Communities."

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health-care system that makes affordable high-quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, homecare providers, and information technology companies—advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

The COVID–19 health pandemic has further exacerbated the substance use disorder (SUD) crisis in the United States. From May 2019—June 2020, the number of deaths related to drug overdoses rose 20% and a record number of Americans died from overdoses.[1] Preliminary data expects 2020 to be the worst year on record for drug overdoses.[2] In order to respond to this crisis, Congress and federal agencies took swift action to ensure patients struggling with SUDs received proper care. We applaud the Drug Enforcement Agency's (DEA) decision to temporarily waive in-person requirements to prescribe controlled substances. This has allowed patients to continue to receive important medications, particularly buprenorphine. HLC also thanks the Centers for Medicare and Medicaid Services (CMS) for finalizing regulations mandated under the SUPPORT Act that require providers to use electronic prescribing for controlled substances (EPCS). Requiring EPCS puts a more advanced monitoring system in place to ensure that controlled substances are only prescribed when necessary and allows for relevant authorities to monitor potential trends. We encourage Congress to work with federal agencies to further implement flexibilities that would allow patients to receive needed medications through the duration of the public health emergency (PHE) while maintaining robust safety and monitoring programs.

While HLC supports the regulatory flexibilities implemented during the PHE, Congress should further examine ways to combat the SUD crisis. We support efforts to permanently remove the "X-Waiver" provision under the Drug Treatment Act of 2000 that requires providers to receive a special waiver from the DEA to prescribe buprenorphine. We also encourage Congress to allow patients to receive prescriptions for controlled substances via telemedicine permanently once the waivers under the PHE expire.

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[1] Usha Lee McFarling, *As the pandemic ushered in isolation and financial hardships, overdose deaths reached new heights,* STAT News (February 16, 2021), *https://www.statnews.com/2021/02/16/as-pandemic-ushered-in-isolation-financial-hardship-overdose-deaths-reached-new-heights/*.

[2] Chris Sweeney, *A crisis on top of a crisis: COVID–19 and the opioid epidemic,* Harvard T.H. Chan School of Public Health (February 16, 2021), *https://www.hsph.harvard.edu/news/features/a-crisis-on-top-of-a-crisis-covid-19-and-the-opioid-epidemic/*.

As stakeholders continue to respond to the growing SUD challenges, we encourage Congress to work with federal agencies and additional partners to continue to develop educational resources on appropriate use of controlled substances as well as resources for patients struggling with SUDs. These tools will allow stakeholders to take sustainable steps in responding to the substance use disorder crisis by identifying best practices in prevention and treatment and ensure that patients have essential SUD healthcare options.

The COVID–19 health pandemic has also created barriers to accessing mental health services. A January study found that over 40% of adults have reported struggling with anxiety or depression since the beginning of the pandemic.[3] If left untreated, many of these mental health challenges can further exacerbate SUD. We applaud Congress for providing over $4 billion in the Consolidated Appropriations Act for mental health services. HLC hopes that Congress will continue to examine ways to improve access to mental health services, particularly through telehealth.

HLC, through its National Dialogue for Healthcare Innovation, continues to be focused on ways to address the substance use disorder crisis and make continued investments in mental health. Please feel free to contact Tina Grande at 202–449–3433 or tgrande@hlc.org with any questions.

Sincerely,

Mary R. Grealy
President

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May 21, 2021

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Debbie Stabenow
Chair
U.S. Senate
Committee on Finance
Subcommittee on Health Care
Washington, DC 20510

The Honorable Steve Daines
Ranking Member
U.S. Senate
Committee on Finance
Subcommittee on Health Care
Washington, DC 20510

**Re: Comments for the Record for the May 12, 2021 Hearing on "The COVID–19 Pandemic and Beyond: Improving Mental Health and Addiction Services in Our Communities"**

Dear Chairmen Wyden and Stabenow and Ranking Members Crapo and Daines:

On behalf of national organizations representing consumers, family members, mental health and addiction professionals, advocates, payers and other stakeholders, we thank you for your ongoing leadership to address the rising demand for mental health and substance use disorder treatment and to advance telehealth both during the COVID–19 Public Health Emergency (PHE) and beyond.

As you are well aware, the flexibilities granted by the δ1135 emergency telehealth waivers have provided critical stability for healthcare professionals, patients and families across the nation during this challenging time. In particular, telehealth access for mental health and substance use disorder treatment services have served as a lifeline for many Americans struggling with isolation, grief, future uncertainty, and other new stressors this past year. On August 14, 2020, the Centers for Disease Control and Prevention (CDC) reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics.[1] Of

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[3] Nirmita Panchal et al., *The Implications of COVID–19 for Mental Health and Substance Abuse,* Kaiser Family Foundation (February 10, 2021), *https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/*.

[1] *https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932-H.pdf?deliveryName=USCDC_921-DM35222.*

grave concern, the report indicated that *over 1 in 4 young adults had recently contemplated suicide.* Additional research revealed that *over 40 states saw a rise in opioid-related overdose deaths* since the start of the pandemic.[2] Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020—signifying an almost 20% increase year over year, with no indication that this trend is reversing.

To that end, we applaud the Committee for holding this important hearing to examine policy considerations for mental health and substance use treatment and telehealth as the nation moves out of the COVID–19 Public Health Emergency. With a surge in demand for behavioral health services that are only expected to increase, our nation needs to apply every tool at our disposal to ensure that Americans have access to the mental health and substance use services they need. As such, our respective organizations offer the following recommendations to the Committee as Congress reviews next steps on telehealth.

**I. Extend all telehealth flexibilities for mental health and substance use disorders at least one year beyond the end of the PHE to maintain access to care and better inform policymakers how to make permanent telehealth policies that increase equitable access to quality, evidence-based care**

Telehealth helps to reduce the stigma around seeking mental health or substance use disorder treatment for those who want to seek care confidentially, and it makes access to services more available to those without childcare or transportation. Furthermore, audio-only telehealth, which has been a digital equalizer for those who lack access to broadband Internet or video-enabled devices and for those who cannot utilize dual audio-video devices, is a critical flexibility. The ability to communicate between patients and behavioral health providers according to individuals' own needs is crucial to eliminating artificial barriers to care.

Extending these flexibilities for at least one year beyond the conclusion of the PHE will allow for additional time to evaluate questions associated with cost, utilization, efficacy, and compliance. *Taking this step is fully consistent with recent recommendations to the Congress from the Medicare Payment Advisory Committee, which asked for an extension of current telehealth flexibilities—including audio-only—for up to 2 more years to gather more evidence about the impact of telehealth on access, quality, and cost, and for policymakers to use this evidence to inform any permanent changes.*[3] This additional time could provide more baseline data to address concerns, such as those relative to Congressional Budget Office (CBO) scoring, by allowing real world data rather than non-dynamic projections to guide policy decision making. Historical advancements have been made in telehealth over the last year and consumer support for continuing these advancements remains strong, particularly for mental health and substance use disorder treatments. We therefore implore this Committee to take action—via seeking an extension of telehealth flexibilities at least one year beyond the PHE—to ensure that these immense gains in virtual care are not lost or discontinued abruptly.

**II. Allow telephonic (audio only) services for mental health and substance use disorder services after the PHE concludes**

In 2019, the Federal Communications Commission (FCC) reported that between 21.3 and 42 million Americans lacked access to broadband. Many older adults and people with disabilities lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have access to them. Likewise, many in racial/ethnic and low-income communities lack access to broadband or video-enabled devices.

Additionally, there is strong evidence to support the efficacy of telephonic behavioral health services. A review of 13 studies found reduced symptoms of anxiety and depression when therapy was conducted via telephone.[4] Patients have also benefited from receiving various interventions over the telephone, such as combined tele-

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[2] *https://www.ama-assn.org/system/files/2020-11/issue-brief-increases-in-opioid-related-overdose.pdf.*

[3] Medicare Payment Advisory Commission, Report to Congress (March 15, 2021).

[4] Coughtrey, A.E., and Pistrang, N. (2018). The effectiveness of telephone-delivered psychological therapies for depression and anxiety: A systematic review. *Journal of Telemedicine and Telecare,* 24(2), 65–74. *https://doi.org/10.1177/1357633X16686547.*

pharmacotherapy and tele-cognitive-behavioral therapy (tele-CBT),[5] tele-CBT alone,[6, 7, 8] receiving short-term tele-CBT in primary care settings,[9] and telebibliotherapy for older adults with anxiety.[10] Veterans with comorbid psychological distress and combat-related mild traumatic brain injury have also benefited significantly from receiving telephone-problem solving therapy (Tele-PST).[11] After receiving tele-PST, veterans reported improved quality of sleep and reduction of symptoms of depression and PTSD.

Given the significant increase in demand for behavioral health services and the significant role of audio-only as a digital equalizer, we recommend continuing this flexibility for the provision of mental health and substance use disorder services for at least 1 year beyond the PHE. During this time, regulators may evaluate data to better understand which modalities may be considered for audio-only on a permanent basis.

**III. Remove the in-person requirement for telemental health services**

While we applaud inclusion of the telemental health services in the end-of-year COVID relief package, we urge Congress to remove the in-person requirement it established. Imposing service restrictions on telehealth access through arbitrary in-person requirements undermines the flexibility and access afforded by telehealth and other virtual care modalities. Additionally, as many providers around the nation have created virtual front doors for their services, they have also started serving larger geographic areas. As such, this new requirement, which would go into place after the PHE concludes, would place an unnecessary burden on consumers and providers alike.

**IV. Continue payment parity for telehealth services**

As more providers transitioned to telehealth, payers are starting to evaluate cutting rates, often making the case that delivering care for telehealth is less expensive. This is simply not the case for behavioral health providers that provide both in-person and telehealth services. First, it assumes that behavioral health rates were already actuarially sound. However, because the Mental Health Parity and Addiction Equity Act has not been enforced since its inception over ten years ago, in many cases rates are already below the actuarial costs of delivering care and coverage of behavioral health services is limited.[12, 13] Second, proposing rate cuts for telehealth assumes that telehealth delivery for providers operating a hybrid (in-person and digital) service environment is less costly than the delivery of in-person care. However, this is also inaccurate as many providers continue to maintain much of their brick and mortar overhead while also seeking to invest in telehealth platforms, hire more tech support staff, and make overall and continuing IT investments. These additional costs do not have a reimbursement mechanism and overlay current operating costs. As such, we recommend that telehealth—for mental health

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[5] Ludman, E.J., Simon, G.E., Tutty, S., and Von Korff, M. (2007). A randomized trial of telephone psychotherapy and pharmacotherapy for depression: Continuation and durability of effects. *Journal of Consulting and Clinical Psychology,* 75(2), 257–266. *https://doi.org/10.1037/0022-006X.75.2.257.*

[6] Mohr, D.C., Hart, S.L., Julian, L., Catledge, C., Honos-Webb, L., Vella, L., Tasch, E.T. (2005). Telephone-administered psychotherapy for depression. *Archives of General Psychiatry,* 62, 1007–1014. *https://jamanetwork.com/journals/jamapsychiatry/article-abstract/1108409.*

[7] Stiles-Shields, C., Kwasny, M.J., Cai, X., and Mohr, D.C. (2014). Therapeutic alliance in face-to-face and telephone-administered cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology,* 82(2), 349–354. *https://psycnet.apa.org/fulltext/2014-02032-001.html.*

[8] Stiles-Shields, C., Corden, M.E., Kwasny, S., Schueller, M., and Mohr, D.C. (2015). Predictors of outcome for telephone and face-to-face administered cognitive behavioral therapy for depression. *Psychological Medicine,* 45(15), 3205–3215. *https://doi.org/10.1017/S0033291715001208.*

[9] Watzke, B., Haller, E., Steinmann, M., Heddaeus, D., Härter, M., König, H.-H., Wegscheider, K., and Rosemann, T. (2017). Effectiveness and cost-effectiveness of telephone-based cognitive-behavioural therapy in primary care: study protocol of TIDe—telephone intervention for depression. *BMC Psychiatry,* 17(263). *https://doi.org/10.1186/s12888-017-1429-5.*

[10] Brenes, G.A., McCall, W.V., Williamson, J.D., and Stanley, M.A. (2010). Feasibility and acceptability of bibliotherapy and telephone sessions for the treatment of late-life anxiety disorders. *Clinical Gerontologist,* 33(1), 62–68. *https://doi.org/10.1080/07317110903344968.*

[11] Bell, K.R., Fann, J.R., Brockway, J.A., Cole, W.R., Bush, N.E., Dikmen, S., Hart, T., Lang, A.J., Grant, G., Gahm, G., Reger, M.A., De Lore, J.S., Machamer, J., Ernstrom, K., Raman, R., Jain, S., Stein, M.B., and Temkin, N. (2017). Telephone problem solving for service members with mild traumatic brain injury: a randomized, clinical trial. *Journal of Neurotrauma,* 34, 313–321. *https://doi.org/10.1089/neu.2016.4444.*

[12] *https://www.naatp.org/sites/naatp.org/files/MillimanReport11-20-19.pdf.*

[13] *https://www.statnews.com/2019/03/18/landmark-ruling-mental-health-addiction-treatment/.*

and substance use disorder services—continue to be reimbursed on par with in-person services.

In conclusion, even with today's telehealth emergency waivers, providers around the nation are struggling to meet the growing need for services at a time when many payers are already beginning to decrease rates for telehealth encounters. These combined effects—limited workforce, rate cuts, and an already underfunded system coupled with predictions that demand for behavioral health services will only increase—signals the clear need for urgent and immediate action. Through passing legislation that extends the telebehavioral health flexibilities, including audio-only services, beyond the PHE, removes the in-person requirement for telemental health services, and secures telebehavioral health parity—we can provide additional tools to increase access, break down stigma, and advance health equity.

We thank the Committee for its ongoing attention to addressing the mental health and substance use disorder crisis in our country, as well as for its consideration of the critical role that telehealth access can play for our nation both during and, importantly, beyond the PHE. Should you have any questions, or we can be of further assistance, please reach out to Laurel Stine (lstine@afsp.org), Lauren Conaboy (Lauren.conaboy@centerstone.org), and Elizabeth Cullen (elizabeth.cullen@jewishfederations.org).

Sincerely,

American Art Therapy Association
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychoanalysis in Clinical Social Work
American Association of Child and Adolescent Psychiatry
American Association of Nurse Anesthetists
American Association of Suicidology
American Association on Health and Disability
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Psychiatric Association
American Psychological Association
Anxiety and Depression Association of America
Association for Ambulatory Behavioral Healthcare
Association for Behavioral and Cognitive Therapies
Centerstone
Center for Law and Social Policy
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Association
College of Psychiatric and Neurologic Pharmacists (CPNP)
Confederation of Independent Psychoanalytic Societies
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy & Action
Education Development Center
Global Alliance for Behavioral Health and Social Justice
The Jed Foundation
The Jewish Federations of North America
International OCD Foundation
International Society for Psychiatric-Mental Health Nurses
Mental Health America
NAADAC, The Association for Addiction Professionals
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of County Behavioral Health & Developmental Disability Directors
National Association of Pediatric Nurse Practitioners
National Association for Rural Mental Health

National Association of Social Workers
National Association of State Mental Health Program Directors
National Board for Certified Counselors
National Council for Behavioral Health
National Federation of Families for Children's Mental Health
National League for Nursing
National Register of Health Service Psychologists
Network of Jewish Human Service Agencies
Postpartum Support International
Psychotherapy Action Network (PsiAN)
REDC Consortium
RI International, Inc.
Schizophrenia and Psychosis Action Alliance
SMART Recovery
The American Counseling Association
The Kennedy Forum
The Michael J. Fox Foundation for Parkinson's Research
The National Alliance to Advance Adolescent Health
The Trevor Project
Well Being Trust
Wounded Warrior Project

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NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS
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I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer and utilize health plans of all types. These plans include coverage for mental and behavioral health benefits as is required by law. We are pleased to have the opportunity to submit recommendations to the subcommittee in regards to improving access to behavioral and mental healthcare. These recommendations were put together with the help of NAHU's Mental Health Task Force, a legislative working group made up of NAHU members who are health insurance and employee benefit professionals with an advanced understanding of mental and behavioral health services and how they are provided and used in health plans.

Access to mental health services is a crucial component of healthcare. National discussion has addressed mental health care for years, but often focuses more on physical health. The COVID–19 pandemic has reminded us of the importance of adequate mental health care and exposed a mental health crisis: About 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019.[1] For these reasons it is more vital than ever that consumers are able to access and afford behavioral health services.

**Continuity of Care**

The Mental Health Parity and Addiction Equity Act of 2008 created standards for the financial requirements and treatment limitations that a group health plan or group health plan issuer may impose on mental health and substance use disorder (MHSUD) benefits. MHPAEA established that financial requirements (such as copayments, coinsurance) and treatment limitations (such as limits on the number of outpatient visits, or prior authorization requirements) cannot be more restrictive

[1] March 15, 2021. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID–19 Pandemic. Kaiser Family Foundation. *https://www.kff.org/other/state-indicator/adults-reporting-symptoms-of-anxiety-or-depressive-disorder-during-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

than those that apply to medical and surgical benefits. With regard to financial requirements or quantitative treatment limitations (such as the number of inpatient days covered), a plan cannot impose a requirement or limitation on MHSUD benefits that is more restrictive than what is imposed on two-thirds of the medical and surgical benefits in the same classification. While this legislation made great strides in improving access and affordability, more must be done to improve continuity of care and network adequacy in the behavioral health space.

One major example of an improper break in continuity of care occurs during the appeals process when a claim for mental or behavioral health service is denied. The family, or responsible party, of a patient must sign a financial agreement that makes them liable for the full cost of care during the grievance process if the individual is to remain in treatment while appeals are completed, imposing undue financial and emotional duress.

Currently the time allowed for appeal of a denial of payment for Mental Health Services is 30 days, the same length of time for medical and surgical appeals. For mental health patients, this gap in treatment can lead to the loss or reversal of clinical gains. For some patients this can include life-threatening consequences, readmissions and the potential waste of initial investment in treatment. Ultimately, this gap caused by a long appeal process has an immensely harmful impact on the patient and their family or caregiver, emotionally and financially. For these reasons, NAHU recommends requiring all appeals of denials and grievances for MHSUD to automatically be escalated to urgent status. Urgent status usually allows a review time of significantly less than 30 days and will ensure that these appeals are expedited leveraging an existing method.

**Network Adequacy**

Another way in which Congress can improve Americans' access to mental and behavioral health services is by addressing network adequacy. Network adequacy has been an issue in the mental and behavioral health service sphere for quite some time. While attempts have been made to make improvements in this area, there is still a significant amount of ground to cover. There are 119.3 million Americans that live in areas designated as "Mental Health Professional Shortage Areas."[2] Often it is difficult for patient to locate a provider that accepts insurance at all, much less participates in their insurer's network. If a provider does participate, that participation may not be consistent resulting in provider directory inadequacy. A survey of privately insured patients found that 53 percent of those that used provider directories found inaccuracies in their insurer's provider directory, often leading them to receive care from out-of-network providers.[3]

NAHU recommends that Congress consider incentives to encourage providers to participate in network plans including plans that use mental health carve-outs, as well as increase incentives for plans with mental health carve-outs to contract with willing MHSUD providers, possibly by increasing the percentage of the Medicare rate at which they are reimbursed. We also recommend increasing incentives for carriers with mental health carve-out plans to expedite the contracting process, and prioritize updating provider lists. The contract negotiation process between carriers and providers is a source of inefficiency, as the process can take a significant amount of time and can add yet another barrier to receiving care.

**Collaborative Care Model**

One glaring cause of inefficiency impeding Americans' access to mental and behavioral health is the lack of communication between behavioral health and primary care providers. Since mental and behavioral health is often not integrated with primary care, this leaves patients with undiagnosed or poorly managed mental and behavioral health conditions, despite the fact that mental and behavioral health conditions often initially appear in a primary care setting.

Currently, primary care clinicians provide mental health and substance use care to the majority of people with mental and behavioral disorders and prescribe the majority of psychotropic medications. NAHU believes that a collaborative care model that incorporates behavioral health and primary care could significantly decrease

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[2] September 30, 2020. Mental Health Care Health Professional Shortage Areas (HPSAs). Kaiser Family Foundation. *https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

[3] Busch, S. and Kyanko, K. June 2020. Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs.* Retrieved February 1, 2020 at *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.*

the weight of other illness, lessen the demand for mental and behavioral health services, and thereby lower medical costs and reduce disparities in identification and the effectiveness of treatment for behavioral health issues.

**Telehealth**

Because of the pandemic, rules related to all aspects of telehealth, including tele-behavioral health (TBH), have been loosened. This has resulted in immense increase in the use of tele-behavioral health services, enabling cross-state care which has been critical to underserved areas and rural communities. TBH has the potential to overcome patient stigma and improve access and efficiency of care for mental and behavioral health services. In general, when patients keep their first appointment, they are more likely to keep subsequent appointments; and when patients are satisfied with treatment, they are more likely to continue with their course of therapy which could lead in a decrease in cost for treatment of an individual over the course of their care.

Unfortunately, many older adults and people with disabilities, lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have them. Likewise, many in ethnic and low-income communities lack access to broadband or video-enabled devices, which only expands the health inequities in the U.S. Due to this, NAHU recommends eliminating cross-state border restrictions on tele-behavioral health, permanently, as well as adopting technology-neutral requirements, permitting use of different types of technology platforms that are designed for telehealth.

**Mental Health Parity**

Fully insured and self-funded ERISA plan sponsors are required to comply with the quantitative treatment limits imposed by the Mental Health Parity Act. However, fully insured and ERISA plan sponsors have no control over the non-quantitative treatment limits associated with Mental Health parity laws since they rely on their intermediaries such as third party administrators to monitor and comply with network adequacy requirements for access to mental and behavioral health care. There have been several lawsuits related to the non-quantitative treatment limits of mental health parity laws. NAHU recommends that the federal government create a safe harbor status for fully insured and self-insured ERISA plan sponsors which rely on independent certification of compliance with Mental Health parity requirements as included in the MHPAEA and most recently the Consolidated Appropriations Act of 2021.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595–0639 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
CEO, National Association of Health Underwriters