COALITION FOR WHOLE HEALTH

November 1, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: **Stakeholder input on improving access to mental health and substance use disorder care**

Dear Chairman Wyden and Ranking Member Crapo:

The Coalition for Whole Health is a broad coalition of local, State, and national organizations in the mental health and substance use disorder (MH/SUD) prevention, treatment, and recovery communities. The Coalition has worked together for over 10 years to improve coverage for and access to the full range of effective MH and SUD services, supports, and care. We appreciate the opportunity to provide the Committee with recommendations about how Congress can strengthen access to MH/SUD care.

Almost one in four adults (24.5%, or 61.2 million people) in the United States is living with a mental illness, substance use disorder, or both. Approximately one in five adults (20.6%, or 51.5 million people) is living with a mental illness. Additionally, 20.4 million people ages 12 and older had a substance use disorder in 2019.

Suicide is the tenth leading cause of death in the United States, and the second leading cause of death for people ages 10 to 34. New CDC data indicates that nearly 80,000 people died of drug overdoses between June 2019 and May 2020, the highest number of overdose deaths ever recorded during a 12-month period. Overdose mortality rates have continued to rise among Black, Asian, Latinx, and indigenous Americans as well as among older adults. These devastating statistics are unfortunately worsening due to the COVID-19 pandemic, as U.S. adults report experiencing worsening mental health, increased substance use, and greater suicide ideation in June 2020, with younger adults and people of color being hit the hardest.

Improving coverage for and access to high quality mental health and substance use disorder (MH/SUD) care will help people, families, and communities to become healthier and to lead better lives. There is a critical need, and a tremendous opportunity, for Congress to take swift and decisive action to strengthen access to MH/SUD care.

Recommendations: Strengthening the workforce

The infrastructure of the MH/SUD field must be strengthened to ensure there is adequate capacity to help the millions of Americans who are currently unserved. As documented by the Institute of Medicine and other public health experts, the MH and SUD service fields faces a serious shortage of workers, an aging workforce, unacceptably low counselor salaries, the need for a more diverse, culturally effective workforce, and the continuing stigma associated with MH/SUD. In addition to the need for investment in educational and training opportunities for MH/SUD workforce professionals, career development and loan forgiveness within the MH and SUD fields, and a diverse and culturally and linguistically effective workforce, there is a dire need to integrate more linkages to the medical field.

- Congress should **prioritize building a diverse, inclusive MH and SUD workforce**, including through greater use of incentives and required joint SAMHSA/HRSA/CMS guidance on ways to strengthen recruitment, retention, and career development so that the MH and SUD workforce (staff and leadership) is representative of the people being served. These efforts should include peer support workers and community health workers. Congress should increase HRSA funding for these purposes.
- Congress should require HHS to work with DOL on joint guidance, technical assistance, and funding initiatives to **strengthen employment opportunities for people with MH and SUD**, including ways to better support people with lived experience building careers in the MH and SUD service workforce.
- Congress should swiftly pass the **Excellence in Mental Health and Addiction Treatment Expansion Act**, extending and expanding the Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration program.

Recommendations: Increasing integration, coordination, and access to care

Racism in our systems, laws, policies, and practices has led to Black and brown people having poorer access to quality health care and more adverse encounters with the health care system when they do access care. Better addressing health care needs, including MH/SUD, with health responses is critically important to helping people avoid contact with the criminal legal system and ensuring that transitions from jail and prison to the community are successful. To promote more equitable access to MH/SUD care, Congress should:

- Increase HHS funding to **strengthen the infrastructure of community-based culturally and linguistically effective care**. Funding should incentivize states and localities to develop policies and practices that are driven by and responsive to community needs and ensure equitable access to high quality MH and SUD care in every community.
- Require HHS to detail the agency's plans to **improve the health outcomes of Black, brown, and other people of color** and to strengthen access to culturally and linguistically effective community-based care, including MH and SUD care.
- Require every state, territory, and locality to **collect, analyze, and publicly report on health (including MH/SUD) outcomes by race, ethnicity, primary language, and disability status**.
- Pass legislation that encourages state and local governments to **utilize MH/SUD diversion programming as an alternative to arrest and incarceration**. Legislation should include provisions to ensure program admission and retention criteria is equitable and require data collection and reporting on race, ethnicity, sexual orientation and gender identity of program participants.
- Pass into law the **Medicaid Reentry Act**. Congress should also appropriate discretionary funding to **strengthen reentry planning and improve access to high quality culturally and**

linguistically effective health care, including MH and SUD services, prior to release to strengthen continuity of care in the community.
- Significantly increase funding for **effective crisis interventions**, including mobile crisis teams, led by and staffed with teams of mental health MH and SUD experts and people with lived experience rather than law enforcement, to respond 24/7 to emergency calls related to people experiencing a health in crisis.
- Increase funding for **effective harm reduction services**, including syringe exchange services, and should fund demonstrations for overdose prevention sites.
- **Protect the safety net** by increasing funding for programs, including the SAMHSA Block Grants, FQHCs, TANF/SNAP, SSI/DI, and federal housing assistance, that fund essential services and supports for uninsured or underinsured people with MH and SUD care needs.
- Appprove a **permanent reauthorization of the Money Follows the Person** program which includes provisions to ensure equitable access, particularly for people of color.
- Make **HCBS a mandatory Medicaid benefit** and should expand and strengthen the HCBS infrastructure by passing the HCBS Infrastructure Investment Act.

To strengthen coordination of and integration with physical health care, Congress should:
- Require CMS to issue **guidance to states on ways to more effectively deliver MH and SUD care in medical settings**. Congress should look to integration work of the Health Resources and Services Administration (HRSA), Veterans Affairs (VA), and the Department of Defense (DOD) over the past 10 years which has demonstrated that introducing MH and SUD services in medical settings improve health outcomes and lower costs.
- Require CMS, SAMHSA, and HRSA to **jointly work to strengthen more seamless access to MH, SUD, and physical health care**; this should include the issuance of joint HRSA/SAMHSA guidance and incentive payments to community health centers to partner with community-based MH and SUD care providers.
- Require HHS, CMS, and the Department of Labor (DOL) should **create incentives to encourage all payors to reimburse for integrated care**, such as through the Collaborative Care Model, thereby improving the quality of patient care and ensuring greater financial sustainability for providers.
- Increase funding to:
  - Incentivize health care providers to **implement integrated care**
  - **Train clinical care staff**
  - **Support health information technology**
  - **Invest in Electronic Health Records**, and
  - **Formalize collaboration agreements between primary care and MH/SUD care providers** and to improve referral coordination and communication.
- Require CMS to issue guidance on how states can **implement** the Certified Community Behavioral Health Clinic (CCBHC) and Prospective Payment System **financing models** via Medicaid Waiver or State Plan Amendment.
- Extend the **CCBHC program as a combined Medicare/Medicaid demonstration**.

Recommendations: Ensuring parity between MH/SUD and physical health care

Coverage and reimbursement of the full range of effective MH/SUD services, medications, and supports must be comprehensive and consistent across payer types. Despite passage of the federal Mental Health Parity and Addiction Equity Act (Parity Act) over a decade ago, implementation and enforcement of the law have been uneven, and thus people needing care for MH/SUD often face discriminatory insurance barriers. The Parity Act mandates that health insurance plans' standards for MH and SUD benefits be comparable to, and be no more restrictive than, the standards for other medical/surgical benefits. Yet

individuals and families seeking care across the country are often rightly overwhelmed by the difficulty in finding accessible and affordable treatment for MH/SUDs through their insurers. During the especially difficult time of dealing with crises related to a SUD or mental illness, this experience of not being able to find or afford care can be truly devastating. People who are not able to access the appropriate level or amount of care, including appropriate FDA-approved medications, rely on more costly and less effective care, such as repeated use of hospital emergency departments.

Despite the growing need for services, Medicare's coverage of MH, SUD, and co-occurring disorder care is strikingly limited and out of sync with evidence-based treatment models and the current delivery systems of MH and SUD treatment. Unlike most private and employer-based insurance and Medicaid plans, Medicare is not subject to the 2008 Mental Health Equity and Addiction Parity Act (Parity Act). Medicare coverage is particularly weak for patients with SUDs. A significant number of Medicare beneficiaries need SUD treatment, but Medicare does not cover essential SUD benefits or services. Approximately 1.7 million Medicare beneficiaries report having a SUD, yet only 11% received any SUD treatment in the past year (6% for beneficiaries over age 65, and 17% for those with long-term disabilities under 65).[1] Among those who did not get SUD treatment, 38% of Medicare beneficiaries over age 65 (and 28% of those under 65) reported financial barriers – including insurance not covering treatment – as a reason. Comprehensive and non-discriminatory coverage of MH and SUD benefits and providers in Medicare is necessary to ensure access to treatment and continuity of care.

To ensure greater parity of MH/SUD with physical health, Congress should:

- **Require plans to annually submit Parity Act compliance reports** and quantitative data and ensure that parity **violations are resolved prior to sale** of or enrollment in the plan.
- Require the agencies with federal enforcement authority for the Parity Act to **issue guidance on the requirement that all medical necessity determinations for MH/SUD care be based on generally accepted standards of care** and clinical appropriateness that have been applied faithfully, and that all health plans are required to comply with the Parity Act's disclosure requirements of medical necessity criteria.
- **Reduce barriers** to medications for opioid use disorder by **directing state Medicaid programs to reduce prior authorization and other utilization management barriers to medications for opioid use disorder** (MOUD).
- **Pass legislation to require all health insurance carriers to submit Parity Act compliance reports** and quantitative data with consistent standards on an annual basis and ensure that parity violations are resolved prior to sale of the plan. Congress should further require HHS, CMS, DOL, and State Insurance Departments to report annually on parity enforcement activities.
- **Enhance reimbursement rates for MH/SUD providers** to improve networks and establishing adequate rates for any bundled episode of care payments for services across the continuum of care.
- **Remove utilization management practices** that impose unnecessary barriers to care, such as prior authorizations for MOUD and medical necessity reviews that are not comparable to and more stringent than those for medical/surgical benefits.
- **Extend the Parity Act to Medicare** in the same way it applies to most Medicaid and private insurance plans. Both traditional Medicare and Medicare Advantage plans must be prohibited from imposing discriminatory quantitative or non-quantitative treatment limitations for SUD or mental health care. Some of the most problematic limitations include discriminatory reimbursement rate setting practices, inadequate networks, and burdensome utilization

[1] Parish, W. J., Mark, T. L., Weber, E., & Steinberg, D. (2021). Substance use disorders among Medicare beneficiaries: Insights from analysis of the National Survey of Drug Use and Health. *Working paper*.

management practices such as prior authorizations and quantity limits for services and prescription drugs.

- **Close SUD coverage gaps in Medicare** by:
    - A**uthorizing the Full Continuum of SUD Services**
        - ***ASAM Levels of Care***: Congress should authorize delivery of and reimbursement for all ASAM levels of care, including: intensive outpatient programs (IOP), partial hospitalization programs (PHP) for individuals with SUDs, and all levels of residential treatment.
        - ***Crisis Services***: Congress should authorize delivery of and reimbursement for crisis services that meet the holistic needs of people with SUDs, including mobile crisis team services and crisis stabilization services. Access to affordable and comprehensive crisis services in the community is necessary to implement the new 988 suicide prevention helpline and save lives. These services must focus on recovery-oriented care, incorporate a significant role for peers, and utilize community-based partnerships to divert people in crisis away from law enforcement.
        - ***Contingency Management***: Congress should authorize delivery of and reimbursement for contingency management services for the treatment of methamphetamine use disorder and other SUDs to meet the growing demand for treatment of these conditions.
    - **Authorizing Community-Based Settings Where SUD Care is Delivered:** Congress should authorize delivery of and reimbursement for community-based SUD treatment facilities, in the same way it authorizes community mental health clinics and other similar treatment settings.
    - **Authorizing and Appropriately Reimbursing the Full Range of SUD Practitioners**: Congress should authorize delivery of and reimbursement for SUD services by Licensed Professional Counselors, Certified Alcohol and Drug Counselors, and Peer Support Specialists. Congress should also eliminate the current reimbursement percentage decrease for psychologists and licensed clinical social workers (85% and 75% of physician fees) and identify a fair reimbursement rate.
- **Congress should eliminate the 190-Day Lifetime Limit in Medicare for Inpatient Psychiatric Care**: Congress should eliminate the discriminatory limit that prevents patients from receiving inpatient psychiatric care for more than 190 days over their lifetime, when such a limit does not apply to medical conditions.

Recommendations: Furthering the use of telehealth

While telehealth has already proven to be an effective tool for helping rural Americans access MH/SUD care, the COVID-19 pandemic has illustrated that telehealth can help meet MH/SUD care needs for people across the country to limit risk of exposure to the virus and conserve resources while delivering high quality and effective care. As the demand for MH/SUD services continues to grow during the pandemic, with an exacerbated effect on Black and brown individuals, it is essential to expand telehealth to promote safety, access to MH/SUD care, and quality outcomes. Any expansions must also be coupled with investments in broadband and other resources to reduce the digital divide to ensure that all people – regardless of their income, race, geographic location, or technological literacy – can use telehealth, including audio-only telephone calls.

Congress should:

- **Revise CMS's definition of telehealth** in the Medicare program to authorize and allow reimbursement for **audio-only service delivery**. Congress should also require CMS to make clear that Medicare beneficiaries with MH conditions can receive MH services in their homes, as it did

for beneficiaries with SUDs, and to **expand the definition of home** to be wherever the patient is located to meet the needs of patients who are experiencing homelessness and those who lack privacy or safety in their home. Congress should also require CMS to **cover phones as durable medical equipment**.

- **Make permanent the regulatory flexibilities granted to expand telehealth** – including audio-only telephone calls – access during COVID-19, particularly those related to access of MH, SUD, and co-occurring disorder services. This includes **allowing patients in Opioid Treatment Programs to continue to initiate mediations for addiction treatment (MAT) via telehealth** without an in-person evaluation and increased take home doses.
- Incentivize and approve **interstate provider compacts** to address the needs for people to receive culturally and linguistically effective MH and SUD care via telehealth when such providers are not available where patients are physically located.
- **Allocate targeted funding to help patients** with MH/SUD get technology, WiFi, broadband, phone minutes, and other resources to **facilitate their use of telehealth and mitigate the digital divide**.

Recommendations: Improving access to behavioral health care for children and young people

Medical experts agree that MH and SUD are diseases that can be prevented. In addition, research shows that MH/SUD prevention and early interventions reduce the incidence of other costly co-occurring chronic illnesses such as diabetes, hypertension, heart disease and certain cancers in both individuals and their family members. Early intervention must also address the health and social determinants of health needs of the individuals, rather than promote family separation or punitive responses.

Many adults with MH/SUD developed these conditions as children or young adults—half of all lifetime cases of mental illness begin by age 14 and adolescents who use alcohol and other drugs are much more likely to misuse drugs and alcohol as adults. Targeted youth prevention and early intervention can help mitigate many of the adverse outcomes associated with these conditions. The federal government can expand value-based payment models, support effective community-based programming, dedicate resources, and issue guidance to help school systems and states promote overall wellness and ensure early access to MH and SUD services.

Funding, data collection, and coordination with other agencies – including Medicaid, SAMHSA, and CDC – are necessary to support the 14 million students that are in schools with law enforcement officers but no counselors. Such efforts are critical to prevent students with disabilities and Black and brown students from unnecessary and harmful discipline that contributes to the school-to-prison pipeline, when we can be addressing their MH and SUD needs as well as social determinants of health. At the same time, the federal government must allocate greater resources and funding to the communities, so that youth and families have opportunities outside of school to get the supports and services they need.

Addiction and mental illness have also had a disproportionate and devastating impact on children and families. The stress and trauma of these illnesses when unaddressed can serve as adverse childhood experiences (ACEs) that can lead to social, emotional, and cognitive impairments and an increased likelihood of chronic disease in later years. Prevention and early interventions help to ensure that children in high-risk environments can minimize their own risk of MH/SUD, and unnecessary involvement with the criminal legal system, and stay in school and build healthier relationships.

Congress should:

- Ensure **close collaboration and coordination of the federal agencies with oversight over youth programming**, including SAMHSA, CDC, the Office of National Drug Control Policy

(ONDCP), the Surgeon General, and the Department of Education (DOE) through joint guidance, funding initiatives, and technical assistance to the field.

- **Appropriate financial incentives to encourage collaboration** at the state and local levels between those implementing public health and MH/SUD prevention and mental health promotion strategies and interventions.
- **Bring to scale** programming that is effective in **addressing Adverse Childhood Experiences and building resiliency**.
- Require HHS to **prioritize integrated pediatric primary care** to reduce the incidence of adult MH and SUD.
- Ensure that the **988 roll out** can be as effective as possible by **addressing the infrastructure, staffing, and training needs** across the country.
- Support **pre-natal and peri-natal screening for maternal depression and SUDs**, as well as **referral into treatment** for those who need care.
- Explicitly allow **ESSA funding to be spent on a broad range of MH/SUD professionals**, including peers; comprehensive MH/SUD prevention, early intervention, and treatment services; and restorative justice and non-punitive disciplinary practices in schools. Congress should encourage schools to **limit the use of punitive zero-tolerance and other exclusionary discipline practices**.
- Expand support for **substance use recovery support services to youth and young adults** enrolled in high school or an institution of higher education and build communities of support for youth and young adults in substance use recovery, including peer support services.

Congress should increase funding for:

- **Effective substance use prevention and mental health promotion programming**, including through SAMHSA and CDC.
- **Public education on suicide prevention**, screening, recognition, and response, and ensure that resources that are effective in preventing suicide are widely available.
- Title IV, Part A of ESSA to support **hiring at least one full-time behavioral health clinician in every school.**
- **Youth peer supports**.
- **The Prevention and Public Health Fun**d.
- The **public health infrastructure** and strengthen the public health workforce.
- **Mental health awareness trai**nings like Mental Health First Aid and target specialty populations including youth and teens, first responders, law enforcement officers, and active military and veterans.
- NIH to support additional **prevention-related research**.

We appreciate your consideration of these recommendations; if you have any questions, or would like any further information, please contact Gabrielle de la Guéronnière (gdelagueronniere@lac-dc.org). Thank you. We look forward to working with you.