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To: Senate Finance Committee Chairman Ron Wyden and Ranking Member Mike Crapo

From: Community Catalyst

Date: November 9, 2021

Re: Response to Public Request for Policy Proposals to Enhance Behavioral Health Care

Dear Chairman Wyden and Ranking Member Crapo:

Community Catalyst appreciates this opportunity to respond to your September 21, 2021 [request for information](#) regarding data-driven legislative proposals *“that will improve access to health care services for Americans with mental health and substance use disorders.”* We support the Senate Finance Committee’s efforts and offer our input on how to transform the system of treatment and services for mental illness and substance use disorders to meet people’s needs.

We offer recommendations grounded in two decades of work with communities, policymakers and providers across the nation to improve access and equity in health care, driven by what communities need.

[Community Catalyst](#) is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. Our Program on Substance Use Disorders and Justice-Involved Populations works to advance racial justice by centering community needs, particularly of those most marginalized, and advocating for policy and practice changes to ensure addiction is treated as a health issue and not a criminal one. The program has focused extensively on improving access to and quality of services. In addition, Community Catalyst’s [Center for Consumer Engagement in Health Innovation](#) has helped advance health system transformation and integration of physical health, behavioral health and long-term services and supports. In our comments, we focus mostly on substance use disorders.

We believe that long-term solutions require comprehensive strategies that extend beyond the scope of the Senate Finance Committee and will require broad congressional support. We start here with a brief description of those strategies and specific “reach” goals. Following this, we turn to specific recommendations within the Committee’s jurisdiction that we believe can gain bipartisan support.

Reach goals and comprehensive strategies

- **We need universal health insurance coverage for everyone in the United States; closing the Medicaid coverage gap is one major step in that direction.** Medicaid expansion gives more people access to needed services for substance use disorders. Most people who need treatment and services for substance use disorders are not able to access them. Lack of coverage is a major reason. A [recent study](#) shows a drastic increase in the number of people seeking and receiving treatment for substance use disorders in Medicaid expansion states. People of color remain disproportionately without insurance in states that have not expanded Medicaid, and people of

color face more barriers to accessing substance use disorders treatment than their white counterparts. Implementing Medicaid expansion in all states will help narrow racial inequities in health coverage and remove a significant barrier to treatment, services and recovery. **The alternative path for Medicaid expansion in the Build Back Better proposal is an excellent step forward.**

- **In addition, we recommend specific improvements to Medicaid and Medicare:**
 - **Increase the federal matching rate for substance use disorders and mental health services** by passing the Medicaid Bump Act, [S.1727](#), and prioritizing the funds for increasing integration of services with physical health care. Increasing federal funds to support behavioral health in state Medicaid programs would help states more fully address the needs of people with substance use disorders and mental illness in their states.
 - **Require coverage for recovery support services including those provided by peers in Medicaid and the ACA marketplace plans.** Requiring coverage for these services instead of leaving coverage optional would improve health outcomes since more people could access these non-clinical wrap-around supports.
 - **Modernize Medicare to cover the full continuum of substance use disorders services**, including all [American Society of Addiction Medicine](#) levels of care and crisis services. In addition, authorize Medicare to include a full range of health care providers who treat substance use disorders including peers and certified alcohol and drug counselors, expand the Mental Health Parity and Addiction Equity Act to Medicare, and remove the 190-day lifetime limit for inpatient psychiatric care. Older adults and people with disabilities experience substance use disorders but Medicare now leaves them with scant options for covered services. The Medicare improvements we recommend are essential to ending these discriminatory policies, and helping people with substance use disorders better access the care they need. Please refer to Legal Action Center's resource [Modernize Medicare to Treat Substance Use Disorders: A Roadmap for Reform](#) for more information.
- **We recommend fully integrating substance use disorders and mental health services into the health system, and expanding funding for the full continuum of services delivered through Medicaid, Medicare, CHIP, the ACA Marketplaces and other private insurance.** This continuum includes prevention and early intervention, including harm reduction and crisis services; inpatient and outpatient treatment; and residential services and long-term peer recovery supports, including those provided by Recovery Community Organizations. We also recommend full implementation of parity across substance use disorders, mental health, and physical health services. We recommend an intensive and tailored focus on children and young people to prevent harmful substance use later in life.
- **We recommend collaboration among the U.S. Department of Health and Human Services [Office of Minority Health](#), the Centers for Medicare and Medicaid Services (CMS) [Office of Minority Health](#), and the [Office of Behavioral Health Equity](#) at the Substance Abuse and Mental Health Services Administration** to ensure all health system transformation efforts enhance local service delivery, center solutions that will improve health outcomes and empower the most marginalized communities.
- **We recommend investment in comprehensive public health solutions to addiction through community centered approaches such as those outlined in [S.1365 - Comprehensive Addiction Resources Emergency Act \(CARE Act\)](#).** The CARE Act would be an important public health

response to addiction, reducing health inequities by focusing on community investment and planning councils that are representative of the community and reflect community needs.

- **We recommend diversifying the health care workforce, particularly in the fields of mental health and substance use disorders**, by following the [American Medical Association's recommendation](#) to dedicate “funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.” We recommend coupling these efforts with other strategies to address financial barriers to education, particularly among Black and brown communities, by dedicating more funding to the National Health Service Corps (NHSC) and other scholarship and loan forgiveness programs to expand providers in the substance use and mental health fields. We also recommend expanding the NHSC and the Rural Community Loan Repayment Program to include peer recovery support workers and Recovery Community Organizations.

While full transformation of the health system will require actions across federal programs, and commitment at the local, state and national level, there are a number of steps the Committee can take to improve behavioral health services in the U.S. We now outline for the Committee specific problems we suggest you focus on, and recommendations the Committee can act on.

THE PROBLEMS

The recently released [2020 National Survey on Drug Use and Health](#) found that only [6.5 percent](#) of the more than 40 million people ages 12 and older with a history of substance use disorder received treatment. [Common reasons](#) individuals who wanted treatment reported not being able to access it include lack of health insurance, treatment cost, not finding the kind of treatment they wanted, and stigma. Even before the COVID-19 pandemic, the unmet need for mental health and substance use services in the United States was significant, and data suggests these conditions worsened for many people during COVID. As a nation we face compounding problems—a shortage of quality services and providers across the continuum of care (i.e., harm reduction, prevention, early intervention, crisis, treatment and recovery) and multiple barriers to access, including gaps in health insurance coverage, bifurcated mental health and substance use treatment systems, stigma, and discriminatory practices. Research shows that [barriers are greater](#) for African-American and Latinx populations compared to white populations. All of these health care problems hit communities of color and other [marginalized groups](#) hardest.

- **Workforce shortages, and not enough diversity of providers to reflect community needs:** There is a national shortage of mental health and substance use providers across all settings, [especially for children and adolescents](#) who are [most at risk](#) for developing addiction as a result of substance misuse. Research suggests that youth are [more likely](#) to access support and [complete treatment](#) when mental health services are [provided in schools](#), but the [latest national data](#) suggest schools don't have the behavioral health personnel needed to adequately provide this support. This provider shortage creates barriers to care across the continuum. In addition, the lack of provider diversity, including [racial and ethnic diversity](#), results in a workforce that neither represents nor adequately serves the communities most in need. Many systemic factors contribute to this provider shortage: inadequate reimbursement rates, limited funding for

community providers, licensing and certification issues, convoluted billing processes (especially for schools), and a lack of quality training and medical education.

- **Reimbursement rates for mental health and substance use service providers are significantly lower than for medical providers – an issue of parity** – leading to poor network participation and [maldistribution](#) of providers. [Studies show](#) that few health insurers adequately reimburse for mental health services, reducing the incentive to provide comprehensive care and creating barriers to access.
- **Insurance coverage for substance use disorders treatment and services is not comprehensive and services don't meet quality standards:** Insurance does not cover the full continuum of substance use disorders services and supports. For example, Medicare does not cover essential intermediate levels of care such as intensive outpatient/partial hospitalization services and residential services, and Medicaid does not require coverage of recovery support services, including those delivered by peers. For people who are able to access care, it is difficult to find high quality services based on their priorities and needs. Because of the paucity of quality measures for substance use disorders services, many patients and their caregivers do not have the information they need to make informed decisions about treatment and recovery support services, leaving them at greater risk of the harmful consequences of addiction. Gaps in full enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) mean discriminatory practices persist, making it even harder for people to get the care they need. Results from Legal Action Center's study "[Parity Tracking Project: Making Parity a Reality](#)" detail the many issues with parity enforcement across the country. Specific to youth services, an [examination](#) of Medicaid fee schedules, federal statutes and clinical practice guidelines suggest that many state Medicaid plans and private health insurers do not cover children's behavioral health services to the degree required by federal law.
- **Behavioral health care is siloed from other health care and is not coordinated:** In addition to the provider shortage, the lack of behavioral health integration and care coordination create significant barriers to access and quality. Mental health and substance use services aren't included as standard practice in primary care for either adults or youth. Specialty care continues to operate in silos. While some integration efforts are underway, they typically include mental health but exclude substance use services. Gaps in services can lead to recurrence of illness, serious consequences, and can even be fatal; this is especially true for people returning to their communities after incarceration. Addiction continues to be criminalized and about [two-thirds](#) of the U.S. prison population has a substance use disorder. People reentering the community after incarceration are [129 times](#) more likely to die of an overdose than the general population. Again, this hits communities of color hardest because of mass incarceration of Black and brown people especially through the punitive policies of the [War on Drugs](#).
- **Telehealth advancements are in jeopardy:** While telehealth provides one promising opportunity to expand access to care, the progress made during the COVID-19 pandemic is now in jeopardy because many of those policy changes are limited to the duration of the COVID-19 public health emergency. Although CMS's new physician fee schedule extended some flexibilities, more are set to expire or can't be fully in effect without congressional action (e.g. eliminating geographic restrictions on originating sites). If telehealth again becomes more restricted, it will particularly harm patients facing mental health and substance use challenges in rural locations and other areas with provider shortages.

- **Lack of connection with social services:** [Eighty percent](#) of health outcomes are determined by social determinants of health (SDOH), including factors such as access to nutritious food, transportation, employment, housing, social supports, and reduction or elimination of discrimination. Housing and several other factors are particularly important for the recovery of people with substance use disorders and mental illness, but few treatment programs fully [combine substance use treatment and mental health services with social supports](#), and this is particularly lacking for people returning to the community from incarceration.

We agree with the Committee that our nation must move to address these huge gaps in access to life-saving and life-improving services for substance use disorders and mental illness. Our recommendations below aim to address these issues, and include strategies for expanding the behavioral health workforce for youth and adults; improving coverage and quality of care; improving integration and care coordination, increasing access through telehealth, and building holistic models of care by integrating social services into health care delivery.

THE RECOMMENDATIONS:

To build a diverse behavioral health workforce, we recommend the Committee:

- **Increase support for Graduate Medical Education (GME) and Children’s Hospitals Graduate Medical Education (CHGME) programs.** We recommend the Senate Finance Committee increase the number of GME positions in substance use disorders and mental health, especially in rural areas, communities harmed by the War on Drugs, communities hardest hit by the overdose crisis, health professional shortage areas, and other designations for highest need, lowest resourced areas. Targeted GME investment in these areas will help advance health equity. The Committee could include targeted behavioral health positions in [S.834 - Resident Physician Shortage Reduction Act of 2021](#), a bipartisan bill to authorize 2,000 medical residency positions per year over seven years (14,000 total), or the Committee could amend the language in the House Build Back Better bill. Because GME funding is not directed toward children’s hospitals, we also recommend direct investment into the pediatric workforce through increased funding for CHGME. Specific slots for pediatric addiction and mental health providers could be added to the Children’s Hospital Association’s specific [CHGME funding recommendations](#). Please refer to [Community Catalyst’s previous work on this topic](#) about how increasing CHGME resources can address the pediatric workforce shortage.
- **Authorize grants for states to expand their school-based behavioral health workforce, building on promising state models.** Research shows that adolescence is a critical time for preventing and treating [mental illness](#) and [substance use disorders](#), and youth are [more likely](#) to access services and complete treatment in schools than in community-based settings. However, most schools do not have the staff needed to meet the demand for school-based care. New grant funding for school-based behavioral health workers – following models like [Oklahoma’s School Counselor Corps](#) – could help meet the demand. Multi-year funding is critical to ensure school take up and enough time to sustain a new workforce.

- **Attract more providers by expanding reimbursement for mental health and substance use services in Medicaid and Medicare.**
 - **Increase Medicare Reimbursement Rates for Clinical Social Workers (CSW) and others who provide mental health and substance use services.** For example, build on Medicare: [S.870 - Improving Access to Mental Health Act of 2021](#), which would align Medicare payment for CSWs with that of most other non-physician providers by increasing the reimbursement rate from 75% to 85% of the physician fee schedule.
 - **Authorize grants accompanied by technical assistance that support state innovation to expand the types of providers eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit reimbursement.** [New York's Family and Treatment Support Services program](#) delineates eligible providers by specific services (e.g., assessment, planning, coordination) rather than broader service buckets (e.g., crisis intervention), allowing more types of health professionals to deliver services according to their skill and qualifications. This model maximizes the ability of the existing workforce to provide behavioral health EPSDT services to young people.
- **Pass the Ensuring Access to Primary Care for Women & Children Act, [S.1833](#),** and expand primary care provider education on screening for substance use disorders. The legislation would help improve youth access to screening in primary care by ensuring payment parity in Medicare and Medicaid for primary care providers.

Additional recommendations related to expanding and diversifying the peer workforce are described below, in the context of expanding access to recovery support services.

To strengthen parity enforcement, improve health insurance coverage for behavioral health, and improve quality of services for mental health and substance use disorders, we recommend the Committee:

- **Expand MHPAEA to apply parity requirements to Medicare, all of Medicaid, and Tricare.** We also recommend eliminating the option for self-funded non-federal government plans to opt out of MHPAEA, as recommended by President Obama's Parity Task Force.
- **Strengthen parity enforcement by authorizing the Department of Labor to issue monetary penalties for parity violations, as included in the House Build Back Better bill:** Studies and reports from patients continue to show that health plans are not fully complying with the Mental Health Parity and Addiction Equity Act. Patients continue to be denied essential and life-saving treatment. Authorizing the Labor Department to issue these fines will help patients get the services they need. This is especially important now, as the COVID-19 pandemic has increased the need for comprehensive, equitable services for substance use disorders and mental health.
- **Dedicate funding for state mental health/substance use disorders ombudspersons to educate and support consumers on parity issues.** Please see detail in this [Model State Parity Law](#).
- **Authorize multi-year grant funding accompanied with technical assistance to states to expand adult and youth Medicaid recovery support services, and increase the peer workforce.** Recovery support services are essential community services and supports, including housing, employment support, counseling, peer coaching, and other non-clinical services that help individuals live healthy lives. We recommend the Committee fund innovative approaches to

increasing recovery support services. We recommend the grant and technical assistance program include a focus on how states can expand their adult and youth peer support workforce, building on promising state models. Too often in the U.S., health care models—including the providers themselves and care delivery—don't reflect community membership or community needs, whether community is defined by race or ethnicity, geographic area, culture, particular health conditions, or another identifying factor. To bridge this divide, community-driven workforce models, including peers, empower community members to care for their fellow community members. Strengthening the peer workforce is an essential element of promoting health equity, and diversifying and growing the substance use provider workforce. Peer support services have been [shown](#) to reduce depression, anxiety, substance use, and other behavioral health conditions, reducing hospital stays and increasing treatment effectiveness. Peer support works for youth and adults, and would also serve as a [bridge to services](#) for many people who need treatment but currently don't seek it. Increased funding to establish peer services would help states meet increased demand for behavioral health services, connect more people to services, and assist people with lived experience in building behavioral health careers. The programs could subsequently be sustained through the existing state Medicaid option. Promising models to train youth peers include [PeerPlus](#), in Oregon.

- **Strengthen quality of services for substance use disorders by funding rapid development of outcomes measures based on patient priorities and requiring reporting on these measures** using disaggregated data in Medicaid, Medicare and ACA marketplace plans. Collecting data by demographics such as race, ethnicity and gender is necessary in order to identify where health inequities exist, and subsequently make the health system changes needed to eliminate those inequities. The [House Build Back Better bill](#) provisions regarding development of quality measures for home and community-based services provides a model for the Committee to build on for developing and implementing measures on quality and effectiveness of substance use disorders services. There are currently only a handful of validated process quality measures for substance use services. For information on how to improve the quality of health services based on the outcomes prioritized by community members, please refer to the [Peers Speak Out](#) report from Community Catalyst, Faces & Voices of Recovery, and the American Society of Addiction Medicine.

To integrate substance use disorders and mental health services with primary care and improve care coordination, we recommend the Committee:

- **Support efforts to coordinate access to and expand coverage for substance use disorders and mental health crisis services.** Crisis services, including mobile crisis response, are essential services along the continuum of behavioral health services that help connect individuals to life-saving care, yet too often these services are inaccessible, not covered by insurance, and not coordinated within the health system. We recommend the Committee support efforts to require insurance coverage of crisis services, such as building on the bipartisan Behavioral Health Crisis Services Expansion Act, [S.1902](#). Sponsored by Committee members Senators Cortez Masto and Cornyn, the bill provides a step forward by expanding the definition of Essential Health Benefits (EHB) to include crisis services, and by requiring coverage of these services in Medicare and Medicaid. We recommend the Committee support similar efforts to increase access to

coordinated crisis services, and to fund models that do not include law enforcement as first responders.

- **Sustain and expand the Certified Behavioral Health Clinics (CCBHC) program so these can be established in every state by passing the [Excellence in Mental Health and Addiction Treatment Act of 2021](#).** Funding to support the CCBHCs operating in 42 states ends in 2023. These centers integrate services for substance use, mental health and primary care, as well as crisis care, and have [dramatically increased](#) access to treatment, helped address the overdose crisis and prevented hospital readmissions.
- **Incentivize CCBHCs and Federally Qualified Health Centers (FQHCs) to strengthen integration of behavioral health and primary care through an integration bonus payment.** Under the current demonstration, CCBHCs can receive a quality bonus payment based on performance across a variety of metrics. Despite an expectation of partnership with FQHCs in the demonstration, the bonus payments are not available to FQHCs. This is a missed opportunity to further expand and strengthen integrated care at FQHCs. We recommend the Committee amend [The Protecting Access to Medicare Act \(PAMA\) of 2014](#) to make federally funded bonuses available to both CCBHCs and FQHCs that work together.
- **Incentivize primary care practices to implement the Collaborative Care model, and establish Collaborative Care Technical Assistance Centers to assist those practices by passing the Collaborate in an Orderly and Cohesive Manner Act ([H.R.5218](#)).** The Collaborative Care model increases coordinated and expedited access to both mental health and substance use disorders treatment within the office of a primary care physician, avoiding gaps in handoffs and helping to treat the whole person. But start-up costs and processes are a barrier to wider use of this model, particularly for small and rural practices. This bill would help with both.
- **Increase continuity and care coordination of health services for incarcerated individuals during their reentry to the community by passing the Medicaid Reentry Act [S.285 - Medicaid Reentry Act of 2021](#), as included in the House Build Back Better bill.** If more people were able to have continuous health coverage and access to life-saving addiction treatment through Medicaid during reentry, fewer people would die. [Evidence from Ohio's reentry program shows](#) the benefits of strengthening reentry services for individuals, in particular that "having Medicaid made it easier for them to get substance use treatment." It is essential for people upon release to have uninterrupted access to the health services they need to stay alive and stay healthy.
- **Reinstate the Medicaid Innovation Accelerator program with a focus on promoting integration of mental health and substance use services together with physical health care, and including expanded case management.** [Arizona provides an example](#) of the type of integration and coordination that other states could be assisted to establish. The state includes a Targeted Investments Program through an 1115 waiver to support integration for (1) adults and children with both physical and behavioral health needs and (2) individuals transitioning from incarceration into the community. Under the program, Arizona also provides incentive payments to providers that meet benchmarks for behavioral health integration.
- **Establish a grant program to states to build capacity for behavioral health integration, particularly to help small independent practices integrate care.** States that participated in the Center for Medicare & Medicaid Innovation's State Innovation Models (SIM) initiative received awards to advance multi-payer health care payment and delivery system reform models. Few states included a focus on improving behavioral health integration, and those that did focused

almost exclusively on mental health. Those that made progress added state resources to build infrastructure to support provider performance including health information technology and data analytics. To foster more integration of mental health *and* substance use services, we recommend the Committee create new grants focused on building infrastructure, particularly at independent practices.

To improve telehealth services, we recommend the Committee:

- **Expand Medicare telehealth coverage for mental health and SUD services by passing [S.1512 - CONNECT for Health Act of 2021](#).** Telehealth is particularly important in expanding access to behavioral health services in rural communities and other communities with provider shortages. Community members have told us expanded telehealth access during COVID-19 has been life-saving. We urge the Committee to: make permanent this expanded access, including audio-only telehealth without requirements for providers to have both audio and video (which helps people without internet); remove geographic restrictions on originating sites (i.e., the location of the beneficiary); allow the home of the beneficiary to serve as the originating site for all services; and allow initiation of telehealth at Critical Access Hospitals to serve underserved communities.
- **Remove restrictions on Medicare beneficiary access to mental and behavioral health services offered through telehealth by passing [S.2061 - Telemental Health Care Access Act of 2021](#).** There is no clinical evidence to support the requirement for patients to have an in-person visit every six or twelve months, and this requirement exacerbates health inequities by restricting access for those individuals with barriers preventing them from traveling to in-person care. We recommend the Committee remove this requirement and allow patients to access timely and appropriate care.

To integrate social services with health care delivery, we recommend the Committee:

- **Remove barriers for justice-involved population accessing the Supplemental Nutrition Assistance Program (SNAP) by passing the Making Essentials Available and Lawful (MEAL) Act of 2021 ([S.2667](#))** Successful reentry into society from the criminal justice system requires being able to meet basic needs such as food, health care, and housing as well as access to employment and training services. Denying access to basic needs programs, such as SNAP, makes it harder for people with convictions to get back on their feet. Such exclusions are grounded in stereotypes about who receives public assistance, and they are especially punitive for Black and Latinx communities due to the War on Drugs' uneven enforcement of drug laws and targeting of communities of color with low incomes.
- **Provide flexibility in multiple federal funding streams to support Accountable Communities for Health (ACH) infrastructure that strengthens integration of social supports.** Social and economic factors, including structural racism, contribute to greater prevalence of substance use disorders and mental illness, and interfere with members of oppressed communities obtaining high-quality behavioral health care. [The Accountable Health Communities Model](#), operating in 21 states, addresses a critical gap between clinical care and community services in the health care delivery system. This is a key component in achieving comprehensive mental health and

substance use disorders services for everyone, and especially Black, Latinx and Native American populations. [Emerging evidence suggests](#) that ACHs need flexible infrastructure funding for long-term success in incorporating social supports.

Thank you for prioritizing improving access to mental health and substance use disorders treatment and services. Please let us know how we can help you further.

Alice Dembner, adembner@communitycatalyst.org, who heads our Program on Substance Use Disorders and Justice-Involved Populations, is our lead on this issue.

Sincerely,

A handwritten signature in black ink that reads "Emily Stewart". The signature is written in a cursive style with a long horizontal flourish extending to the right.

Emily Stewart
Executive Director
Community Catalyst