Coalition for Whole Health
Recommendations to the Biden-Harris Transition Team to
Strengthen Access to Mental Health and Substance Use Disorder Care
Executive Summary

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 for over 10 years to improve coverage for and access to the full range of effective MH and SUD services, supports, and care. Co-chaired by Ron Manderscheid, President/CEO of the National Association of County Behavioral Health and Developmental Disability Directors and the National Association for Rural Mental Health, and Paul Samuels, Director/President of the Legal Action Center, the Coalition for Whole Health offers the below policy recommendations to improve coverage and expand access to needed MH and SUD services and care. 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.

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.

At the same time, 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 only expected to worsen as a result of 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. People living with MH and SUD are at a higher risk for contracting COVID-19, and they experience disproportionately adverse outcomes when they do receive a COVID-19 diagnosis.
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 the incoming Biden-Harris Administration and Congress to take swift and decisive action to combat these converging public health emergencies, especially as they continue to have a disproportionately adverse impact on our Black and brown communities.

Key actions the Biden-Harris Administration can take in the first 100 days include:

Achieving Health Equity

- Establishing a White House Office of Health Equity with explicit focus on the ability of Black and brown people, indigenous people, immigrants, and other people of color to access high quality clinically appropriate MH and SUD services, medications, and supports.

- Detailing HHS'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.
- Requiring every state, territory, and locality to collect, analyze, and publicly report on health outcomes by race, ethnicity, primary language, and disability status.
- Immediately restoring Section 1557 non-discrimination protections and rescinding the public charge rule.

Addressing the Needs of People with MH and SUD as a Part of COVID-19 Response

- Prioritizing for COVID-19 vaccine distribution people with MH and SUD and their service and care providers and ensure non-discriminatory, equitable access to COVID testing, treatment, and vaccination.
- Ensuring MH, SUD, and harm reduction service providers are identified as frontline essential health workers and that they have good access to PPE and vaccination.
- Requiring data collection, analysis, and public reporting of all COVID testing, cases and deaths by race, ethnicity, disability status, gender identity, sexual orientation, and age.
- Revising CMS's definition of telehealth in the Medicare program to authorize and allow reimbursement for audio-only service delivery.

Health, Not Punishment

- Incentivizing the expansion of equitable pre-arrest diversion programming to culturally and linguistically effective community-based MH, SUD, and other health care and wraparound services.
- Implementing, through CMS, Section 5032 of the SUPPORT Act, which required the agency to convene a best practices stakeholder group which would inform the development of policy guidance on continuity of care for the justice-involved population.
- Swiftly approving the several pending Medicaid Reentry section 1115 waiver applications to strengthen health outcomes as people leave incarceration.

Covering People Who Need MH and SUD Care

- Creating incentives to encourage the states that have not yet expanded their Medicaid population to do so and make regulatory changes to make Marketplace coverage more affordable for people without job-based coverage.
- Rescinding harmful Medicaid work requirement and block grant guidance and withdraw approvals of state waivers that restrict coverage.
- Removing barriers to enrollment, by expanding outreach, support for navigators and establishing a special enrollment period.

Improving Access to MH/SUD Services and Health Outcomes

- Identifying how HHS will work with Congress to secure adequate investment in the infrastructure of community-based culturally and linguistically effective MH and SUD care.
- Issuing guidance requiring plans to annually submit Parity Act compliance reports and quantitative data and ensuring that parity violations are resolved prior to sale of or enrollment in the plan.
- Issuing 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.
- Reducing barriers to medications for opioid use disorder by enforcing the SUPPORT Act requirements for coverage of all FDA-approved addiction medications in each state's Medicaid

program and directing state Medicaid programs to reduce prior authorization and other utilization management barriers to medications for opioid use disorder (MOUD).

Promoting Delivery System and Payment Reforms

- Issuing guidance to states on ways to more effectively deliver MH and SUD care in medical settings.
- Issuing Medicaid guidance to the states on ways to leverage section 1115 waiver opportunities to strengthen access to the full continuum of MH and SUD care, improve care integration for children and adults, and better meet the needs of people at risk for or who have been involved in the criminal legal system[1].

Chronic Disease Prevention, Early Intervention, and Wellness

- Detailing the Administration's plan to cohesively and comprehensively address the mental health needs of children and young people, including by addressing adverse childhood experiences, supporting early childhood development, and engaging with primary care and schools to ensure effective early intervention to keep children and young people healthy.
- Issuing guidance to states and localities on better addressing young people's prevention and early intervention substance use and mental health needs that have been exacerbated by the COVID-19 pandemic.
- Conducting outreach and engagement to inform the public about the 988 mental health crisis service.

[1] The phrase "criminal legal system" refers to the full continuum of programming provided in the community by law enforcement, in the courts, including drug and other specialty courts, at reentry from incarceration, and though community supervision including parole and probation, and in correctional settings such as jails and prisons at the federal, state and local levels. Currently there are nearly seven million people under the supervision of the United States criminal justice system, with 2.3 million people incarcerated in jails and prisons, 840,000 people on parole, and 3.6 million people on probation.

Coalition for Whole Health Recommendations to the Biden-Harris Transition Team on Improving Coverage for and Access to Mental Health and Substance Use Disorder Care

Introduction

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. Young adults ages 18-25 are experiencing mental illness at an even higher rate (29.4%). Additionally, 20.4 million people ages 12 and older had a substance use disorder in 2019.

At the same time, 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. Over 48,000 people died by suicide in 2018, and another 1.4 million people attempted suicide in 2019 alone. More than 67,000 people in the U.S. died from drug overdoses in 2018. While this number represented a small overall decrease from the previous year, overdose mortality rates have continued to rise among Black, Asian, Latinx, and indigenous Americans as well as among older adults.

These devastating statistics are only expected to worsen as a result of 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. In October 2020, mental health-related visits to the emergency department increased 24% for children ages 5-11 and 31% for children ages 12-17 compared to October 2019. People living with MH and SUD are at a higher risk for contracting COVID-19, and they experience disproportionately adverse outcomes when they do receive a COVID-19 diagnosis. There is a dire need for the incoming Biden-Harris Administration and Congress to take swift and decisive action to combat these converging public health emergencies, especially as they continue to have a disproportionately adverse impact on our Black and brown communities.

As the Biden-Harris Administration and the new Congress consider various actions to improve access to health care, including mental health and substance use disorder care, we urge policymakers to prioritize:

1. Achieving Health Equity
2. Addressing the Needs of People with Mental Health and Substance Use Disorders as a Part of COVID-19 Response
3. Health, Not Punishment
4. Covering People Who Need Mental Health and Substance Use Disorder Care
5. Improving Access to Services and Health Outcomes
6. Promoting Delivery System and Payment Reforms
7. Chronic Disease Prevention, Early Intervention, and Wellness

Issue 1: Achieving Health Equity

Summary of the Issue: 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. The COVID-19 pandemic has highlighted and exacerbated these racial health disparities. Although utilization of buprenorphine – a medication for the treatment of opioid use disorder – has increased dramatically in recent years, there has been no increase in the number of prescriptions to Black patients, such that white patients are approximately 35 times more likely to receive a buprenorphine prescription even though overdose deaths are rising faster for Black people. Providing culturally effective care requires improved data collection, analysis and public reporting – including measuring and reporting by race, ethnicity, sexual orientation, and gender identity on health outcomes – and targeted, fully funded efforts to engage communities with significant health disparities to ensure their voices and perspectives direct the solution. MH and SUD services must be tailored to meet the needs of their patients, including youth, and there must be sufficient funding – including through Medicaid and safety net funding for the un- and underinsured– to provide culturally, linguistically effective care. Investments are also needed to develop a more inclusive diverse workforce based on race, ethnicity, gender identity, sexual orientation, primary language, and disability status or lived experience with MH/SUD.

People with pre-existing health conditions, including those with MH, SUD, and other co-occurring health conditions, should continue to be able to purchase coverage at a fair price and receive treatment for those conditions, especially as the prevalence of MH/SUD is rising. Strong non-discrimination protections are essential to prohibit insurers or providers from discriminating against individuals on the basis of their illness or disability. Furthermore, the previous Administration promulgated a range of regulations that have exacerbated health disparities, including the Public Charge rule and the change to the Affordable Care Act's Section 1557 non-discrimination provision. It is imperative that the incoming Biden-Harris Administration rescind these detrimental policies that particularly exacerbate health disparities among immigrants, the LGBTQ+ community, and people whose first language is not English, and fully enforce non-discrimination protections. Each of the other sections outlined in this document also have health equity implications and we encourage the new Administration and Congress to examine any and all proposals through a racial and health equity lens.

Executive Branch Proposals

Executive Action and Cross-Federal Agency Coordination

- The Department of Health & Human Services (HHS) should immediately and directly acknowledge the historic and persistent role of racism in our health care system and its policies and practices. HHS should specifically acknowledge the disproportionate harmful impact experienced by Black, brown, and other people of color with MH and SUD care needs, and the unacceptable health disparities they continue to face, and should commit to examining all of the agency's planned actions and policy priorities through a racial and health equity lens. In the first 100 days, HHS should detail the agency's plan to improve health outcomes for people of color and to strengthen access to culturally and linguistically effective community-based care. This plan should identify how HHS will work with Congress to secure adequate funds to reverse these health disparities and promote greater health equity.
- The Administration should establish a White House Office focused on achieving health equity which would coordinate activities through a racial equity lens across the federal government; particular attention should be paid to the impact of systemic racism on the ability of Black and

brown people, indigenous people, immigrants, and other people of color to access high quality clinically appropriate MH and SUD services, medications, and supports.

- Federal efforts to address the social determinants of health must address racism. As a part of its work to promote health equity, the Administration should examine the role of racism in the public health system and ways to address systemic inequities.

Data Collection, Analysis, and Public Reporting

- HHS should prioritize data collection, analysis, and public reporting by immediately requiring every state, territory, and locality to measure and report on health outcomes by race, ethnicity, primary language, and disability status. HHS should also work to ensure that the agency's funds are tied to outcomes to end health disparities and ensure greater equity across health and social service systems.

Non-Discrimination Protections

- The Centers for Medicare & Medicaid Services (CMS) must immediately restore all of the non-discrimination protections that were eliminated in the 2020 final rule implementing Section 1557, as well as other anti-discrimination protections that have been undermined through regulations, guidance, and executive orders.
- CMS should work with the Department of Homeland Security to immediately rescind the public charge rule that threatens the health of immigrants.

Diverse, Inclusive Workforce

- HHS should expand its efforts to build a diverse, inclusive MH and SUD workforce, including through greater use of incentives and 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.

<u>Legislative Proposals</u>

- 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. Congress should also increase HRSA funding to support a strong, diverse, inclusive MH and SUD care workforce.
- Congress should pass the Health Equity and Accountability Act (HEAA).
- Congress should 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.

Issue 2: Inclusion of MH and SUD in COVID-19 Response Initiatives

Summary of the Issue: COVID-19 has significantly exacerbated mental health and substance use issues for children, adolescents, and adults. In a nationwide survey to assess COVID-19's impact on mental health from June 2020, one in three adults reported symptoms of anxiety or depression (30.9%), one-quarter reported a trauma-and stressor-related disorder (26.3%) and more than one in ten (13.3%) reported starting or increasing their use of alcohol or drugs because of COVID-19. The prevalence of anxiety and depressive disorders were three and four times greater, respectively, than that reported in the second quarter of 2019 and more than twice as many adults reported suicide ideation in 2020 than in 2018 (10.7% compared to 4.3%). 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. A study of health records of over 69 million patients in the United States, with over 62,000 COVID-19 cases, found that patients who survived COVID-19 have a significantly higher rate of being diagnosed with anxiety disorders and mood disorders in the 3-month period following their COVID-19 diagnosis. Nearly one in five adults received a psychiatric diagnosis (18.1%) in the 3-month window following their COVID-19 diagnosis, and the risk of a new psychiatric diagnosis was doubled for adults with COVID-19. COVID-19 is also exacerbating the mental health of youth and children, including significantly higher rates of depression and anxiety.

Furthermore, people with MH/SUD have an increased risk of contracting COVID-19 and suffering adverse health outcomes as a result. Patients with a recent MH diagnosis are 65% more likely to get COVID-19 than those with similar physical risk factors but no MH diagnosis. Patients with a recent or lifetime SUD diagnosis also have a significantly higher risk of contracting COVID-19 than those without, among which patients with an opioid use disorder have the highest risk. The increased use of personal protective equipment (PPE) and telehealth have helped protect patients with MH/SUD across the country, but there remains a need for Congress and the new Administration to address the lack of resources and temporary regulatory flexibilities to ensure continuity of care for these vulnerable populations.

Black and brown individuals are hit the hardest by these dual crises. Black and brown individuals reported significantly higher rates of suicidal ideation – 15.1% and 18.6%, respectively – which is double the rate for white individuals (7.9%). Among individuals with COVID-19, Black patients with SUDs have suffered the highest hospitalization and death rates across all patient populations. Black patients with COVID-19 and a recent diagnosis of SUD were hospitalized at a significantly higher rate than white patients with a SUD diagnoses (53.6% versus 37.7%). Black patients with COVID-19 and lifetime SUD died at a significantly higher rate than white patients with a SUD (13% versus 8.6%). Communities of color are also hit the hardest by the digital divide, such that they disproportionately lack access to the technology or infrastructure that would allow them to use telehealth to meet their MH/SUD needs.

Congress and federal regulators have a crucial role to play to meet the increased demand for MH/SUD services resulting from the pandemic and to mitigate the spread of COVID-19 among people with MH/SUD, who are at greater risk and more susceptible to adverse health outcomes because of their preexisting conditions. At the same time, privacy and confidentiality must be addressed to prevent the criminalization of people with MH/SUD during contact tracing.

Executive Branch Proposals

Access to COVID Testing, Treatment, and Vaccination, and Provider Protections

- The Centers for Disease Control and Prevention (CDC) should recommend that individuals with MH/SUD be given priority for getting the COVID-19 vaccination, given their increased risk of contracting the virus and their disproportionately adverse health outcomes when they are diagnosed with COVID-19. Providers of SUD prevention, treatment, recovery, harm reduction, and MH services should also receive prioritization as frontline health workers and should be included as health care providers who can help distribute the vaccine. The Administration must ensure that vaccine distribution is accessible to people with disabilities.
- CDC should ensure equitable coverage for and access to COVID-19 testing, treatment, and vaccination, including for people with MH and SUD.
- HHS should issue guidance to the states making clear that MH, SUD, and harm reduction service providers are frontline essential health workers who should have good access to PPE and COVID-19 vaccination.

Data Collection, Analysis, and Public Reporting

- The Administration should instruct all appropriate agencies of the federal government in all COVID-19 testing, cases, and deaths, in all settings and by setting, to collect, analyze, and regularly publicly report COVID-19 and co-occurring demographic factors including disability status, race, ethnicity, sex, age, primary language, sexual orientation, gender identity, and socio-economic status. This COVID-19 disability status data template should serve for use in all public health and health funded programs.

Telehealth

- CMS should revise its definition of telehealth in the Medicare program to authorize and allow reimbursement for audio-only service delivery to ensure all people have the ability to access the MH/SUD services they need, recognizing that older adults and people with disabilities face more challenges in using audio-visual technologies.
- CMS should strengthen telehealth access to people with MH and SUD by covering phones as durable medical equipment.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) should extend the Public Health Emergency (PHE) flexibilities to allow 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.
- The Drug Enforcement Administration (DEA) should extend telehealth flexibilities under the PHE to allow prescribers to initiate patients onto methadone via telehealth without an in-person evaluation.

Contact Tracing and Privacy

- HHS should issue guidance to address privacy and criminalization concerns related to people with MH and SUD and for those who use drugs in contact tracing.

Housing Access

- The Federal Emergency Management Agency (FEMA) should work with HHS and engage with Congress to provide housing for people with MH/SUD during national emergencies.

<u>Legislative Proposals</u>

- As a part of state and local fiscal relief, Congress should allocate sufficient targeted funding to support and sustain community-based MH and SUD providers and providers of harm reduction services, at this time when the demand for these services is growing. Congress should also make clear that MH, SUD, and harm reduction service providers are frontline essential health workers who should have good access to PPE and COVID-19 vaccination.

- Congress should 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.
- Congress should authorize providers to prescribe controlled substances for the treatment of MH/SUD without an in-person evaluation, such that patients can access the medications they need without jeopardizing their health and safety.
- Congress should 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.

Issue 3: Health, Not Punishment

Summary of the Issue: Many people come into contact with the criminal legal system due to poor access to health care, including MH and SUD care, in their communities. This, combined with the ongoing criminalization of MH and SUDs and persistent racism in both the health and criminal legal systems, have resulted in the majority of people with these medical conditions becoming incarcerated rather than receiving quality community-based health care. Preventing entry of people with MH/SUD into the criminal legal system should be the primary goal.

While diversion to treatment and other services in the community rather than incarceration provides the best outcomes, it is vastly underutilized. By targeting the underlying problems that led to the crime in the first place, effective diversion programs , particularly at the front-end but also throughout the criminal legal system, can improve long-term community safety and reduce recidivism far more effectively than warehousing someone in a prison cell before they return home. Responding to MH/SUD crises with health care, rather than policing and punishment, should be the top priority.

Black people and other people of color are disproportionately impacted by the criminal legal system. Despite similar rates of committing crime, Black people are incarcerated at more than five times the rate of white people. In 2018, the incarceration rate of Black men was 5.8 times higher than that of white men, and Black young men ages 18-19 years old were 12.7 times as likely to be incarcerated as white young men in the same age group. The number of women incarcerated increased by more than 700 percent from 1980-2016. In 2018, Black women were 1.8 times as likely to be incarcerated as white women, and Black girls were three times more likely to be incarcerated than white girls. Upon release, these disparities persist: the combined effect of race, socio economic status and a criminal record can present major barriers to successful reentry.

As a result of systemic and institutional racism and discrimination; collateral consequences of arrest or conviction that ban or limit legal access to housing, employment and licensure, food, living, and education supports; and a limited investment in resources for the large number of people returning each year, these individuals – who are predominantly Black – return to their communities without the basic support and tools needed for long-term success. Access to appropriate health care, including overdose prevention and behavioral health care, is difficult and sometimes impossible to secure. Better addressing health care needs, including MH/SUD, 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. With the coverage expansions of the Affordable Care Act (ACA), and provisions of the law that have specifically improved coverage of MH and SUD care, there is a significant opportunity to strengthen access to care for the justice-involved population. A strong Medicaid program is essential to improving care access, and public safety outcomes, for justice-involved people.

Most people with criminal legal system involvement have untreated MH/SUD. Although approximately 65% of the United States prison population has an active SUD and another 20% were under the influence of alcohol or drugs at the time of their crime, however, the majority of jails and prisons offer little or no treatment for these illnesses, including denying people access to life-saving medications for opioid addiction. Although the ACA did not amend the "inmate exclusion provision" of Medicaid law which precludes federal Medicaid matching funds for health care services provided to incarcerated people, under the Affordable Care Act, many more people in the criminal legal system are eligible for Medicaid coverage. Tied to this new coverage, states can collect 90 percent in federal

matching funds for health care services provided to newly Medicaid-eligible people. As a result, states are increasingly considering policy changes to prevent Medicaid coverage disruptions as people move throughout the criminal legal system and between the system and the community and use of Medicaid demonstration waivers to better meet the needs of justice-involved people with complex co-occurring health conditions. In addition, there has recently been greater bipartisan focus in Congress, including through the Medicaid Reentry Act, on the possibility of expanding use of Medicaid in prisons and jails to better support continuity of care and reentry to the community. CMS is also considering a number of state section 1115 waiver applications to improve Medicaid reentry.

Congress and federal regulators have an important role to play in strengthening Medicaid policy and practices for justice-involved people. By supporting additional leveraging of Medicaid by the criminal legal system, unnecessary use of incarceration for health issues will decrease, health and reentry outcomes will improve, and costs to state and local systems health and criminal legal systems will be reduced.

Executive Branch Proposals

Pre-Arrest Diversion, Including Crisis Intervention

- The Administration should establish incentives to prioritize equitable pre-arrest diversion to community-based MH, SUD, and other health care and wraparound services. CMS, SAMHSA, and the Department of Justice (DOJ) should work together, through joint policy guidance, technical assistance and funding initiatives, to prioritize policies and initiatives that increase support for pre-arrest diversion to culturally and linguistically effective community-based MH, SUD, and other health care and wraparound services. Focus should be on helping states and localities introduce new and bring to scale existing community diversion initiatives. These policies should incentivize diversion as early as possible (pre-arrest), though there should be opportunities for diversion throughout the criminal legal system. Incentives should also be utilized to encourage equitable and inclusive policies and practices; data collection, analysis, and public reporting on program participant race, ethnicity, sexual orientation, and gender identity should be required.
- The Administration should do outreach and engagement to inform the public about the 988 mental health crisis service. The Administration should also coordinate with state and local suicide prevention efforts, advocacy groups, and the Federal Communications Commission (FCC) to ensure that the 988 roll out can be as effective as possible by addressing the infrastructure, staffing, and training needs across the country. The Administration should also work to promote text-based crisis services to serve teens and young adults.
- CMS's Center for Medicare and Medicaid Innovation (CMMI) should develop a special initiative with cities to test innovative approaches to emergency response and crisis stabilization. The Administration should support, through funding opportunities, technical assistance, and policy guidance, counties and communities forming regional response networks to leverage their collective power to develop comprehensive and integrated approaches in emergency response and crisis stabilization where they otherwise lack individual community capacity.

Coverage and Care for People in the Criminal Legal System

- All relevant federal HHS and DOJ agencies should work together to strengthen coverage and access to care for people in the criminal legal system.

- CMS should immediately implement Section 5032 of the SUPPORT Act, which required CMS, by October 2019, to convene a best practices stakeholder group which would inform the development of policy guidance on continuity of care for the justice-involved population.
- CMS should swiftly approve the several pending Medicaid Reentry waiver applications to strengthen health outcomes as people leave incarceration.
- CMS should release guidance requiring states to:
    - Implement Medicaid eligibility screening and enrollment throughout the criminal legal system
    - Suspend an individual's Medicaid during incarceration and reactivate coverage 30 days before release (for eligible individuals serving more than one year)
    - Activate Medicaid upon jail admission (for eligible individuals who will be serving a term of less than one year)
- CMS should encourage states to utilize Medicaid waivers and initiatives to support innovation and improve the ability to seamlessly meet the co-occurring physical, mental and SUD care needs of people in the criminal legal system.
- DOJ and the HHS should jointly issue guidance on how people in the criminal legal system, through arrest and other processes, should be screened for SUD, MH and health conditions and corresponding care needs, and how to ensure people throughout the criminal legal system receive clinically appropriate MH and SUD services and medications.
- HHS should educate people in the criminal legal system about their federal and state confidentiality rights that apply to their mental MH and SUD patient records to encourage adherence to treatment to achieve recovery and train MH and SUD care providers about how to explain and apply these rights to and for their patients.

<u>Legislative Proposals</u>

- Congress should 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.
- Congress should 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.
- Congress should expand funding for MH/SUD services and supports for the families and children of people involved in the criminal legal system.
- Congress should swiftly approve the Medicaid Reentry Act, which would allow Medicaid to finance care in the last 30 days of incarceration to promote linkages to care.
- Congress should appropriate additional 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.
- Congress should authorize and fund mechanisms that link people in the criminal legal system who are uninsured (including those who are not eligible for Medicaid) to care, including community health centers, and programs that provide MH and SUD services, harm reduction services, and linkage to social services
- Congress should ensure that people in the criminal legal system have non-discriminatory, equitable access to programs, benefits and services.

- Congress should require and fund education and training of key leadership and line staff throughout the criminal legal system on addiction, mental illness, and effective treatment and recovery services and medications.

Issue 4: Health Care Coverage

Summary of the Issue: Strengthening mechanisms to cover more people, including the Affordable Care Act's Medicaid expansion and the law's provisions aimed at making private insurance more affordable, is critical to improving care access for people with MH, SUD, and co-occurring health conditions.

The Medicaid program is critical to supporting people with MH and SUD. In 2014, 25 percent of all MH spending and 21 percent of the nation's SUD expenditures were attributed to Medicaid. The Medicaid program includes many MH and SUD benefits while giving states the option to cover additional services, such that Medicaid coverage can be more comprehensive than some private insurance coverage. The current Medicaid program allows for considerable flexibility and promotes innovation, as demonstrated by the many Medicaid waivers – including the emergency actions that have been critical for responding to the COVID-19 pandemic – and other state-specific initiatives that have reduced costs and improved health outcomes. Expanding Medicaid eligibility has allowed more people with MH/SUD to receive services and medications to help them become and remain well. Approximately 29 percent of persons who receive health insurance coverage through the Medicaid expansion have a MH condition and/or SUD. However, the current Administration has issued harmful federal policies and guidance around work requirements and block grants that allow states to discriminate against people with MH/SUD and prevent people from getting coverage to which they are entitled. There is an ongoing need to maximize coverage through Medicaid expansion, ensure that all Medicaid plans offer MH and SUD benefits in a way that is comparable to and no more restrictive than medical/surgical benefits, and increase the availability of MH/SUD services.

Private insurance coverage must be affordable and comprehensive so that people can remain insured and access quality MH and SUD services. Private insurance companies pay far less overall for MH and SUD than Medicaid and Medicare, even though approximately twice as many people are on private health insurance than public. Excluding prescription drugs, private insurance MH spending ranged between 2.2% and 2.4% of total healthcare spending between 2013 and 2017, and spending for SUD care ranged from 0.7% to 1%. As a result of inadequate provider networks and reimbursement rates, the costs are shifted to consumers, who have to pay out-of-pocket to get the MH/SUD care they need at a far greater rate than they do for primary or other specialty care, on top of the premiums they are already paying despite not having access to the services they need. Restoring and expanding the ACA's cost-sharing reductions; funding for education, outreach, and navigator services; and full open enrollment period are further necessary to ensure that all individuals can access affordable health insurance.

Executive Branch Proposals

Closing Coverage Gaps

- CMS should close coverage gaps, with Congressional engagement, by encouraging and incentivizing the states that have not yet expanded their Medicaid population to do so and by increasing support (including through restored and expanded subsidies) to make Marketplace coverage more affordable for people without job-based coverage.
- CMS should immediately rescind harmful Medicaid guidance and withdraw approvals of damaging state waivers including the Healthy Adult Opportunities block grant guidance and work reporting requirements guidance. In addition, the Administration should end approval of Section 1115 waivers that create barriers to care such as those that seek to use block grants or

per capita caps, and those that charge premiums and cost-sharing for emergency care, eliminate retroactive eligibility, eliminate non-emergency medical transportation, implement work reporting requirements and lock out periods, and eliminate Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits for 19 & 20-year olds. CMS should issue guidance making clear that state proposals to require drug testing for benefits are inconsistent with the purposes of the Medicaid program and will not be approved.

- CMS should support comprehensive coverage by limiting use of plans that offer "skinny" coverage, including by rescinding the short-term limited duration plan rule, and limiting use of association health plans and "grandfathered" plans.

Maximizing Enrollment

- CMS should remove barriers to enrollment and maintaining coverage by extending enrollment periods, working with Congress to adequately fund education and outreach programming (including navigators with MH and SUD expertise), streamlining processes to make it easier to enroll in and maintain coverage for CHIP, Medicaid, SNAP, TANF, SSI/DI and other essential programs, and instituting other policies to minimize coverage disruptions, including by making enrollment automatic.

<u>Legislative Proposals</u>

- Congress should 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.
- Congress should support strong Medicaid funding without changes to the program's current structure. Congress should also pass legislation that triggers an automatic FMAP increase during economic downturns so that states can continue to provide quality and comprehensive Medicaid coverage after the current public health emergency ends and during future recessions.
- Congress should expand Medicaid eligibility and coverage to pregnant women for the twelve months post-partum to ensure that new mothers have access to comprehensive and affordable MH/SUD care.

Issue 5: Improving Access to MH/SUD Care and Health Outcomes

Summary of the Issue: Equally important as the coverage of people, 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.

To ensure that people have access to the MH and SUD care they need, health insurance providers must cover the full continuum of effective services and a robust network of providers to deliver those services. When networks are limited, consumers are forced to wait or travel long distances for care, pay higher costs for treatment from a non-network provider, or forgo care altogether. Network gaps for MH and SUD providers are particularly problematic. Consumers with private health plans access MH and SUD services from out-of-network providers at a significantly higher rate than for other medical services, a disparity that was twice as bad for children, and thereby paying more out-of-pocket for that care. Network utilization disparities have persisted even though the Parity Act bars discrimination by virtually all health plans in network adequacy standards, the admission of providers to networks and reimbursement practices. Multiple strategies are needed – such as the adoption of quantitative access standards and improved regulatory oversight – to create robust networks and protect consumers who cannot find a network MH or SUD provider from out-of-network costs for covered services. These efforts are also necessary for ensuring culturally and linguistically effective care from a diverse range of providers and adequate networks of adolescent and child MH/SUD providers to meet the needs of kids and families.

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, such that older adults and people with disabilities lack the care they need, particularly for patients with SUDs. Medicare, while often the standard-setter for other health care financing systems, falls far behind the MH and SUD benefit coverage standards that have become more common in private insurance and Medicaid since the enactment of the ACA, including residential treatment and intensive outpatient treatment. While Congress and federal regulators have taken important steps in recent years to expand access to opioid use disorder treatment, they have fallen short of covering the full continuum of care for MH and SUDs. 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), which requires health plans that offer MH and SUD benefits to provide coverage on par with the medical and surgical benefits they offer. Without this anti-discrimination requirement, Medicare has not systematically addressed significant gaps in the coverage of MH and SUD benefits, and Medicare beneficiaries have more limited access to MH and SUD care than to medical care. 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. Furthermore,

Medicare's protected classes policy, an integral part of the Medicare Part D program, was recently placed at risk. The protected classes policy provides safeguards within the program to ensure plans are providing Medicare beneficiaries access to appropriate and needed medications. Medicare beneficiaries often have complicated health status with multiple co-morbidities and disabilities. It is imperative that these individuals with the most complex conditions have access to the right combination of prescription drugs and that Medicare's protected class policy be reaffirmed.

Executive Branch Proposals

Capacity of Culturally and Linguistically Effective MH and SUD Care

- HHS should identify the agency's plan to engage Congress to increase HHS funding to strengthen the infrastructure of community-based culturally and linguistically effective care and improve access to care. Programming 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.

Enforcing the MH/SUD Parity Act

- HHS, CMS, and the Department of Labor (DOL) should require all commercial carriers, Medicaid plans subject to the Parity Act, Federal Employees Health Benefit plans, and TRICARE plans 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 or enrollment in the plan. HHS, CMS and DOL should report annually on parity enforcement activities.
- HHS, CMS, and DOL should 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, in line with the recent decision in *Wit v. United Behavioral Health*, and that all health plans are required to comply with the Parity Act's disclosure requirements of medical necessity criteria.
- HHS, CMS, and DOL should improve consumer education, awareness, and information about the Parity Act so consumers know their rights, can meaningfully access the benefits available under their plans, and can file complaints and appeals when they are unable to access those benefits in a timely and reasonable manner. These agencies should also incentivize the adoption and support for Ombud programs to assist consumers navigate access to MH and SUD care.
- HHS, CMS, and DOL should issue guidance prohibiting plans from imposing prior authorization requirements or step therapy requirements for medication for opioid use disorders (MOUD), prohibiting plans from excluding coverage of any such medication or wraparound services on the grounds that such medication or services are court-ordered, and requiring plans to place all such medications on the lowest tier of their drug formularies.

Essential Health Benefits

- CMS should strengthen Essential Health Benefits (EHB) by reversing the recent relaxation of EHB requirements and working with states to enforce EHB requirements to cover the full continuum of effective MH and SUD services, medications and supports in various settings. Minimally, CMS should require states to select a new EHB benchmark plan for plan year 2022. Many states have been relying on 2017 EHB benchmark plans for several years despite findings that these plans are non-compliant with ACA requirements and provide inadequate coverage for critical SUD benefits. A subsequent study of a national sample of ACA plans found continued noncompliance and inadequate benefit coverage in plans sold in 2017. It was particularly disappointing to find that discriminatory methadone coverage worsened in the midst of the opioid crisis. These findings suggest that the EHB requirement has failed to ensure

sufficient coverage of SUD services. CMS should carefully evaluate whether the EHB benchmark process is appropriate for defining benefits in the mental health and substance use disorder EBH category and consider alternative approaches, including defining the EHB SUD and MH benefits. Defining benefits would also reduce the confusion and complexity involved in enforcing and monitoring compliance with the EHB and parity requirements.

Addressing Gaps in MH and SUD Coverage

- CMS should encourage states to continue to use Medicaid waivers (including Section 1115 and 1332 waivers) and to leverage other agency initiatives to address gaps in MH and SUD care.
- CMS should focus ACA oversight and enforcement action on those MH and SUD services, medications, and supports that remain not well covered.
    - Medication for Opioid Use Disorder (MOUD)
        - CMS should enforce the SUPPORT Act MOUD requirements for coverage of all FDA-approved addiction medications in each state's Medicaid program. CMS should also direct state Medicaid programs to reduce prior authorization and other utilization management barriers to MOUD, as it did for Part D prescription drug plans.
        - Consistent with parity and EHB requirements, HHS should similarly require qualified health plans to cover all forms of FDA-approved medications. HHS should take enforcement action against plans that exclude addiction medications in violation of federal law.
        - HHS, CMS, and DOL should authorize coverage of MOUD initiation in emergency departments in Medicaid and commercial insurance, similar to the CY 2021 Physician Fee Schedule changes to Medicare, to promote access to medication and linkages to other services and supports.
    - Prescription Drugs
        - The Administration should reaffirm the importance of the protected classes policy by making final a regulation recognizing Medicare's existing six protected classes of drugs, as required by the Affordable Care Act, and establishing criteria for future evaluation of clinical classes of concern. The six existing protected classes are: anticonvulsants, antidepressants; antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection.
        - The Administration should continue robust review and enforcement of Part D plan compliance with the statutory policy to protect Medicare beneficiaries' access to all drugs in the existing six protected classes of drugs.
    - Residential SUD treatment
        - CMS should continue expanding access to residential SUD treatment, and the use of the American Society for Addiction Medicine (ASAM) criteria across the continuum of care, by granting state section 1115 waiver applications.
    - Recovery supports, including those provided by peers
        - CMS should issue guidance to help states to cover MH and SUD recovery support services, including those provided by peers, in the way that comparable supports are covered by Medicaid for other chronic health conditions.

Network Adequacy

- HHS, CMS, and DOL should adopt parity-compliant quantitative network adequacy standards for a wide range of MH and SUD providers in public and private insurance, respectively, to improve access to affordable treatment and identify the cause of network gaps. These standards

should include, at a minimum: metrics on appointment wait time, travel distance, and provider-to-enrollee ratios, and the inclusion of essential community providers in networks.

- HHS, CMS, and DOL should continually monitor compliance with network adequacy standards and utilize a number of different compliance tools, including market conduct surveys; collecting and analyzing data on out-of-network claims, MH and SUD provider availability, and reimbursement rates; and consumer surveys and complaints. They should require carriers to explain any disparities and demonstrate that such disparities do not violate the Parity Act.
- HHS, CMS, and DOL should require greater transparency about network design, reimbursement rate setting standards, and compliance with network adequacy requirements, which should be publicly available in plain language to inform consumers.
- To ensure consumers continue to have a choice in the service delivery model through which they receive their care, plans should only be able to use telehealth appointments to satisfy network adequacy requirements if a telehealth service is available, accessible, clinically appropriate, and the consumer elects to receive the service by telehealth.

Privacy Rights

- HHS should enforce privacy protections to ensure people feel safe to access SUD and MH care. HHS should ensure that people with lived experience, health care providers, and other key stakeholders are informed of the recent changes to the federal SUD confidentiality law.

Harm Reduction Services

- HHS, including CMS, SAMHSA, and the Centers for Disease Control and Prevention (CDC), should work to improve access to harm reduction services. DOJ should drop the current lawsuit challenging the Philadelphia overdose prevention site.
- The Administration should support and fund public education on overdose prevention, recognition, and response, and ensure that tools (including standing orders for naloxone) that are effective in preventing overdose death are widely available.

Access to Housing and Employment

- HHS should work with the Department of Housing and Urban Development (HUD) to improve affordable, integrated, accessible housing options for people with MH and SUD histories. The agencies should jointly provide technical assistance to states about leveraging Medicaid for housing-related supports.
- HHS should 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. The Administration should prioritize funding for peer certification and education/training as a part of a broader health workforce development agenda, including providing candidates for peer certification with scholarships.

<u>Legislative Proposals</u>

- Congress should 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.
- Congress should pass legislation to expand the Parity Act to apply to traditional Medicare and Medicare Advantage Plans to ensure beneficiaries have comprehensive access to MH and SUD care without discriminatory barriers. At the same time, Congress should work to close the gaps in coverage by:

    - Authorizing freestanding MH and SUD treatment facilities to become certified Medicare providers.
    - Authorizing Licensed Professional Counselors, Marriage and Family Therapists, Certified Drug and Addiction Specialists, and Certified Peers to become certified Medicare providers.
    - Authorizing residential treatment and intensive outpatient programs (IOP) for MH and SUD, as well as partial hospitalization programs (PHP) for people with a primary diagnosis of SUD, in the Medicare program.
    - Enhancing 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.
    - Removing 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.
- Congress should amend the Americans with Disabilities Act (ADA) and Fair Housing Act to provide anti-discrimination protections to people who use drugs illegally.
- Congress should significantly expand its investment in the community-based system of MH and SUD care.
- Congress should increase funding for effective harm reduction services, including syringe exchange services, and should fund demonstrations for overdose prevention sites.
- Research on MH and SUD, prevention, treatment and recovery services and medications should be expanded and funding for research should be increased.

Issue 6: Delivery System and Payment Reforms

Summary of the Issue: The MH and SUD care infrastructure must be strong to ensure that people at risk or suffering from MH, SUD, or co-occurring disorders can access the quality care and supports they need to become and remain well. However, 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 competent 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. Primary care physicians and practices are often the first line of defense for people with MH/SUD, and they can play a significant role in helping their patients get the treatment and resources they need with adequate training and collaboration. They are even more important for children, who frequently lack access to appropriate providers at a time when they are most likely to develop MH/SUD conditions, and when prevention and health-centered early intervention can have the greatest impact. System reforms should also focus on improving access to quality MH/SUD care in rural communities, where integrated care is even more critical.

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.

Furthermore, there are a range of person-centered and integrated reforms that states can implement to deliver MH/SUD services to Medicaid beneficiaries to reduce costs and allow people to remain in their homes and communities. For example, state options for Home and Community-Based Services (HCBS) allow individuals – including those with MH, SUD, and co-occurring illnesses – that would otherwise require an institutional level of care to receive the services and supports they need in the least restrictive setting and to avoid the need for more costly care in the future. However, these programs are inconsistent across the country as the eligible populations and services vary from state to state, and there are significant waiting lists that prevent people from getting the care they need in a timely manner. The lack of federal guidance or standardized outcome measurements also prevent states from most effectively serving beneficiaries with MH/SUD in such programs. The federal government can incentivize value-based payments and integrated care models to prioritize high quality and person-centered care to focus on achieving the best possible outcomes for people with MH and SUD.

Executive Branch Proposals

System Transformation

- As transformation of the health care system occurs, HHS should ensure that MH, SUD, and co-occurring disorder care is fully and equitably included and that care delivery is person-centered.

Payment Reforms

- CMS should ensure MH and SUD services are fully and equitably included in Alternative Payment Models.
- CMS should ensure that MH/SUD services are included in value-based reforms such as Accountable Care Organizations, Patient Centered Medical Homes, and Medicare Shared Savings Programs.
- CMS should expand use of high-value quality measures at the intersection of MH/SUD and medical care.

Utilizing Medicaid 1115 Waivers

- CMS should issue Medicaid section 1115 waiver guidance to encourage states to:
    - Integrate a full continuum of SUD services with physical health, mental health, and long-term care services for children and adults, including the use of Section 2703 health homes, integrated care models, alternative payment models, and value-based reforms.
    - Maximize opportunities to expand needed inpatient and residential SUD treatment through waivers of the Institution for Mental Diseases (IMD) rule while building out community-based services.
    - Expand recovery services, access to housing services, and other social determinants of health.
    - Focus efforts on youth substance use prevention and early intervention services.
    - Focus on justice-involved populations at risk of arrest and returning to the community from incarceration.

Integrated Care

- CMS should issue guidance to states on ways to more effectively deliver MH and SUD care in medical settings. The Administration should build on 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.
- CMS, SAMHSA, and HRSA should work together to strengthen more seamless access to MH, SUD, and physical health care; this should include issuing joint HRSA/SAMHSA guidance and incentive payments to community health centers to partner with community-based MH and SUD care providers.
- CMS should 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.
- CMS should extend the CCBHC program as a combined Medicare/Medicaid demonstration. HHS should prioritize integrated pediatric primary care to reduce the incidence of adult MH and SUD.
- 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.

Telehealth

- CMS should revise its definition of telehealth in the Medicare program to authorize audio-only service delivery to ensure all people have the ability to access the MH/SUD services they need, recognizing that older adults and people with disabilities face more challenges in using audio-visual technologies.
- CMS should enable Medicare beneficiaries with MH conditions to receive MH services in their homes, as it did for beneficiaries with SUDs, and CMS should 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.

- CMS should issue additional guidance to states on the telehealth flexibilities in Medicaid, including the ability to authorize and reimburse for audio-only service delivery and for patients to receive services in their homes or wherever they may be located.
- CMS should strengthen telehealth access to people with MH and SUD by covering phones as durable medical equipment.
- SAMHSA should extend the Public Health Emergency (PHE) flexibilities to allow 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.

Home and Community-Based Services

- CMS should support the Home and Community-Based Services (HCBS) program, which enable individuals with disabilities of all ages to live in their own homes and communities by:
    - Working with states and stakeholders on HCBS improvement strategies including by permanently incorporating positive changes from emergency waivers and Appendix Ks into HCBS programs.
    - Prioritizing strong implementation of the HCBS Settings Rule, including by providing additional guidance, technical assistance (TA) to states, and ongoing monitoring, with a focus on the heightened scrutiny process.
    - Finalizing and working with states to implement core HCBS quality measures that emphasize person-centered services, compliance with the HCBS Settings Rule, equity in access to HCBS, and best practices.
    - Identifying racial and other inequities in HCBS and develop strategies for addressing those inequities, including requiring states to develop equity plans for their HCBS programs, providing TA and funding for outreach to Black, Indigenous, and other communities of color, including non-native English speakers and LGBTQ+, and providers that serve them, and prioritize transition efforts in institutions disproportionally with residents from those communities.

<u>Legislative Proposals</u>

- Congress should fund research to identify treatment outcomes that matter to people and to develop corresponding outcome measures to assess those outcomes.
- Congress should increase funding to:
    - Incentivize health care providers to implement integrated care
    - Train clinical care staff
    - Strengthen the workforce for peer support and community health workers
    - Support health information technology
    - Invest in Electronic Health Records and Care Management Tracking Systems, and
    - Formalize collaboration agreements between primary care and MH/SUD care providers and to improve referral coordination and communication.
- Congress should approve a permanent reauthorization of the Money Follows the Person program which includes provisions to ensure equitable access, particularly for people of color.
- 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.

- Congress should make HCBS a mandatory Medicaid benefit and should expand and strengthen the HCBS infrastructure by passing the HCBS Infrastructure Investment Act.

Issue 7: Chronic Disease Prevention, Early Intervention, and Wellness

Summary of the Issue: 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. Effective mental health check-ups, screening for MH/SUD and suicidality, and early intervention for MH/SUD should be available across the lifespan in primary care, school, juvenile justice and other settings where prevention services are especially needed. 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. Home- and community-based services, and support for family-centered recovery, can help families work through these experiences and prevent them from interfering with our children's full potential. Promoting positive early childhood development is critical. Mental illness prevention initiatives should be aimed at addressing risk factors and increasing children's protective factors. Pre-natal and peri-natal screening for maternal depression and SUDs should be encouraged, as well as referral into treatment for those who need care.

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.

Executive Branch Proposals

Federal Coordination

- 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), should collaborate and closely coordinate including through joint guidance, funding initiatives, and technical assistance to the field.

Scaling Effective Interventions

- The Administration should use 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.
- The Administration should continue supporting and investing evidence-based mental health awareness training programs like Mental Health First Aid that teach people the signs and symptoms of mental illness as well as an action plan to engage individuals in psychiatric crisis. Additional investment should be made for specialty populations including youth and teens, first responders, law enforcement officers, and active military and veterans.
- The Administration should bring to scale programming that is effective in addressing Adverse Childhood Experiences and building resiliency.
- NIH should invest in more prevention-related research.

Suicide Prevention

- The Administration should support and fund public education on suicide prevention, screening, recognition, and response, and ensure that resources that are effective in preventing suicide are widely available.
- The Administration should do outreach and engagement to inform the public about the 988 mental health crisis service. The Administration should also coordinate with state and local suicide prevention efforts, advocacy groups, and the Federal Communications Commission (FCC) to ensure that the 988 roll out can be as effective as possible by addressing the infrastructure, staffing, and training needs across the country. The Administration should also work to promote text-based crisis services to serve teens and young adults.

Screening and Early Intervention through Primary Care

- HHS should continue engaging with primary care – through regulations, guidance, and increased funding – to increase rates of mental health and substance use screenings, early interventions, and, when appropriate, referral to treatment and other services. There should be continued work with payors to ensure these services are offered without cost-sharing.
- The Administration should provide pre-natal and peri-natal screening for maternal depression and SUDs, as well as referral into treatment for those who need care.

School-Based Interventions

- The Administration should support and promote health in schools:
    - Issue guidance from the CMS for states to implement the Medicaid Free Care Rule Reversal as a financing mechanism for school-based services that includes a template state plan amendment (SPA) for states to use.
    - Re-issue the Every Student Succeeds Act (ESSA) guidance to 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.
    - Reinstate the Obama Administration's 2014 Joint DOJ-ED School Discipline Guidance Package that encouraged schools to limit the use of punitive zero-tolerance and other exclusionary discipline practices. The guidance should be reinstated with an addendum

that includes model policies for school discipline and the use or possession of drugs and alcohol.

Recovery Support to Young People

- The Administration should provide 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.

Chronic Disease Prevention

- The Administration should ensure that any broad chronic disease prevention initiatives have a specific and required focus on preventing mental illness and substance use disorders.
    - The Administration should work to bring proven substance use and mental illness prevention strategies/services to scale and to incorporate them into broader chronic disease prevention initiatives.

<u>Legislative Proposals</u>

- Congress should increase funding for effective substance use prevention and mental health promotion programming, including through SAMHSA and CDC.
- Congress should increase funding for Title IV, Part A of ESSA to support hiring at least one full-time behavioral health clinician in every school.
- Congress should increase funding for youth peer supports.
- Congress should restore and sustain funding for the Prevention and Public Health Fund.
- Congress should increase the federal investment in the public health infrastructure and strengthen the public health workforce.
- Congress should increase the federal investment in mental health awareness trainings like Mental Health First Aid and target specialty populations including youth and teens, first responders, law enforcement officers, and active military and veterans.