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**Ensuring Access to Behavioral Health Care:
Making Integrated Care a Reality**

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Invited Testimony

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Hearing on “Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration”

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I. Formal Greeting

Good morning. Thank you, Members of the Senate Finance Committee, for inviting me to speak today on the critical topic of ensuring that behavioral health services are accessible to people residing in the United States. Chairman Wyden and Ranking Member Crapo, you have both been leaders on this pressing issue, and I am hopeful that your bipartisan commitment to advancing solutions will lead to progress.

II. Personal Story and Background

I am Reggie Williams, and I lead the International Health Policy and Practice Innovations Program at the Commonwealth Fund. I also co-lead our work on behavioral health, which includes a focus on mental health and substance use.

For over 10 years, I have also volunteered my time in the mental health community — currently serving on the boards of the Youth Mental Health Project and Fountain House and, in the past, chairing the board of directors of Mental Health America. My focus has been on improving the systems — or lack thereof — that people and families are forced to navigate to achieve the lives they want to live.

I testify today not only as someone who has spent more than 20 years in health policy but also as a Black man who strives to manage his own mental health — and as someone who has personally witnessed the impacts of mental health and substance use on my family, friends, coworkers, and my greater community.

III. Magnitude of the Crisis

There is a behavioral health crisis in the United States. When I say behavioral health, I mean the promotion of mental health, resilience, and wellbeing; the prevention, early identification, and treatment of mental illness and substance use; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

The crisis is being felt nationwide, without regard for political affiliation, economic prosperity, or education level — but, like so many other areas of our health care system, it is particularly acute for economically disadvantaged and underserved communities. The crisis predates COVID-19 but was exacerbated by the social

isolation, economic disruption, and upheaval of the U.S. health system that accompanied the pandemic. At the core of the crisis is unmet need.

There have been incredible strides made toward closing the coverage gap and achieving mental health parity with the passage of the Affordable Care Act in 2010. Access to behavioral care and treatment, however, remains a major issue in the U.S., especially for Black and Hispanic populations, for youth, and for Medicare and Medicaid beneficiaries.¹

Data from U.S. Department of Substance Abuse and Mental Health Services Administration (SAMSHA) show that among adults age 18 or older in 2020, 21 percent (or 52.9 million people) had any mental illness (AMI) and 5.6 percent (or 14.2 million people) had serious mental illness (SMI) in the past year. In 2020, 40.3 million people age 12 or older (or 14.5%) had a substance use disorder (SUD) in the past year, including 28.3 million who had alcohol use disorder.²

There is a mismatch between the demand among people seeking behavioral care and the supply of behavioral health providers. Some 142 million people in the U.S. live in one of the 6,127 mental health professional shortage areas, with an estimated 7,400 behavioral health providers needed.³

When compared to other high-income countries, the U.S. is an outlier in access to behavioral health services. The 2020 Commonwealth Fund International Health Policy Survey revealed that U.S. respondents with mental health needs were more likely than respondents in other countries to face access barriers. Analysis of the responses further revealed that Black and Hispanic Americans faced even greater access problems. In totality, these data draw attention to the need for continued investment in our nation's behavioral health system.⁴

¹ Jesse C. Baumgartner, Gabriella N. Aboulafia, and Audrey McIntosh, "The ACA at 10: How Has It Impacted Mental Health Care?" *To the Point* (blog), Commonwealth Fund, Apr. 3, 2020.

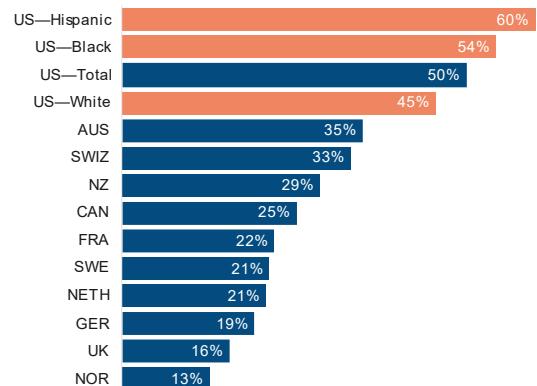
² SAMHSA, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health," U.S. Department of Health and Human Services, Oct. 2021.

³ HRSA, "Shortage Areas," U.S. Department of Health and Human Services, Mar. 2022.

⁴ Reginald D. Williams II and Arnav Shah, *Mental Health Care Needs in the U.S. and 10 Other High-Income Countries: Findings from the 2020 Commonwealth Fund International Health Policy Survey* (Commonwealth Fund, Oct. 2021).

Exhibit 1. Black and Hispanic Americans Were Most Likely to Report Cost-related Problems Accessing Health Care

Percentage of adults age 18+ with a mental health need who reported any cost-related access problem



Cost-related access problem: Respondent either 1) had a medical problem but did not consult with or visit a doctor because they could not afford it; 2) skipped a medical test, treatment, or follow-up that was recommended by a doctor because of the cost; or 3) did not fill a prescription for medicine or skipped doses of their medicine because of the cost.

Population: Among respondents who reported they had ever been told they had depression, anxiety, or other mental health conditions, 1 said there was a time in the past 12 months they wanted to talk with a health care professional about their mental health.

Data: 2020 Commonwealth Fund International Health Policy Survey.



The current behavioral health crisis is particularly notable for its impact on our nation's youth. Late last year, the U.S. Surgeon General issued a crisis advisory for children's mental health.⁵ In 2020, less than half of adolescents (42%) with depression in the past year reported receiving any treatment, with Black and Indigenous people and youth of color having even worse access to care (only 37% of Hispanic youth reported accessing care) than white young people, teenagers, or adolescents. Among young adults with mental illness, 47 percent reported unmet needs for mental health care.⁶ Hospitals are reporting more emergency department (ED) visits among adolescents due to mental health and substance use issues as well as waits in the ED of days, sometimes even weeks, before treatment options become available.⁷

The Medicaid program serves as the single largest provider of behavioral health services in the U.S., and yet half of all Medicaid members (50%) with serious mental illness, and nearly 70 percent of Medicaid members with an opioid use disorder, have reported not receiving treatment.⁸

⁵ Office of the Surgeon General, "[Youth Mental Health Reports and Publications](#)," U.S. Department of Health and Human Services, Dec. 2021.

⁶ [Highlights for the 2020 National Survey on Drug Use and Health](#) (SAMHSA, 2021).

⁷ Rebecca T. Leeb et al. [Mental Health – Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic – United States, January 1–October 17, 2020](#) (CDC, Nov. 2020).

⁸ NAMD, "[Federal Policy Briefs: Behavioral Health Integration](#)," National Association of Medical Directors, 2022.

One-quarter of all Medicare beneficiaries have mental illness. Analysis from the Commonwealth Fund shows that, compared to adults over age 65 in other high-income countries, Medicare beneficiaries are the most likely to see a health care professional to manage their depression or anxiety — and the most likely to report having cost-related access problems or stress about paying for food, rent, or utilities.⁹ The prevalence of mental illness is greatest among beneficiaries under 65 who qualify for Medicare because of disability, as well as among low-income beneficiaries who are dually eligible for Medicare and Medicaid.¹⁰

Nearly one-third of individuals dually eligible for Medicare and Medicaid have been diagnosed with a serious mental illness such as schizophrenia, bipolar disorder, or major depressive disorder, a rate nearly three times higher than for non-dually eligible Medicare beneficiaries.¹¹

Prior to the pandemic, 22 percent of U.S. adults were experiencing social isolation or loneliness. Organizations across the globe have been implementing programs to curtail the effect of growing isolation.¹² The COVID-19 pandemic only intensified the unmet need for services and gaps in access to care for behavioral health services, with a higher percentage of adults in the U.S. reporting mental health concerns, as well as difficulty accessing services, than adults in other high-income countries.¹³

The problem is big and complex. However, there are tools that can be leveraged to make meaningful change in people's lives. Here's what we can do:

1. Increase access to behavioral health services by integrating mental health and substance use treatment and services with primary care. This includes supporting integration and care coordination with innovative payment approaches.

⁹ Munira Z. Gunja, Arnav Shah, and Reginald D. Williams II, *Comparing Older Adults' Mental Health Needs and Access to Treatment in the U.S. and Other High-Income Countries* (Commonwealth Fund, Jan. 2022).

¹⁰ Beth McGinty, *Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement* (Commonwealth Fund, July 2020).

¹¹ Logan Kelly, *Coordinating Physical and Behavioral Health Services for Dually Eligible Members with Serious Mental Illness* (Center for Health Care Strategies, Dec. 2019).

¹² Laura Shields-Zeeman et al., "[Addressing Social Isolation and Loneliness: Lessons from Around the World](#)," To the Point (blog), Commonwealth Fund, Jan. 27, 2021; Melinda K. Abrams et al., "[Solutions from Around the World: Tackling Loneliness and Social Isolation During COVID-19](#)," To the Point (blog), Commonwealth Fund, Apr. 30, 2020.

¹³ Reginald D. Williams II et al., *Do Americans Face Greater Mental Health and Economic Consequences from COVID-19? Comparing the U.S. with Other High-Income Countries* (Commonwealth Fund, Aug. 2020).

2. Expand and diversify the behavioral health workforce, by engaging a wide variety of providers to meet people's unique needs.
3. Leverage the potential of health technology to fill gaps and meet unfulfilled needs with telemedicine and digital health solutions.

IV. Integrate Mental Health and Substance Use Treatment and Services into Primary Care

Expanding the capacity of primary care providers to meet the behavioral health needs of their patients provides an opportunity to increase access to early intervention and treatment as well as to promote social connectedness and suicide prevention.

Compared to other countries, the U.S. has a smaller workforce dedicated to meeting mental health needs. Countries like the Netherlands, Sweden, and Australia more frequently include mental health providers on primary care teams.¹⁴ This compounds the comparative underinvestment in primary care teams in the U.S., which spends 5 percent to 7 percent on primary care as a share of total health care spending, compared to 14 percent in other countries belonging to the Organisation for Economic Co-operation and Development (OECD).¹⁵

Studies repeatedly show that patients view primary care providers as trusted sources of information. For example, in recent history, primary care providers ranked as the preferred source of information around COVID-19 vaccination for all age groups, races, and geographical location — regardless of political party.¹⁶ This trusted environment also offers an opportunity to combat stigma associated with discussing mental health and substance use and seeking treatment.

U.S. primary care providers are making strides in treating the behavioral health needs of their patients, but they are often working without necessary resources and supports. And they are working within a health care system that does not yet fully support providing integrated care. As many as 80 percent of people with behavioral health needs present in emergency departments and primary care settings; between 60 percent and 70 percent of these individuals leave without treatment for their

¹⁴ Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021) and Molly Fitzgerald, Munira Z. Gunja, and Roosa Tikkanen, *Primary Care in High-Income Countries: How the United States Compares* (Commonwealth Fund, Mar. 2022)

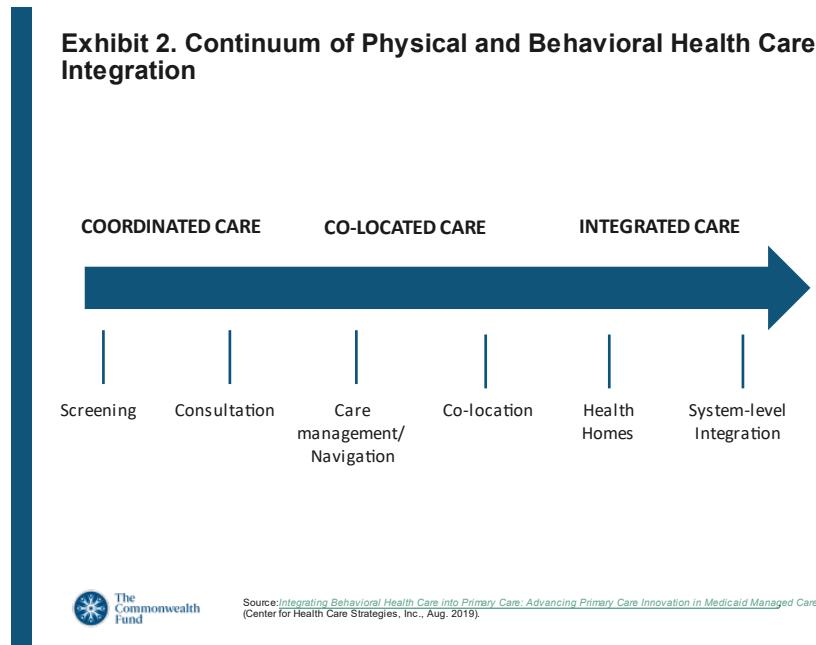
¹⁵ Yalda Jabbarpour et al., *Investing in Primary Care: A State-Level Analysis* (Patient-Centered Primary Care Collaborative, July 2019).

¹⁶ “[American COVID-19 Vaccine Poll](#)” (African American Research Collaborative, 2021).

conditions.¹⁷ Primary care providers see 45 percent of people within 30 days of a suicide attempt, and data show the primary care providers have an opportunity to intervene with routine depression screening and treatment to prevent suicides.¹⁸

The Case for Primary Care and Behavioral Health Integration

The term “integration” describes the bringing together of various providers and services. Integration has been used to reference everything from consultation to colocation to a setting of shared health goals around treating the whole person without clear boundaries.¹⁹ It is helpful to view models of care delivery as spanning a continuum of ways to integrate physical and behavioral health care (both mental health and substance use).²⁰



¹⁷ Sarah Klein and Martha Hostetter, “[In Focus: Integrating Behavioral Health and Primary Care](#),“ *Newsletter Article*, Commonwealth Fund, Aug. 28, 2014.

¹⁸ [Tackling America’s Mental Health and Addiction Crisis Through Primary Care Integration](#) (Bipartisan Policy Center, March 2021).

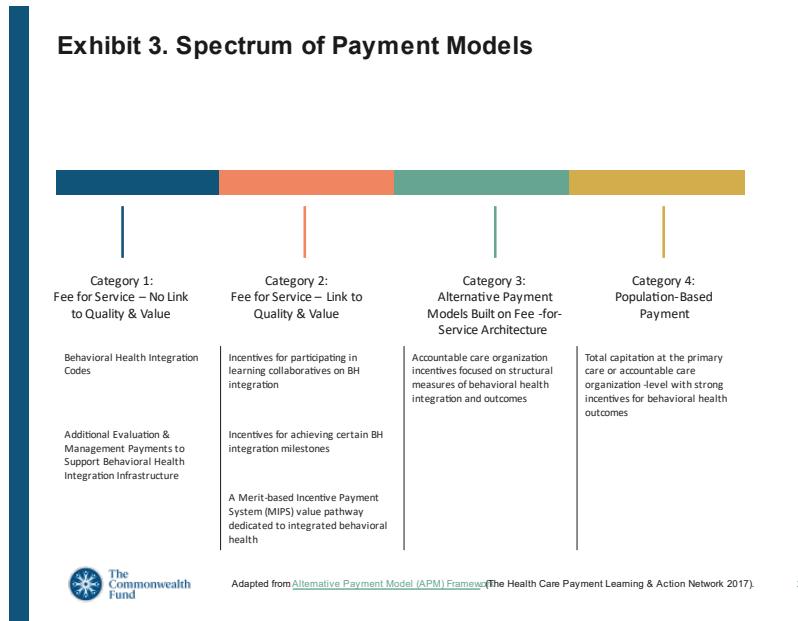
¹⁹ [A Standard Framework for Levels of Integrated Healthcare](#) (SAMHSA-HRSA Center for Integrated Health Solutions, April 2013).

²⁰ [Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care](#) (Center for Health Care Strategies, Inc., Aug. 2019).

It has been projected that effective medical and behavioral health service integration that includes a focus on primary care could generate nearly \$70 billion in U.S. health care costs savings annually.²¹

Support Innovative Payment Approaches

New approaches to payment policies, including models that hold providers accountable for improving quality and controlling overall costs, and programs led by Medicaid and Medicare, offer promising approaches to encouraging integration.



Approaches that can be used to pay for integrated care include: 1) new fee-for-services billing codes (e.g., Washington State’s Collaborative Care Model codes); 2) care management payments (e.g., New York’s case rates for qualified Collaborative Care Model providers); 3) bundled payments (e.g., Minnesota’s Diamond model); and 4) primary care capitation (e.g., Rhode Island’s primary care capitation framework).²² Each of these payment approaches can also be tied to value-based incentives around progress toward evidence-based behavioral health care integration or quality performance, depending on which program is being implemented.

Implementation can be further supported by financing evidence-based learning collaboratives for providers, in addition to financing integrated care directly.

²¹ “[Potential economic impact of integrated medical-behavioral healthcare](#),” Milliman Research Report, January 2018.

²² [Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care](#) (Center for Health Care Strategies, Inc., Aug. 2019).

Collaboratives help build practices' capacity to adapt to new work streams, team-based care, and digital technologies and improve integration with community resources.

As policymakers are contemplating ways to support the Centers for Medicare and Medicaid Services (CMS) and the states, there are many promising models to consider in support of the integration of behavioral health with primary care. Illustrative models include:

- Providing incentives for providers to achieve quality performance milestones related to behavioral health care integration and participate in quality improvement collaboratives, as Arizona did with its Targeted Investments Program, part of a Medicaid waiver program. Evaluation reports found a general increase in integration levels across all participating providers.²³
- Integrating substance use disorder services within an existing primary care setting, as the Southwest Montana Community Health Center, a federally qualified health center (FQHC) in Butte, Montana, does. This health center links people to counseling and other community programs by deploying evidence-based models like screening, brief intervention, and referral to treatment (SBIRT). In a large study of SBIRT outcomes, at six-month follow-up, illicit drug use was 68 percent lower and heavy alcohol consumption was 39 percent lower among individuals who had screened positive for hazardous drug and alcohol use.²⁴
- Addressing isolation through psychosocial rehabilitation, as Fountain House does. Health and wellness programming ensures people with SMI can access primary and psychiatric care, care management, and home- and community-based services, which have been shown to reduce hospitalizations and decrease costs for Medicaid.²⁵
- Embedding mental health teams with primary care practices to build stronger local service provider relationships that are responsive to community needs, as

²³ “[Tackling America’s Mental Health and Addiction Crisis Through Primary Care Integration](#),” Bipartisan Policy Center, March 2021.

²⁴ “[Integration of Mental Health Services in Primary Care Settings](#),” Rural Health Information Hub, 2022; Suneel M. Agerwala and Elinore F. McCance-Katz M.D., “[Integrating Screening, Brief Intervention, and Referral to Treatment \(SBIRT\) into Clinical Practice Settings: A Brief Review](#),” *Journal of Psychoactive Drugs*, 44:4, 307-317 (Sept. 2012).

²⁵ Joshua Seidman and Kevin Rice, *Brief Summary of Evidence Supporting Clubhouses* (Fountain House, Jan. 2022).

Australia's GP Clinic does. To improve access to primary health care, a multidisciplinary team consisting of mental health nurses, a social worker and psychologist seek to help manage complex needs of people in rural settings.²⁶

V. Expand and Diversify the Workforce by Engaging a Wide Variety of Providers

The evidence supports engaging a wider array of providers in the behavioral health care team, a broader set of providers than most people have access to today. Medicare covers only a set of traditional providers, such as psychiatrists, psychologists, and social workers, but not other types of licensed providers, such as marriage and family therapists or counselors. Through their flexibility, state Medicaid managed care plans often cover a range of providers that also increasingly include paraprofessionals. Paraprofessionals encompass a range of workers, from certified peer support specialists to community health workers, that play important roles across the care continuum.

Trained and accredited peer support specialists leverage their lived experience of mental health or substance use conditions to support others in recovery. There is evidence that peer support specialists can be effective in engaging people with treatment, reducing the use of emergency rooms and hospitals and reducing substance use among people with co-occurring substance use disorders.²⁷ Peer support, which was developed in response to the lack of access to effective care in many communities, is now increasingly part of the continuum of care. Approximately 25 percent of mental health treatment facilities and 56 percent of facilities treating substance use disorders self-reported offering peer support services in 2018.²⁸ As of 2018, 39 states allowed for Medicaid billing of peer support specialists.²⁹

Often, peer support specialists assist with the transition from hospital to community or participate in intensive programs, providing necessary additional support as part of a care team. Increasingly though, peer support specialists are being engaged earlier and can be a critical partner and extender for integrated care models, including in collaborative care, where they help with navigating treatment and other services while

²⁶ Scott J. Fitzpatrick et al., “[Coordinating Mental and Physical Health Care in Rural Australia: An Integrated Model for Primary Care Settings](#),” *International Journal of Integrated Care* vol. 18, no. 2 (2018).

²⁷ “[Peers Supporting Recovery from Mental Health Conditions](#),” SAMHSA, 2017.

²⁸ C. Page et al., “[The Effects of State Regulations and Medicaid Plans on the Peer Support Specialist Workforce](#),” *Health Services Research* vol. 55 issue S1 (Aug. 2020).

²⁹ Lynn Videka et al., [National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement](#) (University of Michigan School of Public Health Behavioral Health Workforce Research Center, Aug. 2019).

building key self-management skills.³⁰ Clinicians appreciate peer support specialists for the additional support they lend and for keeping care grounded in the needs of the individual, ensuring that the services ultimately advance recovery.³¹

Community health workers, on the other hand, work closely with the community in more of a public health role. Research has demonstrated that for every dollar invested in a community health worker intervention, it returned \$2.47.³² In behavioral health, community health workers can educate the community about mental health and substance use issues, help people identify needs and get connected to care, and even offer some frontline interventions to reduce stress. For example, community health workers in Louisiana effectively worked with pregnant women to facilitate virtual interventions and provide social support to prevent the onset of postpartum depression.³³

Furthermore, engaging community health workers who are representative of the populations they are seeking to reach can be an important way to reduce disparities in communities where people might not feel comfortable reaching out for help.

Integrated behavioral health models that include paraprofessionals illustrate the potential for improving access to care and treatment. These include:

- Primary care providers who assess patients based on intensity of symptoms and then refer them to different types of providers based on level of need. Such providers could include a therapist for moderate to high needs or, for those with milder needs, lower-intensity therapies from providers of evidence-based mindfulness, self-help strategies, and well-being workshops. This model is akin to a stepped-care approach like the United Kingdom's Improving Access to Psychological Therapies, which seeks to address patients' needs upstream by providing first-line approaches for people normally untreated or undiagnosed with a behavioral health condition.³⁴

³⁰ Matthew Menear et al., “[Strategies for engaging patients and families in collaborative care programs for depression and anxiety disorders: A systematic review](#),” *Journal of Affective Disorders* vol. 263 (Feb. 15, 2020).

³¹ Marianne Storm et al., “[Peer Support in Coordination of Physical Health and Mental Health Services for People With Lived Experience of a Serious Mental Illness](#),” *Frontiers in Psychiatry* vol. 11 (May 08, 2020).

³² Shreya Kangovi et al., “[Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return On Investment](#),” *Health Affairs* 39(2): 207-213 (Feb. 2020).

³³ Christopher Mundorf et al., “[Reducing the Risk of Postpartum Depression in a Low-Income Community Through a Community Health Worker Intervention](#),” *Maternal and Child Health Journal* vol. 22, 520-528 (Dec. 29, 2017).

³⁴ “[Adult Improving Access to Psychological Therapies Programme](#),” NHS.

- The engagement of peer specialists as a part of clinical teams, as both the Institute for Community Living in New York City and the Lowell Community Health Center in Lowell, Massachusetts, have done. These initiatives demonstrated improvements in patient engagement, supported the delivery of interventions in smoking cessation and exercise, and provided chronic disease management support.³⁵
- The introduction of a new type of provider to fill workforce gaps, like general practice mental health workers, who are health professionals with a background in social support, basic psychology training, or nursing and work under supervision of a primary care provider. In the Netherlands, the integration of general practice mental health workers into primary care settings has improved patients' quality of life as well as prevented mental health conditions from developing or further intensifying.³⁶

Despite the evidence on improved outcomes and cost savings, most Americans do not currently have access to the providers described here. To remedy that, policymakers could:

- Ensure that incentives, financing, and support for integrated care are inclusive of the paraprofessional workforce.
- Provide specific incentives for systems to recruit, integrate, and retain paraprofessionals, and other workforce extenders.
- Implement learning collaboratives and quality improvement initiatives around integrating a broader workforce into the continuum of care, including issues around effective supervision and delineation of roles to maximize impact.
- Consider how to improve coverage of a broader workforce, including reimbursement for peer support specialists in Medicare.

VI. Leverage Telemedicine and Digital Health Solutions

Now is the time to be optimistic about the potential of technology to address behavioral health needs. The pandemic caused a sudden shift: at a time when the need for support was greater than ever, people sought mental health care over the telephone and via online platforms. In addition, technology-enabled solutions have resulted in unprecedented investment in digital health tools that can help solve the provider shortage through on-demand therapy, guided mediation, chat-bots and more.

³⁵ Mary Docherty et al., *How Practices Can Advance the Implementation of Integrated Care in the COVID-19 Era* (Commonwealth Fund, Nov. 2020)

³⁶ Joost Wammes et al., “[Netherlands](#),” in Roosa Tikkanen et al., *International Health Care System Profiles* (Commonwealth Fund, June 2020).

Telemedicine can be an effective way to improve mental health, especially through cognitive behavioral therapy. Evidence shows that telemedicine is at least as effective as face-to-face interventions in tackling depression and anxiety, symptoms of obsessive-compulsive disorder, insomnia, and excessive alcohol consumption.³⁷ Telemedicine has also been shown to alleviate maternal depression symptoms.³⁸

The COVID-19 pandemic, and the expanded flexibilities that were authorized around the provision of telehealth services, brought about sharp increases in the number of facilities providing telehealth treatment for both mental health and substance use services. The proportion of substance use treatment facilities offering telehealth services jumped from 28 percent in 2019 to 59 percent in 2020. For mental health facilities, the share grew from 38 percent to 69 percent over the same period.³⁹

Among Medicare beneficiaries, visits to behavioral health specialists accounted for the largest increase in telehealth in 2020. Telehealth comprised a third of total visits to behavioral health specialists. Yet despite the increase in available services, Black and rural Medicare beneficiaries had lower telehealth use compared with white and urban beneficiaries, respectively. Telehealth use varied by state, with higher use in the Northeast and the West and lower use in the Midwest and the South. Urban beneficiaries had about 50 percent higher telehealth use than rural beneficiaries — 1,659 visits per 1,000 urban beneficiaries versus 1,112 visits per 1,000 among rural beneficiaries. Compared with pre-pandemic levels, this represents a 140- and 20-fold increase in telehealth use for urban and rural beneficiaries, respectively.⁴⁰

As Congress and the Biden administration weigh options for extending the telehealth flexibilities beyond the public health emergency,⁴¹ it will be essential to understand the barriers faced by Black and rural beneficiaries in accessing telehealth and tele-mental health services, so that policies serve to ameliorate disparities rather than exacerbate them.

³⁷ Tiago C.O. Hashiguchi, *OECD Health Working Paper No. 116: Bringing Health Care to the Patient: An Overview of the Use of Telemedicine in OECD Countries* (OECD, Jan. 2020).

³⁸ Uthara Nair et al., “[The effectiveness of telemedicine interventions to address maternal depression: A systematic review and meta-analysis](#)” *Journal of Telemedicine and Telecare* vol. 24, issue 10 (Oct. 22, 2018).

³⁹ Herman A. Alvarado, *Telemedicine Services in Substance Use and Mental Health Treatment Facilities* (SAMHSA, Dec. 2021).

⁴⁰ Lok W. Samson et al. *Medicare Beneficiaries’ Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location* (ASPE Office of Health Policy, Dec. 2021).

⁴¹ Josh LaRosa, “[Avoiding the Cliff: Medicare Coverage of Telemental Health and the End of the PHE](#),” *To the Point* (blog), Commonwealth Fund, Mar. 23, 2022

It is also noteworthy that the temporary continuous coverage requirement that kept Medicaid coverage intact during the health emergency helped to ensure access to medical and behavioral health services.⁴² Multiple studies have found that living in a Medicaid expansion state was associated with relative reductions in poor mental health by improving access, including access to services delivered through telehealth.⁴³ It is critical that expansion of telehealth and other digital innovations in medicine be undertaken with universal and equitable access to care in mind.

CMS has already begun to pilot some innovative models, such as Community Health Access and Rural Transformation (CHART), that specifically provide technical assistance to rural providers to help them fully benefit from technological innovations with both financial and regulatory flexibilities. The Committee could consider opportunities to provide additional support for these types of models, with a specific focus on building capacity for providers to offer telehealth for behavioral health as well as meeting the various access needs of beneficiaries so they can benefit from these innovations. This could include helping to identify spaces available to primary care providers that can be set aside for telehealth visits when patients do not have access at home or the knowledge to use the technology.

Digital mental health is expanding, with a host of startups offering solutions that promise to fill gaps in access to care. Digital health startups offering mental health services raised \$5.1 billion — \$3.3 billion more than any other clinical service, including diabetes and cancer care, in 2021.⁴⁴ The vast majority of these tools target employers, health plans, or consumers directly as app-based subscription services. A few health insurers and provider systems have created “digital formularies” that seek to make digital tools more a part of the system of care. Evidence regarding these tools is highly variable; some demonstrate effectiveness in randomized, controlled trials reflecting real-world conditions, while some have never been tested.

Technology brings a clear promise for extending the existing behavioral health system. The potential benefits include on-demand access, tailored to individual needs, and well-tested interventions. Technology also increases the potential for reducing disparities for people facing the greatest barriers to obtaining access to traditional

⁴² Cindy Mann, “[Stable and Continuous Coverage Provisions in Medicaid Gain Momentum Through Build Back Better Act](#),” *To the Point* (blog), Commonwealth Fund, Feb. 9, 2022.

⁴³ John Cawley et al., “[Third year of survey data shows continuing benefits of Medicaid expansions for low-income childless adults in the U.S.](#),” *Journal of General Internal Medicine* vol. 33, 1495–1497 (June 5, 2018).

⁴⁴ Adriana Krasniansky, Bill Evans, and Megan Zweig, [2021 year-end digital health funding: Seismic shifts beneath the surface](#) (Rockhealth.org, Jan. 2022).

systems of care, such as rural Americans, people who lack access to transportation, or persons with disabilities. On the other hand, digital tools raise concerns: we need our behavioral health dollars spent wisely, and we don't want to champion the use of tools that are ineffective or inaccessible for beneficiaries.

There is an opportunity to build capacity at CMS to work with National Institutes of Health and the Food and Drug Administration to consider payment and coverage implications for innovative new tools as they're being developed, ensuring that our public behavioral health system stays modern and effective. CMS has already taken steps to create codes for certain technologies that are gaining more widespread use (such as remote patient monitoring codes); CMS can build on those actions with additional support to create a permanent pipeline for supporting beneficiaries' access to innovation.

Policymakers can also help CMS work with states to host a learning collaborative and to provide technical assistance on appropriate coverage of digital tools in Medicaid, as well as strategies for ensuring access for the beneficiaries most likely to benefit.⁴⁵ Currently, states often make these decisions in isolation, left to identify, evaluate, and implement digital tools without the benefit of information on models or technologies that have demonstrated success in other health systems or states.

Among the many examples of the potential to harness technological innovations to improve behavioral health, illustrative ones include:

- Utilizing telepsychiatry and sharing electronic medical records to promote and encourage provider communication and co-management of patients, like Cherokee Health Systems, a community mental health center and federally qualified health center in Tennessee, does. Cherokee has embedded licensed behavioral health consultants in its primary care provider teams.⁴⁶
- Introducing a portfolio of digital patient engagement and self-management tools, as Montefiore Medical Center in the Bronx has done. Montefiore uses a secure online application and messaging system that has allowed for long-term clinical monitoring, engagement, and follow-up with patients. Interactions with patients were conducted via HIPAA-compliant text messages, and patients were offered

⁴⁵ Andrey Ostrovsky and Morgan Simko, “[Accelerating Science-Driven Reimbursement for Digital Therapeutics in State Medicaid Programs](#),” *Health Affairs Blog*, Oct. 30, 2020.

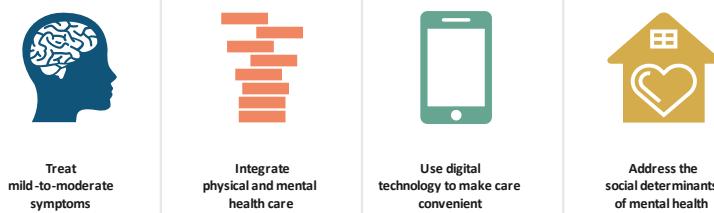
⁴⁶ *Chapter 4: Integration of Behavioral and Physical Health Services in Medicaid* (MACPAC, March 2016).

support, screening, condition monitoring, and prompts/recommendations around behavior modification, mindfulness exercises, and physical exercise.⁴⁷

VII. Conclusion: We Can Be Better

As I stated earlier, the problem is big and complex. However, we have tools to improve people's lives. It is certainly within our power to ensure that people's mental health and substance use needs are better met, especially youth, people with severe mental illness, residents of rural communities, and historically excluded Black, Latino, and Indigenous communities. There are myriad approaches to expanding access to services and prioritizing mental health, making care more convenient, and scaling treatment approaches to help more people.

Exhibit 4. Lessons Learned from Other Countries' Approaches to Expanding Mental Health Services



Data: Martha Hostetter and Sarah Klein *Making It Easy to Get Mental Health Care: Examples from Abroad* (Commonwealth Fund, Feb. 2021).

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This can all be done, and our communities will be the stronger for it. There is inspiration from abroad that we can draw upon.

For example, we can take inspiration from Italy's Trieste, which gives people grappling with mental health issues help with all aspects of their lives, ensuring their physical needs for food, clothing, and shelter are met; helping them forge connections

⁴⁷ Mary Docherty et al., *How Practices Can Advance the Implementation of Integrated Care in the COVID-19 Era* (Commonwealth Fund, Nov. 2020)

with other community members; and supporting them in their pursuit of meaningful activities, including employment.⁴⁸

We can be inspired by Belgium's Geel, a community that has accepted people with severe mental health needs for hundreds of years, supporting them and helping them find their own paths to better health.⁴⁹

In the coming months, we can work to implement policy approaches that reflect our own values and commit the investments necessary to guarantee a better future for individuals, families, and communities in America. You can lead the way by advancing bipartisan policies for meeting these goals.

I believe that, as a nation, we can do better. And by providing new opportunities to expand access to equitable, affordable care and treatment and address our behavioral health crisis, ultimately, we can be better.

⁴⁸ Rob Waters, “[A New Approach to Mental Health Care, Imported from Abroad](#),” *Health Affairs* 39, no. 3 (Mar. 2020): 362–66.

⁴⁹ Angus Chen, “[For Centuries, A Small Town Has Embraced Strangers with Mental Illness](#),” July 1, 2016 in NPR.