November 12, 2021

Chairman Ron Wyden
Senate Committee on Finance
221 Dirksen Senate Office Bldg.
Washington, DC 20510

Ranking Member Mike Crapo
Senate Committee on Finance
239 Dirksen Senate Office Bldg.
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is pleased to offer comments in response to the Senate Committee on Finance's request for information on behavioral health care. As the country's single largest payer for behavioral health services, Medicaid is uniquely positioned to address gaps in our systems of care for mental health and substance use. NAMD encourages the Committee to give state Medicaid programs additional tools to improve the accessibility, affordability, and quality of behavioral health care.

Specifically, we recommend that Congress:

- **Repeal the IMD exclusion,** an outdated provision that unduly limits access to medically necessary intensive inpatient care
- **Allow states to provide Medicaid coverage for incarcerated individuals within 90 days of release,** lowering the risk of behavioral health crises during re-entry
- **Lift the prohibition on Medicaid paying directly for room and board costs** associated with evidence-based behavioral health services
- **Address urgent workforce shortages** by allowing states to claim federal match on training programs and by providing federal resources to support sustainable rate increases
- **Ensure that telehealth services are high-quality and accessible** while preserving access to in-person care where appropriate
- **Build robust crisis continuums** by creating clear Medicaid reimbursement structures for 988 hotlines and providing ongoing funding for mobile crisis teams and crisis stabilization centers
- **Better integrate primary care and behavioral health care** by removing regulatory barriers and promoting coordination
- **Meet the unique needs of children and young adults** by addressing workforce gaps and funding new models of care

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Medicaid's Role in the Behavioral Health Care System

Today, Medicaid covers approximately one in four Americans.[1] Medicaid members have a diverse range of experiences, but do, as a whole, have significant behavioral health needs: 28 percent of adults covered by Medicaid have a mental illness, as compared to 19 percent of adults with private insurance.[2] As the nation's primary source of coverage for low-income people and people with disabilities, Medicaid also often serves individuals with complex behavioral health, physical health, and social needs. Effectively meeting these needs requires holistic interventions that cut across our country's siloed systems of care.

As the single largest payer for behavioral health services in the United States,[3] Medicaid is uniquely positioned to address gaps in our systems of care for mental health and substance use. NAMD encourages the Committee to give state Medicaid programs additional tools to improve the accessibility, affordability, and quality of behavioral health care.

Strengthening Medicaid's Ability to Address Behavioral Health

In addition to the Committee's specific areas of interest, which are discussed in detail below, NAMD has identified overarching opportunities for Congressional action.

Specifically, we recommend that Congress:

- **Repeal the IMD exclusion.** The institutions for mental diseases (IMD) exclusion prohibits Medicaid from paying for care provided in residential treatment centers with more than 16 beds, representing a major barrier to treatment access. Since the IMD exclusion's enactment in 1965, the nation's understanding of mental health and addiction has evolved significantly and states have shifted away from institutional models of care, instead developing robust community-based options. However, residential care is sometimes clinically necessary, and the IMD exclusion prevents states from effectively providing this care. The negative impacts of the exclusion span the behavioral health system: it has hindered states' efforts to use Qualified Residential Treatment Programs (QRTPs) to improve their child welfare systems, limits the ability of Medicaid to fund residential care for substance use, and disproportionately impacts treatment access in rural communities that lack wide provider networks. Repealing the exclusion would significantly expand access to services for Medicaid members and ensure the full continuum of service needs are met.

[1] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html
[2] https://www.macpac.gov/wp-content/uploads/2020/09/Behavioral-Health-in-Medicaid-Work-Plan-and-Initial-Analyses.pdf
[3] https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf

    - NAMD recognizes that the history of institutionalization creates concerns about a potential return to the conditions that led to the creation of the IMD exclusion. To mitigate these concerns and firmly situate IMDs within a full care continuum, Congress could consider establishing quality of care and programmatic standards that ensure members are placed in the least restrictive settings that meet their clinical needs and that stays in institutions are short-term; require states to maintain full continuums of care with robust community-based options; and institute mechanisms to ensure providers deliver care that meets national standards. Such requirements align with those established within current 1115 demonstration waivers allowing IMD coverage in certain circumstances for individuals with substance use disorders or serious mental illnesses.
- **Allow states to provide Medicaid coverage for incarcerated individuals within 90 days of release.** People who are re-entering from incarceration are at significantly higher risk of drug overdoses and other behavioral health crises in the weeks following their release. The option of pre-release coverage allows states to coordinate care, create pathways to services in the community, and prevent gaps in medication access. Together, these efforts can lower the risk of overdose, recidivism, and other negative outcomes.
- **Lift the prohibition on Medicaid paying directly for room and board costs associated with evidence-based behavioral health services.** A lack of stable housing is a major barrier to recovery for many people with behavioral health conditions. Currently, Medicaid is only able to pay for room and board in institutional care settings like nursing homes. This severely limits states' abilities to provide evidence-based interventions like permanent supportive housing that holistically address members' behavioral health needs, along with residential treatment modalities.
- **Create new authorities or modify existing authorities to allow fee-for-service Medicaid delivery systems to provide wrap-around services for behavioral health.** Wrap-around services, such as housing, employment, and family supports, can be crucial elements of behavioral health treatment plans. Currently, states with managed care delivery systems can use mechanisms like directed payments and in lieu-of services to provide these supports to their Medicaid members. Fee-for-service delivery systems should be granted these same flexibilities to ensure equitable access to services across states.

Building a Strong Workforce

States identify workforce shortages as one of the biggest – if not the biggest – challenges facing their behavioral health care systems. Although these issues span the continuum of care, states identified acute shortages among specific provider types (including psychiatrists, social workers, and psychiatric nurse practitioners), multi-lingual providers, and Black/Latino providers. These shortages are compounded by financial

and regulatory barriers that discourage provider participation in Medicaid and CHIP, threatening the ability of Medicaid members to access behavioral health care.

Increasing Medicaid reimbursement rates to be more competitive with commercial rates is an important first step in addressing these challenges. However, we encourage Congress to craft a broader strategy to recruit, train, and retain behavioral health care providers, with a specific focus on diversifying the workforce and ensuring access in rural and underserved communities. We also encourage Congress to address the barriers (including lower reimbursement rates, higher administrative burdens, and higher rates of no-shows) that reduce provider participation in Medicaid and CHIP.

Specifically, Congress could:

- **Allow states to generate federal match on workforce training programs,** including programs focused on developing career paths for peers and community health workers. This would give states the financial resources they need to create strong pipelines to careers in behavioral health. Alternatively, Congress could establish other funding models like grants to support the development of training programs.
- **Diversify the types of providers in the behavioral health workforce by creating incentives for the use of peer support professionals, community health workers, and health navigators and create pathways for these workers to become licensed providers.** These direct support professionals can fill existing gaps in care and create a more stable and resilient workforce. Congress should also create pathways for these types of workers to become licensed providers.
- **Expand scholarship and loan forgiveness programs and create incentives for practicing in rural or underserved communities.** Scholarship and loan forgiveness programs should explicitly aim to increase the number of multilingual and Black/Latino providers. Congress should also consider providing financial incentives like loan forgiveness programs, increased reimbursement rates, and tax credits to providers who agree to practice in rural or underserved communities.
- **Reduce administrative burdens associated with Medicaid and CHIP participation.** This could include loosening documentation requirements like treatment planning, simplifying processes for enrolling as a Medicaid provider, and providing greater flexibility in reimbursement structures to allow for case rates or bundled payments for multiple services.

Developing Robust Continuums of Crisis Services

Adults with mental illness who are covered by Medicaid are significantly more likely to be involved in the justice system than those who are privately insured,[4] highlighting the need for robust crisis intervention services. Recent Congressional actions, including the American Rescue Plan's state option for mobile crisis response teams and the designation of 988 as the nation's crisis hotline, have created new opportunities to build out these services. However, states report ongoing regulatory, financial, and operational barriers to developing full continuums of crisis care.

Specifically, we encourage Congress to:

- **Create clear Medicaid reimbursement structures for 988 hotlines.** Although Medicaid members will undoubtedly utilize 988 hotlines, it is unrealistic to expect hotline workers to gather a person's insurance information while they are experiencing a behavioral health crisis. In order to effectively plan for 988 implementation, states need additional information on Medicaid's approach to reimbursement. Congress should also develop ways to ensure that commercial payers cover their fair share of 988 operating costs, as telecommunications fees and Medicaid reimbursements are unlikely to cover the full costs of operating these hotlines.
- **Create ongoing federal investments in mobile crisis teams**. The American Rescue Plan created new opportunities for states to fund mobile crisis teams through their Medicaid programs. Congress and federal agencies should work with commercial payers and other stakeholders to develop sustainable funding models beyond Medicaid, along with ensuring long-term fiscal support for Medicaid's role in providing these services.
- **Exempt crisis stabilization centers from the IMD exclusion.** Crisis stabilization centers provide short-term residential care to people experiencing behavioral health emergencies, preventing clinically inappropriate and costly stays in emergency rooms and jails. These stays last no longer than 72 hours. As states look to develop their crisis stabilization continuums by creating these settings, there is a risk that the IMD exclusion's 16-bed cap will inhibit the scalability of these services. This challenge is particularly acute in rural communities with limited provider networks. Even if Congress does not repeal the IMD exclusion, NAMD believes that crisis stabilization centers – which, by definition, provide short-term stays – are not the types of institutions that Congress intended to exclude from Medicaid coverage.

Notably, building out a strong continuum of behavioral health services is crucial to ensuring the success of crisis response interventions. Without accessible treatment options, hotlines and crisis teams have nowhere to divert patients. NAMD strongly

[4] https://www.macpac.gov/wp-content/uploads/2020/09/Behavioral-Health-in-Medicaid-Work-Plan-and-Initial-Analyses.pdf

encourages Congress to consider investments in treatment system capacity as a crucial aspect of developing crisis response systems.

Integrating Behavioral Health and Primary Care

Our country's health care system is fragmented, which can make accessing behavioral health services complex and confusing. To address this, we must "meet people where they are" by providing behavioral health assessments, treatment, and care coordination in the places people already go for help. As the nation's largest platform for health care delivery, primary care settings are a key site for this type of integration.

To promote behavioral health and primary care integration, Congress could:

- **Provide comprehensive education on integrated models of care for health care professionals,** including physicians, registered nurses, physician assistants, psychiatric nurse practitioners, social workers, and other providers.
- **Remove regulatory barriers that restrict access to medications for opioid use disorder in primary care settings.** Strict regulations on the provision of methadone restrict the ability of primary care providers to treat opioid use disorder. Congress should also lift the X waiver requirement for buprenorphine prescribing. Together, these actions would facilitate the integration of addiction treatment services into primary care, greatly expanding access to treatments for opioid use.
- **Promote the adoption of electronic health records/electronic medical records by behavioral health providers.** Behavioral health providers were initially excluded from HITECH funds, which slowed the adoption of electronic health records and electronic medical records. This has made coordination between provider types more difficult. Congress should provide additional funding targeted at the behavioral health provider- or clinic-level to support the adoption of interoperable and integrated systems. This could potentially include re-appropriation of HITECH funds with the inclusion of behavioral health providers to correct their initial exclusion from these funds.
- **Evaluate data sharing restrictions and other regulatory barriers that restrict integration.** The Coronavirus Aid, Relief, and Economic Security (CARES) Act included data sharing provisions that better align 42 CFR Part 2 with HIPAA. However, HHS is still developing the final rules,[5] so it is unclear how these changes will impact data sharing, and states report that many providers lack a strong understanding of what data sharing is allowable even under current law. The federal government should evaluate these questions and provide clear guidance to providers. Additionally, Congress should evaluate if there are regulatory barriers in Medicaid reimbursement policy that may restrict integration.
- **Launch Center for Medicare & Medicaid Innovation (CMMI) models** aimed at integrating behavioral health care and primary care for Medicaid members.

[5] https://www.samhsa.gov/newsroom/statements/2021/42-cfr-part-2-amendments-process

As we build capacity in the primary care system to address behavioral health, it is also important to increase the accessibility of specialty care for people with severe and persistent mental illnesses or substance use disorders. Certified Community Behavioral Health Clinics (CCBHCs), which provide timely access to care and robust coordination with social services and the justice system, may be a particularly valuable model for these patients, although many models of specialty care exist.

It is also important to note that the US territories face unique challenges providing behavioral health services, including critical shortages of providers and lack of telehealth access. Congress should consider dedicated funding to build out behavioral health care systems in the US territories, along with addressing the longstanding fiscal challenges[6] faced by the territories' Medicaid programs.

Ensuring that Telehealth Services are High-quality and Accessible

The COVID-19 pandemic dramatically accelerated the uptake of telehealth for behavioral health services. The quality and cost-effectiveness of telehealth relative to in-person care is not yet clear, and we support ongoing research to explore these questions. However, most states report that telehealth appears to increase access to care and retention in services and is generally acceptable to patients.

It is crucial to ensure that the widespread adoption of telehealth does not create new disparities in behavioral health care access. States emphasize the need to close the "digital divide" and ensure that both providers and Medicaid members have access to the technology needed for telehealth services. Telehealth is also not an appropriate or preferred model of care for all patients (for example, people who are experiencing intimate partner violence, participants in group therapy, or patients who are not comfortable using computers or smartphones), so it is essential that in-person options also remain accessible.

To accomplish these aims, Congress could:

- **Allow Medicaid to fund broadband connectivity, along with room and board.** It is very challenging for Medicaid members who lack internet connectivity and stable housing to access telehealth. Funding broadband connectively and lifting the prohibition on Medicaid paying for room and board costs associated with evidence-based behavioral health services can help prevent new disparities in access to behavioral health care.
- **Provide long-term federal funding for technology and broadband connectivity.** Additional federal funding (such as long-term Federal Communications Commission funding) for broadband connectivity and technological devices is crucial to ensuring patient access. Funds should also

[6] https://namdstg.wpengine.com/wp-content/uploads/2022/02/Territory-Operations-Survey.pdf

support providers who are seeking to adopt telehealth modalities, with an emphasis on smaller providers who may lack the funds to pay for these systems.

- **Fund ongoing research into the effectiveness of telehealth for various behavioral health interventions.** The relative effectiveness of telehealth for different models of behavioral health care and different patient populations remains unclear. Congress should fund ongoing research into best practices.
- **Develop reimbursement models that incentivize providers to offer both in-person and telehealth options**. States emphasize that providing in-person care can be associated with additional long-term costs to providers, including overhead costs. Increased reimbursement rates or other financial incentives may encourage behavioral health providers to continue providing multiple modalities of care.

Meeting the Unique needs of Children and Young People

Children and young people face different behavioral health challenges than adults, and Congress should consider distinct approaches to improve the accessibly and quality of care for this population. States report a critical shortage of providers specializing in children's behavioral health, which is compounded by a lack of treatment availability after school or work hours. As in the adult system, enhancing reimbursement rates, creating additional loan forgiveness programs and scholarships, and offering career development opportunities is essential to addressing these shortages. In addition, Congress should specifically consider the needs of young people with co-occurring intellectual and developmental disabilities (IDD) and mental health conditions.

States also emphasize the unique care coordination needs of children and young people. Caregiver or family involvement is critical, and young people are more likely to be involved in multiple systems (including education, child welfare, and the juvenile justice system). In these cases, providing effective treatment often requires a care coordination team or providers who are well-versed in working across systems. Congress should develop reimbursement structures that incentivize this type of care coordination, and clear guidelines for braiding funding across these different systems.

Specifically, Congress should:

- **Develop treatment options for young people with co-occurring IDD and mental health conditions.** States emphasize the lack of treatment options for these young people, who are generally served through Medicaid waiver programs. Congress should convene experts to develop new models of care for this patient population.
- **Address ongoing challenges implementing QRTPs.** QRTPs, which were created by the Family First Act, are a type of setting that provides behavioral health services to young people in foster care. States face challenges implementing this care model due to the IMD exclusion, which prohibits states

from using federal Medicaid funds for mental health facilities with more than 16 beds.

- **Incentivize states to enhance Medicaid reimbursement rates for providers who specialize in children's behavioral health,** and fund scholarships, loan forgiveness programs, and training programs to build a stronger workforce. Congress should also consider specific career development opportunities for peer support specialists, peer family specialists, community health workers, and non-clinical professionals.
- **Develop CMMI models or provide other dedicated funding to help states build cross-system relationships.** Care coordination across health care, juvenile justice, child welfare, and education systems is essential to providing holistic care to young people. Federal agencies should also provide clear guidelines for braiding federal funding sources across these systems.
- **Fund ongoing research specifically into the safety and efficacy of telehealth for children's behavioral health issues.** There are additional considerations associated with providing telehealth to children, including issues of consent and challenges recognizing child abuse. As part of a broader research effort, Congress should create dedicated funding for studying the use telehealth in children's behavioral health services.

Addressing the behavioral health needs of our country will require sustained efforts and creative solutions that cut across providers, payers, and systems. Medicaid is uniquely positioned to help drive these improvements. NAMD appreciates the opportunity to provide these comments to the Committee and looks forward to working together to improve our country's behavioral health care system.

Sincerely,

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