



TO: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS)

FROM: The Commonwealth Fund

DATE: November 4, 2022

SUBJECT: Request for Information on Promoting Efficiency and Equity Within CMS Programs

TOPIC 1: ACCESSING HEALTHCARE AND RELATED CHALLENGES

PRIMARY CARE: CHALLENGES

Decades of underinvestment and provider shortages have limited access to effective primary care in the U.S. Compared to adults from other high-income countries, U.S. adults are the least likely to have a regular physician or place of care. Patients in the U.S. are also less likely to be able to receive care after-hours and get treatment in their own homes—both critical to avoiding unnecessary emergency department trips. These shortcomings disproportionately affect Black and Latinx communities and people living in rural areas.

Source: <https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/primary-care-high-income-countries-how-united-states-compares>

PRIMARY CARE: POLICY RECOMMENDATIONS

To enable access to quality care, experts have called for increased payment for primary care services. CMS can:

- Reform the physician fee schedule's process by developing independent data-collection procedures for its relative value updates and forming a technical expert panel to identify incremental improvements.
- Scale CMMI models that pivot primary care away from relying on Medicare's fee-for-service payments.
- Use its authorities to achieve payment reform within permanent programs (e.g., MSSP).
- Provide state Medicaid agencies with guidance for implementing hybrid payments in primary care, including ways to leverage managed care contracts and incentives to enable community health centers to engage in alternative payment models.

Sources:

<https://www.commonwealthfund.org/blog/2022/evidence-based-strategies-strengthening-primary-care-us>;

<https://www.commonwealthfund.org/blog/2022/paying-differently-primary-care-better-health-greater-equity>;

https://www.commonwealthfund.org/sites/default/files/2021-01/CMWF_DSR_TaskForce_Six_Policy_Imperatives_report_v3.pdf

HOME HEALTH: CHALLENGES

Challenges

Medicare home health services offer an essential alternative to institutional care. However, many beneficiaries are not aware of the benefit, many providers do not order these services for their patients, and home health agencies often do not provide the full range of services.

Beneficiaries often pay out-of-pocket for home care that is eligible for coverage under Medicare, rely on unpaid caregivers, or are forced to receive care at nursing homes due to lack of help from aides with activities of daily living. Reliance on unpaid caregivers has been shown to result in poorer health outcomes and more hospital readmissions.

Sources:

<https://www.commonwealthfund.org/publications/other-publication/2022/jul/improving-medicare-home-health-benefit-lessons-medicaid>;

<https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/community-based-long-term-services-and-supports-are-needs-older>;

<https://www.commonwealthfund.org/publications/issue-briefs/2022/jun/changes-medicare-home-health-use-during-covid-19>;

<https://www.commonwealthfund.org/blog/2022/medicare-home-health-benefit-unkept-promise>

HOME HEALTH: POLICY RECOMMENDATIONS

To prevent unwarranted home health coverage denials, CMS can:

- Implement uniform claims review processes, establish training requirements for Medicare Administrative Contractors (MACs), monitor for outliers, and institute penalties for unwarranted denials.
- Require MACs to report coverage denials by condition, service type, race, age, functional status, cognitive deficit, and episode trigger to identify disparities.
- Establish a baseline level of functional and cognitive impairment that indicates medical necessity, similar to criteria used for chronic care management or Medicaid HCBS.

To improve beneficiary experience and optimize service availability, CMS can:

- Educate certifying providers, beneficiaries, and caregivers on coverage parameters and the full panel of home health services.
- Establish a robust monitoring program to ensure beneficiary needs are met.
- Enforce the family caregiver preparedness requirements included in current home health agency conditions of participation.
- Create a toolkit to help home health agencies determine the appropriate mix of services for a beneficiary.
- Update home health agency conditions of participation to include standards for home health aide staffing, such as staffing ratios, and institute penalties for withholding services.

To ensure that quality metrics and payment policies reward whole-person care, CMS can:

- Confirm that the Home Health PPS adequately captures the costs of providing care for chronic illness and cognitive impairment.
- Adopt measures on reducing racial/ethnic disparities and link payment to meeting performance benchmarks.

Sources:

https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/04/Optimizing-the-Medicare-Home-Health_R0_Web-Ready.pdf;

<https://www.commonwealthfund.org/blog/2022/medicare-home-health-benefit-unkept-promise>

BEHAVIORAL HEALTH: CHALLENGES

Poor access to behavioral health services—often attributed to provider shortages, low reimbursement rates, barriers to accessing services, and stigma—is a serious obstacle to successful treatment. While access has improved for white people over the past decade, there has been less improvement for people of color.

Provider shortages are a major challenge, particularly in rural areas. People in urgent need of help sometimes spend hours or days waiting in the emergency department. The U.S. needs an estimated additional 7,400 mental health providers to meet current demand. Despite evidence that diversifying the workforce to include providers like peer support specialists would help fill these gaps and improve outcomes, many people cannot access these types of providers through their insurance.

Sources:

<https://www.commonwealthfund.org/publications/explainer/2022/sep/behavioral-health-care-us-how-it-works-where-it-falls-short>;

<https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities>

BEHAVIORAL HEALTH: POLICY RECOMMENDATIONS

Integrating behavioral health services with primary care promotes access, addresses workforce shortages, and can reduce disparities. CMS can:

- Provide options for upfront financing to implement integrated care, as with the new Advanced Payment Incentives in MSSP.
- Offer reimbursements that acknowledge additional costs and complexity of running an integrated practice, in addition to the costs of providing each unit of integrated care services.
- Ensure that incentives and financing for integrated care are inclusive of the paraprofessional workforce (e.g., certified peer support specialists, community health workers).
- Implement learning collaboratives and quality improvement initiatives on integrating a broader workforce into the care continuum.
- Consider coverage of a broader workforce, including peer support specialists in Medicare.
- Provide detailed guidance to states on implementing the Collaborative Care Model in Medicaid.

Sources:

https://www.commonwealthfund.org/sites/default/files/2022-03/Williams%203.30%20SFC%20Testimony_Final%20%281%29.pdf;
<https://www.commonwealthfund.org/publications/explainer/2022/sep/integrating-primary-care-behavioral-health-address-crisis>

PAYING FOR CARE: CHALLENGES

Medicare

Older Americans in the U.S. pay more for health care and are more likely to postpone or skip care because of the cost, compared to their counterparts in other high-income countries.

Cost-sharing and gaps in coverage disproportionately impact enrollees of color. Research shows that many Black and Latinx beneficiaries face high out-of-pocket costs that cause them to delay or forgo care. Beneficiaries reported that they felt responsible for staying on top of health costs, and that a lack of clarity around covered services, costs, and billing caused anxiety or frustration.

Sources:

<https://www.commonwealthfund.org/publications/surveys/2021/oct/when-costs-are-barrier-getting-health-care-older-adults-survey>;
<https://www.commonwealthfund.org/blog/2022/older-black-and-latinx-adults-talk-about-affordability-challenges>

Marketplace

Recent Commonwealth Fund research revealed that high premium costs are the main reason reported for forgoing or dropping coverage for marketplace or individual market plans. Even those who purchase coverage often face challenges paying for needed services: 44% of respondents with individual market or marketplace coverage were underinsured, meaning that their coverage was not sufficient to enable affordable access to health care.

The rise of short-term insurance plans has also contributed to high costs by drawing healthier people out of the individual market and marketplaces, increasing premiums for those who remain.

Source: <https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey>

PAYING FOR CARE: POLICY RECOMMENDATIONS

To improve affordability of market and marketplace plans, CMS can place limits on or ban short-term insurance plans and other coverage that doesn't comply with ACA benefit requirements.

Source: <https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market>

RECEIVING CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE: CHALLENGES

Recent Commonwealth Fund research revealed that one in four Black and Latinx older adults report experiencing discrimination in health care settings. These experiences were correlated with worse health status, economic hardship, and dissatisfaction with care. Black and Latinx older adults described experiencing discrimination and bias based on their race, ethnic background, language, age, gender, income, or source of insurance. They reported that providers had made assumptions about their health based on stereotypes, dismissed their complaints of pain, and offered inadequate interpretation services.

Sources:

<https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/how-discrimination-in-health-care-affects-older-americans>;

<https://www.commonwealthfund.org/publications/2022/jul/what-ideal-health-care-system-might-look-like>

RECEIVING CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE: POLICY RECOMMENDATIONS

To promote culturally appropriate care, CMS can:

- Improve oversight and enforcement of ACA requirements for marketplace plans to contract with essential community providers.
- Issue guidance on payment for community-based providers, such as doulas and midwives in Medicaid, pregnancy medical homes, and group prenatal care.

Sources:

<https://www.commonwealthfund.org/blog/2021/how-insurers-can-advance-health-equity-under-affordable-care-act>;

<https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity>

TOPIC 2: UNDERSTANDING PROVIDER EXPERIENCES

REDUCING ADMINISTRATIVE BURDEN: CHALLENGES

The U.S. spends as much as one-third of national health expenditures on administrative costs—far more than peer countries. In addition to being costly, these complex administrative processes—such as obtaining prior authorization, documenting visits, and billing—are a major cause of clinician burnout. As providers devote more time and resources to these tasks, they spend less time with patients, which compromises access to care, quality, and patient experience. Administrative burden is even heavier for independent practices, safety net providers, and providers in rural communities who often operate with fewer resources. Without taking on the administrative complexities in our system that contribute to waste and burnout, we will not be able to achieve a high-performing delivery system.

Source: https://www.commonwealthfund.org/sites/default/files/2021-01/CMWF_DSR_TaskForce_Six_Policy_Imperatives_report_v3.pdf

REDUCING ADMINISTRATIVE BURDEN: POLICY RECOMMENDATIONS

The Commonwealth Fund Task Force on Payment and Delivery System Reform outlines three areas for federal agency action to reduce administrative burden on providers:

1. **Develop uniform standards for billing and payment.** Working with stakeholders, Congress should direct ONC and CMS to create a uniform, national, standardized billing system and process that establishes a clearinghouse for billing claims submission and other national claims forms and protocols:
 - a. HHS should require all private payers and billing agents, including third-party administrators, that wish to enroll Medicare and Medicaid beneficiaries use these new billing processes or else pay the additional costs of using nonstandard processes. Such costs should be excluded from their medical loss ratio for regulatory purposes.
 - b. The federal government should enable patients, on a voluntary basis, to self-register with a national health information system that gathers personal health and administrative data to help their providers manage their health care more effectively. These data would be available, with patients' explicit permission, for research, administrative functions, and quality improvement by health care providers, payers, and public quality regulators.
 - c. CMS should require all Medicare Advantage and Medicaid managed care plans to eliminate or substantially reduce prior authorization requirements for providers that take on meaningful downside risk, use federally certified decision-support tools for specific conditions or situations, and meet quality and equity performance targets.
2. **Streamline and standardize performance metrics.** Congress should direct HHS to establish, in partnership with the Core Quality Measures Collaborative and through an open and inclusive process, a standardized, parsimonious set of core quality and equity metrics for data collection and reporting that will be used by all public and private insurers, purchasers and providers, with limited exemptions for data collection and reporting in cases where data are not clinically relevant.
3. **Remove unnecessary administrative obstacles in care delivery.** HHS should task the National Academy of Medicine with developing policy options to reduce administrative burden at the point of care.

Source: https://www.commonwealthfund.org/sites/default/files/2021-01/CMWF_DSR_TaskForce_Six_Policy_Imperatives_report_v3.pdf

SUPPORTING THE DIRECT CARE WORKFORCE: CHALLENGES

Direct care workers—also referred to as home health aides, personal care attendants, certified nursing assistants, or caregivers—provide services ranging from helping people bathe, dress, and eat to cleaning their homes and preparing meals, managing medication regimens, and providing companionship.

The COVID-19 pandemic exacerbated the challenges facing the direct care workforce, which was already underpaid, undervalued, and understaffed. As indicated in data from the U.S. Bureau of Labor Statistics, demand for direct care workers is expected to increase substantially in coming years, as the population of older adults and people with disabilities in the U.S. grows.

The stressors facing direct care workers include:

- Lack of competitive, livable wages and benefits (e.g., including paid time off and health insurance). Despite the shortage of staff, wages for direct care workers have remained flat. This is in large part because payment for direct care providers is mainly determined by states through their Medicaid long-term services and supports (LTSS) programs, which offer a range of benefits for those with disabilities and other conditions.
- Limited career pathways and advancement opportunities, regardless of levels of experience or skillset.
- Racism and sexism faced by women of color, who predominantly make up the workforce.

Creating a robust, valued, and fairly compensated direct-care workforce will necessitate action in both the public and private sectors. Significant wage increases, family-supporting benefits, and innovative recruitment, pipeline, and career advancement strategies are necessary.

Sources:

<https://www.commonwealthfund.org/publications/2021/jul/placing-higher-value-direct-care-workers>;

<https://www.commonwealthfund.org/publications/other-publication/2022/jul/improving-medicare-home-health-benefit-lessons-medicaid>;

<https://www.commonwealthfund.org/publications/2022/sep/how-better-support-build-direct-care-workforce-interview-kezia-scales>

SUPPORTING THE DIRECT CARE WORKFORCE: POLICY RECOMMENDATIONS

To strengthen the direct care workforce, the federal government could:

- Bolster data collection on the home- and community-based workforce, similar to how the federal government requires skilled nursing facilities to report on CNA and other staffing levels. While there have been discrete efforts to increase recruitment and retention and give more technical skills and supports, there are few rigorous evaluations of what seems to work. Since little is known about this workforce, they tend to get left out of health policy debates and their contributions to supporting people's health and wellbeing go unrecognized. Waivers for home- and community-based services would provide a mechanism by which the federal government could require collection of data on direct care workers and their roles. States could also ask health plans to collect such data and report on the metrics they use to measure their impacts, as some states have done with community health workers. Having a better picture of the direct care workforce would enable employers to make the case to government and private investors for investing in them, says Dr. Kezia Scales of PHI.
- Develop and test new ways to support the direct care workforce via CMMI. For example, CMMI could consider models that hold employers and health plans accountable for worker satisfaction, programs that incentivize training, or pay-for-performance programs involving direct care workers.

Source: <https://www.commonwealthfund.org/publications/2021/jul/placing-higher-value-direct-care-workers>

TOPIC 3: ADVANCING HEALTH EQUITY

RURAL MATERNITY CARE: CHALLENGES

Pregnant women living in rural America face unprecedented barriers to maternity care. First, hospitals are closing at an alarming rate; nearly 100 rural hospitals have closed their doors since 2010. Of those that remain, 20 percent are at risk of closing. Rural hospitals also are shutting down their obstetric (OB) units, leaving fewer than half of rural counties with such units.

These hospital and OB unit closures mean rural women in labor increasingly face lengthy journeys to the hospital, sometimes even hours long. They also have contributed to increases in births outside hospitals, births in hospitals without OB care, and in preterm births—all of which carry greater risks for mom and baby.

RURAL MATERNITY CARE: POLICY RECOMMENDATIONS

Potential solutions for addressing rural maternity care include:

- Medicaid coverage of doulas, who assist women during childbirth and help before labor by creating a birthing plan.
- Increasing Medicaid coverage of telematernity care or other digital support services to ensure providers can connect with rural pregnant women for prenatal care.
- Encouraging states to adopt Medicaid expansion, which is associated with improved finances for rural hospitals.

Source: <https://www.commonwealthfund.org/blog/2019/rural-maternity-care-crisis>

INTERVENTIONS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Social, economic, and location-based drivers of health (DOH)—such as safe housing, reliable transportation, and nutritious meals—have an outsize impact on health. This is especially true for Medicare and Medicaid beneficiaries, who are more likely to be elderly, have low income, or have complex medical needs. Advancing health and well-being for all will require action at the community level (e.g., structural change that improves the social and economic conditions for communities) and the individual level (e.g., identifying and connecting patients with the social services they need beyond the medical system). In our subsequent comments, we focus on the latter.

The Commonwealth Fund recently updated its evidence guide on the costs of health-related social needs interventions and their impact on health care utilization and cost of care for adults with complex health and social needs. This evidence is organized into seven intervention categories:

1. **Housing:** permanent supportive and transitional housing and medical respite care programs
2. **Home Modifications:** delivered as part of multi-component interventions to prevent falls among the elderly and mitigate environmental triggers for asthma
3. **Nutrition:** home-delivered meals, food prescriptions, and nutrition assistance programs
4. **Transportation:** nonemergency medical transportation
5. **Care Management:** programs that may address multiple social needs through multidisciplinary care teams, social worker–led interventions, coaching by community health workers and care navigators, and health and housing integration
6. **Counseling:** legal aid and financial assistance
7. **Social Isolation and Loneliness:** this is a new section with only a few studies, some of which also address other social needs such as nutrition.

This guide aims to be a resource for community-based organizations and their health system partners who are planning sustainable financial arrangements to fund the delivery of social services for patients. The guide may also be helpful for CMS as they continue to test and scale innovative payment and delivery models that meet patients' holistic needs.

Sources:

https://www.commonwealthfund.org/sites/default/files/202209/ROI_calculator_evidence_review_2022_update_Sept_2022.pdf;
<https://www.commonwealthfund.org/roi-calculator>

ADVANCING DRIVERS OF HEALTH AND EQUITY: POLICY RECOMMENDATIONS

A Commonwealth Fund brief assessed evaluation reports and requirements for 40 CMMI care delivery models to understand the extent to which CMMI required or encouraged participants to address patients' DOH needs, examples of how model participants addressed DOH needs, and barriers and incentives for doing so. The brief offers lessons for how CMMI can better enable model participants to address DOH needs:

1. **Standardize DOH screening and measures.** CMS could leverage the FY23 IPPS rule's new screening measures for the Hospital Inpatient Quality Reporting Program for other models. Standardization can improve identification of DOH needs and model evaluation.
2. **Build DOH into model evaluations.** That entails building DOH objectives into model and evaluation design to: compare how models affect DOH for different populations; identify the model's unintended consequences for beneficiaries' needs; determine how beneficiaries' unmet needs impact model performance; and design efforts that better meet these needs.
3. **Strengthen incentives and financial support.** Direct funding to model participants could be used to hire staff to identify CBO partners and create feedback loops. CMMI could require participants to describe how they will address beneficiaries' DOH needs at the beginning of model performance periods to understand participants' capabilities. Similar requirements related to health equity are part of the new ACO REACH model.
4. **Offer technical assistance.** Learning collaboratives and structured trainings could help participants identify and apply promising approaches (e.g., best practices for collecting and using data on patients' DOH needs, developing partnerships with CBOs, and implementing interventions). Given the returns that investing in services targeting DOH needs can yield for health and social organizations, CMMI also could share this evidence with participants to support their efforts to engage with CBOs.

Source: <https://www.commonwealthfund.org/publications/issue-briefs/2022/aug/how-cmmi-payment-delivery-reforms-address-drivers-health>

In reviewing evidence on the past decade of CMMI activity, researchers pinpointed five areas where CMS can advance health equity via payment and delivery system reform:

1. Improve data collection on race, ethnicity, and DOH across payers.
2. Monitor the impact of payment programs on health equity in model evaluations.
3. Shift from pay-for-performance to invest-for-equity to steer greater resources toward providers serving patients in under-resourced communities.
4. Ensure innovative models reach under-resourced communities by increasing safety net provider participation (e.g., giving financial support, ample time for staffing transitions, and technical assistance).
5. Align incentives across programs in CMS and CMMI (e.g., a limited set of equity-focused quality measures).

Source: <https://www.commonwealthfund.org/blog/2022/advancing-health-equity-through-federal-payment-and-delivery-system-reforms>

"Investing in Health: A Federal Action Plan," co-authored by Manatt Health and The Health Initiative and co-funded by the Commonwealth Fund and the Blue Shield of California Foundation, lays out strategies for CMS to consider to better integrate social drivers of health into the health care system:

- Integrate drivers of health into payment policy for providers and payors, such as by building DOH into standardized CMS risk scoring and risk adjustment methods, updating the medical loss ratio calculation across programs to account for investments in DOH, and establishing/quantifying baseline spending on DOH-related expenditures.
- Develop shared assets that enable interventions to address drivers of health, including by supporting the development of networks of community-based organizations and providers with the capacity to sustainably address DOH.
- Maximize participation in public programs that address drivers of health.
- Create new standards for drivers of health quality, utilization, and outcome measurement, including by updating the Medicaid core measures set to include DOH measures and adding DOH to state quality strategy under Medicaid Managed Care.

- Make drivers of health central to CMMI's innovation agenda, such as by developing and testing a social services fee schedule to be used by health care payers and providers to pay for DOH interventions.
- Incentivize community accountability and stewardship, including tying certain supplemental payments to DOH expectations for community stewardship (e.g., standards for providers related to healthy living wage expectations and community benefit obligations) and incentivizing healthy living wages.

The report explores these strategies—and their associated federal actions—in further detail and offers examples of how states have led DOH interventions.

Source: <https://www.manatt.com/insights/white-papers/2021/investing-in-health-a-federal-action-plan>

TOPIC 4: IMPACT OF THE COVID-19 PUBLIC HEALTH EMERGENCY (PHE) WAIVERS AND FLEXIBILITIES

TELEMATERNITY CARE: IMPACTS

The public health emergency and its accompanying flexibilities significantly expanded access to telehealth services among Medicare and Medicaid beneficiaries—including access to telematernity care. States like Arizona, Wyoming, and North Carolina have been covering services like remote patient monitoring under their Medicaid programs, including audio-only visits. Anecdotally, providers have seen a steep drop in no-show rates and increased health literacy among patients. Additional studies should quantify the benefits of telematernity care (e.g., the efficacy of home monitoring devices like blood pressure cuffs and fetal dopplers) and its effects on health disparities.

Source: <https://www.commonwealthfund.org/blog/2021/improving-access-telematernity-services-after-pandemic>

HOME HEALTH: IMPACTS

Rates of patient transfers to home health care increased during the pandemic for all beneficiaries. Black beneficiaries saw a slightly greater increase in the likelihood of being discharged to home health care relative to non-Black beneficiaries, while dual eligibles saw a smaller increase relative to Medicare-only patients. Among high-need patients, researchers found less substitution of home health care for institutional postacute care, such as skilled nursing facilities, consistent with the greater care needs of this population. Although increased use of home health care may reduce Medicare spending, future policies would benefit from further analysis assessing the impact of greater home health use on outcomes for different types of patients.

Source: <https://www.commonwealthfund.org/publications/issue-briefs/2022/jul/did-covid-19-have-disparate-impact-home-health-use-medicare>

MEDICAID ELIGIBILITY AND ENROLLMENT: IMPACTS

The Families First Coronavirus Response Act (FFCRA) of 2020 required states to keep people continuously enrolled in Medicaid in exchange for enhanced federal matching funds through the end of the COVID-19 public health emergency. Seventeen million more people are enrolled in Medicaid and CHIP than in February 2020, largely because of the FFCRA's continuous enrollment provision.

The end of the continuous enrollment requirement will trigger a massive eligibility redetermination effort by states for all people enrolled in Medicaid.

The coverage gaps and churn precipitated by these redetermination efforts will have disruptive consequences for patients' health and access to care. The Commonwealth Fund's recent 2022 Biennial Health Insurance Survey found that people with gaps in coverage were as likely to skip care and report medical bill problems as those who were uninsured at the time of the survey.

Sources:

<https://www.commonwealthfund.org/blog/2022/americans-are-brink-experiencing-premium-pain-and-health-insurance-loss>;

<https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey>

BEHAVIORAL HEALTH: IMPACTS

Telehealth (i.e., the provision of mental and behavioral health services via technology) has a robust evidence base. Numerous studies have demonstrated its effectiveness across a range of modalities (e.g., telephone, videoconference) and mental health concerns (e.g., depression, substance use disorders). Virtual services are safe, effective, and comparable in outcomes to in-person services.

Sources:

<https://www.commonwealthfund.org/blog/2020/using-telehealth-meet-mental-health-needs-during-covid-19-crisis>;

<https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/expert-consensus-impact-covid-medicare-mental-health-substance-use>

BEHAVIORAL HEALTH: POLICY RECOMMENDATIONS

Medicare policy changes made in response to the COVID-19 pandemic may have important implications for the accessibility, quality, and affordability of mental health and substance use disorder care. Recently, Fund-supported researchers conducted an evidence review and a modified Delphi expert consensus process to examine experts' opinions on whether to sustain COVID-response Medicare policies relevant to mental health or substance use disorders.

- Sustaining COVID-era policies that 1) expand telehealth coverage, 2) relax Part D restrictions on prescription supply, refills, and mode of delivery, and 3) increase staffing flexibility would likely increase Medicare beneficiaries' access to mental health and substance use disorder care.
- However, the CMS policy lifting hospital discharge planning requirements is likely harmful to care quality and should be revoked.
- More research is needed to understand how these policies influence quality of behavioral health care, as well as out-of-pocket and insurer spending. For example, telehealth policies may need to be refined to incentivize or require provision of high-value and culturally appropriate care. Future research should also account for documented disparities in telehealth readiness and past research showing that policies designed to benefit everyone often disproportionately assist the most privileged. Going forward, research should study the effects of policies on health equity and identify strategies to address inequities, if they occur.

Source: <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/expert-consensus-impact-covid-medicare-mental-health-substance-use>

To better support individuals with opioid use disorder (OUD) during the public health emergency, the federal government instituted the following flexibilities: allowing opioid treatment programs (OTPs) to provide more take-home methadone doses, allowing buprenorphine treatment initiation via telehealth, and removing buprenorphine waiver training requirements for providers treating 30 or fewer patients.

Data indicate that methadone take-home flexibilities have not been associated with worse outcomes or significant misuse, and telehealth services have been associated with improved medication retention and lower overdose risk. Maintaining these regulatory flexibilities beyond the public health emergency would further improve access to treatment.

The U.S. can follow international precedent and ensure that patients can access methadone through office-based locations and providers, rather than just OTPs which are few and far between in most states. While this would require regulatory change at the Drug Enforcement Agency (DEA), CMS could signal support for such changes to improve patient access and outcomes.

Source: <https://www.commonwealthfund.org/blog/2022/changing-way-opioid-addiction-treatment-delivered-could-reduce-death-and-suffering>