ADVOCATES FOR COMMUNITY HEALTH

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

Thank you for your interest in improving behavioral health care in the United States. I write today on behalf of Advocates for Community Health (ACH), a new organization made up of federally qualified health centers (FQHCs) focused on health equity and innovation. ACH strives to advance the delivery of health care to underserved populations by harnessing the power of community health systems. Our comments below recognize that as the largest health centers in the country, ACH members are often able to invest in leading-edge innovation – but the sustainable expansion of these successful initiatives requires federal support.

According to the National Institute of Mental Health Disorders, approximately 1 in every 4 adults in the United States suffers from a diagnosable mental health illness each year, but the rates are higher in low-income and underserved communities[1]. Studies show that children exposed to poverty often experience higher rates of depressive and anxiety disorders and higher rates of practically every psychiatric condition in adulthood [2]. Adults who are of low socioeconomic status (SES) more often experience depression, anxiety disorders, psychological suffering, and suicide[1]. FQHCs are a critical source of care for these Americans; they are responsible for 14 million mental health visits among underserved communities[3]. FQHCs are actively integrating behavioral health and primary care to improve health outcomes among low SES and underserved communities and have recruited additional behavioral health staff to increase mental health and substance use disorder resources for patients. FQHCs have

[1] Johns Hopkins Medicine. "Mental Health Disorder Statistics." *John Hopkins Medicine*, 2019, www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-disorder-statistics.
[2] Simon, Kevin, et al. "Addressing Poverty and Mental Illness." *Psychiatric Times*, 29 June 2018 www.psychiatrictimes.com/view/addressing-poverty-and-mental-illness.
[3] "Behavioral Health and Primary Care Integration." *Bureau of Primary Health Care*, 21 Sept. 2021, bphc.hrsa.gov/qualityimprovement/clinicalquality/behavioral-health-primary-care-integration.

increased their mental health staff to incorporate a more integrative approach to mental health, hiring psychiatrists, psychologists, social workers, and substance use disorder experts[2]. In addition, FQHCs have incorporated telehealth visits to increase access to primary care and behavioral health services[4].

Across our centers, we are focused on the integration of primary care and behavioral health care. We treat our patients as whole people, working to achieve health in all aspects of their lives. Federal investment must be aligned with the best scientific evidence, which is clear that integration of care leads to the best outcomes over the long term. FQHCs are best able to integrate care and leverage multi-disciplinary, diverse care teams through the flexibility of value-based care arrangements. In the most successful arrangements, in exchange for taking some degree of risk through capitated or population-based payments, FQHCs access flexibility in care delivery through waivers of state and federal requirements. Unfortunately, not all FQHCs have the option to establish the kind of value-based care arrangements with Medicaid and Medicare that support integrated primary and behavioral health care. Under the statute, FQHCs are reimbursed via an encounter-based Medicaid prospective payment system (PPS) that only recognizes certain licensed providers, and only 20 states offer some version of alternative payment arrangements. While some FQHCs participate in Medicare shared savings, capacity to take risk can be a limitation as well. These barriers lead to patients losing access to the best behavioral health care. In addition, FQHCs face barriers due to restrictions on telehealth and challenges in the behavioral health workforce. Our comments offer recommendations to address these issues and support improved behavioral health care for the communities that we serve.

1. **Congress should incentivize state Medicaid programs to establish alternative payment arrangements with FQHCs to promote behavioral care integration.**

    A. Value-based care would eliminate policy barriers to behavioral health integration

The primary care behavioral health (PCBH) model of care is a behavioral health approach to population-based clinical health care, which affords the opportunity for early identification and behavioral/medical intervention to prevent acute problems from becoming chronic health conditions. This model is strongly supported by research.[5],[6] Integrated behavioral health clinics, located in primary care clinics, can provide scheduled appointments or address more urgent needs via a "warm hand-off" from a provider the same day as a primary care visit. Utilizing this model, medical providers can identify if a patient would benefit from behavioral health services during a visit, and immediately refer their patient to a

[4] Solis, Erin. "CMS Waives Telehealth Restrictions for FQHC and RHC Physicians." *Www.aafp.org*, 2020, www.aafp.org/journals/fpm/blogs/gettingpaid/entry/FQHC_covid_telehealth.html.

[5] Balasubramanian BA, Cohen DJ, Jetelina KK, Dickinson LM, Davis M, Gunn R, Gowen K, deGruy FV 3rd, Miller BF, Green LA. Outcomes of Integrated Behavioral Health with Primary Care. J Am Board Fam Med. 2017 Mar-Apr;30(2):130-139. doi: 10.3122/jabfm.2017.02.160234. PMID: 28379819.

[6] Reiss-Brennan, B. et al. 2016. Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost. JAMA. Accessed at https://jamanetwork.com/journals/jama/fullarticle/2545685

behavioral health provider for further screening. These services are generally provided on-site in the primary care exam rooms.

Unfortunately, some states, including California, restrict reimbursement for same day appointments at FQHCs. One of the greatest advantages of co-located, integrated services is quick access to care to reduce gaps in care; this is lost when same day appointments cannot be provided. The very patients who would benefit most from this collaboration would ideally be served by both providers the same day. For underserved, poorer and rural communities this is a much larger barrier. Patients must drive or arrange transportation which costs money and need for taking multiple days off work to come to the clinic on different days for specialty appointments. Allowing FQHCs to establish value based care arrangements without burdensome red tape would allow the flexibility to design superior care models.

B. Value based care would allow expansion of the Certified Community Behavioral Health Clinic Model and other interdisciplinary approaches

Another integrated care model is the Certified Community Behavioral Health Clinic (CCBHC), a federal demonstration program. This model allows for daily or monthly payments for patients receiving behavioral health services. The National Council on Mental Well-Being found that the CCBHC demonstration increased access to mental health and substance use care, largely due to increased availability of same-day appointments, expanded hours of operation facilitated by increased hiring and concerted efforts to conduct outreach to underserved groups[7].

However, FQHCs not participating in the limited demonstration are not able to replicate these outcomes due to payment limitations. Within the payment arrangement for FQHCs, certain staff are not able to trigger an encounter payment under Medicaid. Therefore, discretionary dollars are currently needed to supplement Medicaid funding in order to integrate critical staff such as care coordinators, peer support, and counselors.

If FQHCs were incentivized to move to value-based care, they wouldn't have to patchwork the system of care. They could leverage financial resources for behavioral health support staff, which would allow clinicians to perform at the top of their licenses – which can also help to alleviate provider shortages. Many clinicians are currently having to work on issues that someone who is unlicensed but has a different training can perform. If a therapist, psychiatrist or addiction medicine physician does not have to perform roles that typically a case manager could do better, their time is freed up to serve more patents and they experience less burnout. Rather than another discretionary funding stream, FQHCs should have access to value-based care that allows them to leverage the full care team.

[7] "Transforming State Behavioral Health Systems: Findings from States on the Impact of CCBHC Implementation." The National council on Mental Well-Being, 2021. Accessed online: https://www.thenationalcouncil.org/wp-content/uploads/2021/10/21.10.04_Transformation-State-Behavioral-Health-Systems_Three-Pager.pdf?daf=375ateTbd56

C. *Value Based Care would allow FQHCs to tailor behavioral health interventions to the needs of their communities*

Addressing the behavioral health workforce shortage requires a multi-pronged approach, as hiring or training more physicians or therapists is only one piece of the puzzle. FQHCs must be able to create and support many different interventions beyond the typical 1:1 clinician:patient appointment. Patients facing behavioral health challenges require a comprehensive system in which diverse options of treatment are available, so that the right kind of resources are available for the need the patient presents with. For patients with mild or moderate illness, group visits can serve both the function of an effective intervention and prevent delays in care which will invariably continue to arise if we stick with the1:1 model of care alone. Across ACH members, group interventions have proven to be a very impactful way of providing care for anxiety, depression, post-traumatic stress disorder, and substance use disorder. They can also reduce the wait times for patients after referral to behavioral health treatment. Group interventions also allow for a step-down care option after patients with moderate to severe illness have been stabilized but benefit from ongoing support.

Another example of a tailored intervention is behavioral health care integrated with a co-located community emergency department. East Boston Neighborhood Health Center (EBNHC) is planning to launch an innovative service delivery model that offers a same-day entry point to a full continuum of urgent and ongoing behavioral health services integrated into the general primary care, including 24/7 crisis response and stabilization, clinical triage, and care navigation, with same-day evaluation and referral to treatment. The service includes seamless and immediate access to EBNHC's co-located community Emergency Department, which will also serve as a bridge to same-day enrollment in EBNHC primary care. Given that implementing this model under the current PPS payment methodology will inevitably result in a large operating loss, Massachusetts is developing a new payment model for Community Behavioral Health Center services, which would include an encounter bundle rate for outpatient urgent evaluation and treatment, separate payment for peer support and navigation services, and a separate value-based payment for 24/7 community and mobile crisis services, along with the Pay for Performance bonus payments.

We encourage Congress to work with states to establish alternative payment models that would incorporate the services of care navigators and behavioral health paraprofessionals. Value based care would enable the full integration of highly accessible behavioral health services along the entire continuum of care at the community level, including emergency and urgent behavioral health care and crisis stabilization, specialized outpatient behavioral health services, and coordination of care with inpatient behavioral health providers.

2. Congress should provide additional funding to support targeted interventions for high-risk populations such as prenatal individuals.

A pressing area of unmet need in the mental health space is the perinatal population. Few women receive treatment, which can lead to negative health outcomes for both mother and child. Camarena

Health in California leads a perinatal program focusing on an integrated, person-centered care approach that treats the full spectrum of patients' maternal health needs, including both mental health and substance use problems (referring to outside sources when indicated). With one in five women suffering from depression, anxiety, or both during or after pregnancy, Camarena decided that all behavioral health providers and community perinatal health workers would screen every perinatal patient at least once before and after delivery as part of a "Wellness Visit." That screening then leads to a team-based approach which includes medical providers, medical assistants, behavioral health providers, tele-psych if needed, and community perinatal health workers to help track prenatal and postpartum patients, monitor symptoms, provide patient education, encourage treatment adherence, and deliver psychosocial interventions. Additional support from Congress could help make this model available more widely across the country.

3. **Congress should strengthen the pipeline for behavioral health workforce**

The ability to recruit and retain behavior health staff continues to be a very challenging problem. Behavioral health workforce needs to be more than one therapist; the highest standard of care requires a team of clinicians, case managers, peer support specialists, care coordinators, substance abuse disorder counselors and nurses, especially as front-line clinicians at FQHCs are already stretched due to high need in underserved communities.

One staff position we'd like to highlight is the behavioral health consultant (BHC). In 2012, Yakima Valley Farm Workers Clinic (YVFWC) initiated efforts to pilot Behavioral Health Consultants (BHCs) in two medical clinics to expedite needed mental health services to our Community Health Center patients. This pilot was the beginning of their successful Primary Care Behavioral Health (PCBH) model that exists today. PCBH is an interdisciplinary and integrated approach to behavioral health within the primary care clinics to address the full range of behavioral health disorders and physical health conditions with a behavioral change component. This model of care has expanded to now include 19 of YVFWC's 27 clinic locations with 16 budgeted BHCs. Despite our efforts, YVFWC currently has limited capacity to meet the demand of patients who need access to behavioral health services. Currently, YVFWC has eight vacant BHC positions, and we are challenged to find candidates who are qualified to fill these positions. Therefore, we support pipeline programs that would increase the number of behavioral health specialists including training programs and/or loan repayment programs for behavioral health specialists serving in the FQHC setting. YVFWC partnered with the National Psychology Training Consortium and, through the Association of Psychology Postdoctoral and Internship Centers pre-doctoral internship process, to create a program to host two pre-doctoral interns starting in the summer of 2022. Additionally, YVFWC has also established two post-doctoral Fellowship positions aligning with the internship in the summer of 2022 to complement further integrated behavioral health training within the field of psychology. We have had an overwhelming response from applicants that want to participate in the program and are optimistic that this can be a steady source of talent to address this shortage.

In addition, ACH supports legislative reforms to create licensure designations or certification and reimbursement for services provided by BH paraprofessionals who would be able to participate in federal health care programs, thus creating additional capacity for those needing treatment while also enabling clinicians to work at top of their licenses.

We appreciate your consideration of our comments. We would be pleased to provide further information on the models described in our letter. If you have any questions, do not hesitate to contact me.

Sincerely,

Amanda Pears Kelly
CEO, Advocates for Community Health