November 1, 2021

Submitted via email to mentalhealthcare@finance.senate.gov

The Honorable Ron Wyden
Chairman, Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member, Senate Finance Committee
239 Dirksen Senate Office Building
Washington, DC 20510

Re: Request for Stakeholder Feedback on Addressing Unmet Mental Health Needs

Dear Chairman Wyden and Ranking Member Crapo—

Thank you for the opportunity to provide input to aid in the development of your bipartisan legislation to address barriers to mental health care.

With the new #988 crisis line scheduled to go live in less than a year, it is critical that every community have a functional behavioral health crisis system to provide the care that callers will need. This presents an unprecedented opportunity for a much-needed transformation in behavioral health crisis care, similar to how 911 catalyzed the development of emergency medical systems (EMS) and trauma care. As a pioneering leader in crisis care, Connections Health Solutions appreciates your leadership on this important issue and welcomes the opportunity to provide input at this pivotal moment.

[Note: In this document, we use the term Behavioral Health (BH) to encompass both Mental Health (MH) and Substance Use (SUD) disorders and services.]

Why Behavioral Health Crisis Care is Important

How a community responds to behavioral health emergencies is both a public health issue and social justice issue. Unfortunately, our health care system is often ill-equipped to address the needs of individuals in behavioral health crisis. While there are nationwide standards and expectations for medical emergencies, the response to behavioral emergencies varies widely and rarely delivers comparable quality of care.

A 911 call for chest pain results in an ambulance response with emergency medicine technicians, but a call for suicidal ideation often triggers an armed law enforcement response. Individuals in behavioral health crisis account for a quarter of police shootings and over two million jail bookings per year. Explicit and implicit bias magnify these problems for people of color.

At the emergency department (ED), the patient with chest pain receives rapid assessment, treatment, and, if needed, admission to an inpatient bed upstairs. The behavioral health patient's experience is much different. Many EDs lack the capability to provide psychiatric assessment and treatment. Instead, the behavioral health patient often receives little or no treatment and can "board" for hours, even days,

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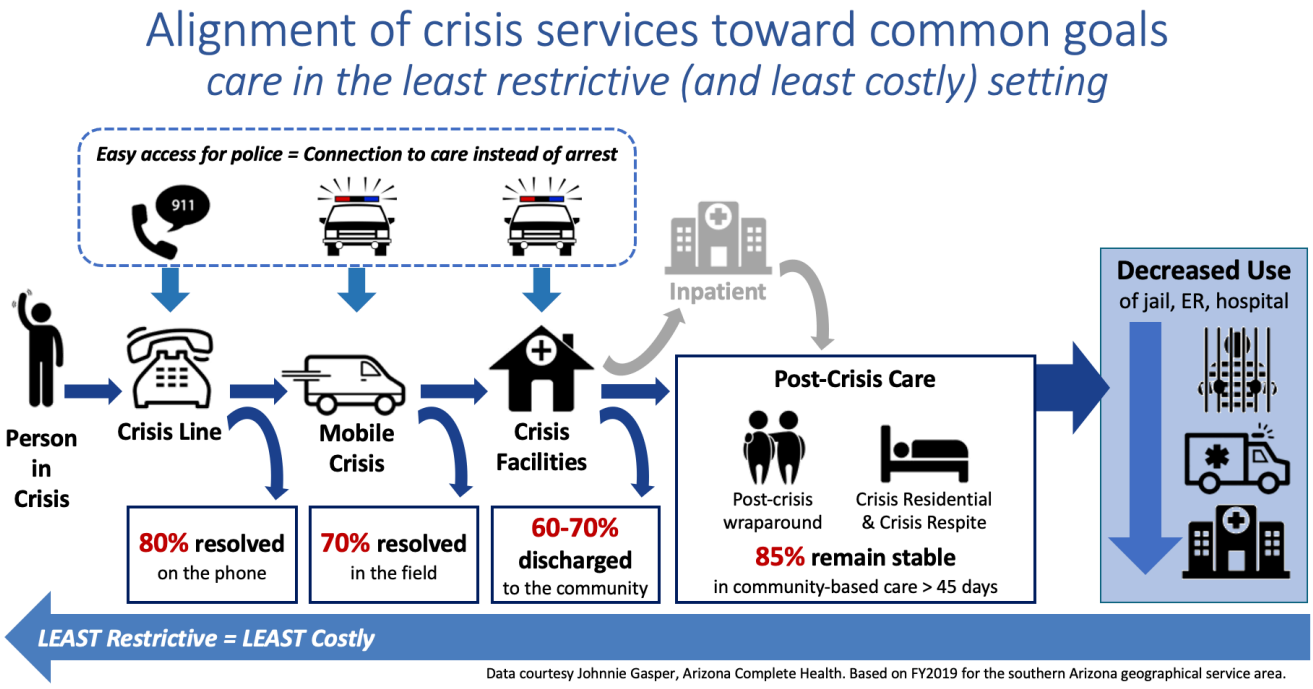
awaiting transfer to an outside facility for inpatient psychiatric admission. Besides the poor experience for the patient, this creates significant operational and financial burdens on the health care system.

Connections Health Solutions' pioneering work in setting the standard for crisis care

Connections Health Solutions (Connections) is a leader in behavioral health crisis care that provides an alternative to EDs and jails for individuals experiencing mental health and substance use emergencies. Connections founding psychiatrists (Drs. Chris Carson and Robert Williamson) pioneered the first crisis observation units in Texas in the 1990s then led the continued evolution of the model in Arizona over the past 15 years. The Arizona model (sometimes called "Crisis Now") is now a national exemplar with a robust continuum of crisis services including phones, mobile teams, and crisis facilities that function as a coordinated system to resolve crisis in the least-restrictive and least-costly setting possible. The Substance Abuse and Mental Health Services Administration (SAMHSA) adopted this concept into its "someone to call, someone to respond, somewhere to go" rubric in its *National Guidelines for Crisis Care: A Best Practice Toolkit*.



Balfour ME, Hahn Stephenson A, Delany-Brumsey A, Winsky J, & Goldman ML (2021). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. Epub ahead of print. doi: 10.1176/appi.ps.202000721. An earlier working version was published online at https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

In the example depicted above, based on the crisis system in Tucson, AZ, a robust continuum of service providers work together as a coordinated system to achieve a common goal of preventing avoidable jail, ED, and hospital use by providing care in the least restrictive setting that can safely meet the needs of an individual experiencing a crisis. ("Least-restrictive" is a concept based on the Supreme Court's *Olmstead* decision, which affirms the rights of people with mental health disabilities to receive care in the most community-integrated, i.e. least-restrictive, setting possible.) Because less restrictive settings tend to be less costly, clinical and financial goals are aligned as well. The crisis continuum is composed of an array of

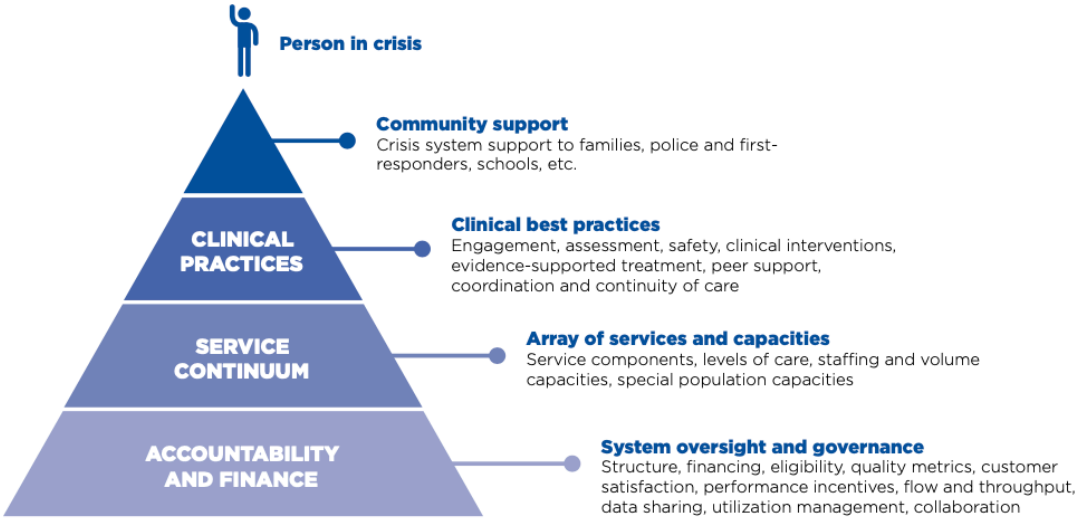
services organized along a continuum of intensity, restrictiveness, and cost. At all points along the continuum, easy access for law enforcement (e.g., co-location of crisis line clinicians within 911, co-responder teams) facilitates connection to treatment instead of arrest. Governance and accountability are key to ensuring that crisis services operate as an organized and coordinated system. In the Arizona model, the Regional Behavioral Health Authority (RBHA) serves as the "accountable entity" via its role as the managed Medicaid payer and regulator for the crisis system. The RBHA is financed via braided funding from a variety of sources (e.g., Medicaid, SAMHSA block grants, state and local funds) and accountable for both clinical and fiscal outcomes. The RBHA contracts with multiple service providers to create the crisis continuum and set expectations for system performance that are aligned with overarching system goals. Service contracts confer a "preferred customer" status to law enforcement, so that, for example, response time targets for mobile teams are faster for calls that involve law enforcement.

The centerpiece of the crisis continuum is a brick-and-mortar crisis receiving facility that can quickly triage, assess, and initiate treatment in a safe and healing environment, staffed with an interdisciplinary workforce of psychiatric providers, nurses, social workers, behavioral health technicians, and peers with lived experience. Connections has pioneered the development of facilities that provide 24/7 access to care for anyone in need, including those who may be actively suicidal, violent, or intoxicated. To incentivize law enforcement to bring individuals to treatment instead of jail, officers are never turned away and back on the street in less than 10 minutes. With rapid assessment, early intervention, and proactive discharge planning, most (60-70%) can be stabilized and transitioned to community-based care within 24 hours, reducing the need for restrictive and costly hospitalization.

Research shows this model works. An analysis of the crisis system in Maricopa County, Arizona—where Connections operates the largest crisis receiving center in the state—estimated that a $100 million investment in crisis care resulted in savings of:

- $260 million in psychiatric inpatient spending
- $37 million in ED costs
- 45 years of ED psychiatric boarding hours
- 37 full-time equivalents (FTEs) of police officer time and salary.

In addition to setting the standard for clinical care, Connections continues to advance the field via thought leadership, research, and advocacy. Connections Chief Quality Officer Dr. Margie Balfour frequently publishes and lectures on crisis care, and her foundational work on crisis outcome measurement has been adopted as a national best practice. She contributed to the SAMHSA guidelines and numerous expert panels for HHS, DOJ, the Joint Commission, and others, and she chairs the workgroup that authored the *Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response*, published by the National Council for Mental Wellbeing earlier this year. The Roadmap report builds on Crisis Now and the SAMHSA guidelines to address the governance, financing, and oversight needed to support a high-performing crisis system. The Roadmap also expands the continuum to include post-crisis services, which are needed for continued stabilization, successful transition to routine community-based care, and prevention of repeated crisis episodes.



The *Roadmap to the Ideal Crisis System* report builds on Crisis Now and the SAMHSA guidelines to address the governance, financing, and oversight needed to support a high-performing crisis system and expands the continuum to include post-crisis services, which are needed for continued stabilization, successful transition to routine community-based care, and prevention of repeated crisis episodes. [National Council for Mental Wellbeing & the Group for the Advancement of Psychiatry (2021) *Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response*. http://www.CrisisRoadmap.com]

Passage of the #988 crisis hotline legislation in the 116th Congress was a significant step forward toward improving access to crisis care. However, communities need a coordinated crisis system in place to provide the care that callers will need. Otherwise, already overwhelmed EDs and jails will remain the default destination for those with the highest needs for crisis care. To ensure that all individuals in crisis have their needs met appropriately and effectively, policymakers should consider using the *Roadmap to the Ideal Crisis System*, with Connections' model of care as an example, to guide the creation of a coordinated, effective, and sustainable system of crisis care for every community.

Developing Bipartisan Legislation to Address Barriers to Mental Health Care

Connections applauds your bipartisan effort to advance the discussion and craft legislation that will address barriers to mental and behavioral health care in the U.S. The five key areas set forth in your request for feedback—(1) strengthening the workforce, (2) increasing integration, coordination and access to care, (3) ensuring parity between behavioral and physical health care, (4) furthering the use of telehealth, and (5) improving access to behavioral health care for children and young people—will serve as a solid foundation and guiding roadmap to achieving true, innovative behavioral health care reform.

In the paragraphs below, we address three of these key areas, along with related feedback on the need to update mental and behavioral care programs to improve availability, cost management, and quality, as well as efforts to better plan for and allocate federal funds and resources.

Strengthening Workforce

Focusing on enhanced and innovative care delivery in local communities is paramount to improving behavioral health care services, and crisis care in particular. In many communities today, the behavioral health crisis system is not really a system at all, but rather a combination of services provided by law enforcement and hospital EDs that are typically not designed to meet the needs of individuals in the midst of behavioral health crises.

In working to improve the delivery of behavioral health care within local communities, a core theme must be that behavioral health crisis systems are an essential community service that should be at least on par with the responsiveness of emergency and urgent medical care—every person gets the right response every time. Such services must be welcoming, hopeful, trauma-informed, recovery-oriented, integrated and designed with the goal of eliminating disparities in response for those who are most vulnerable and marginalized.

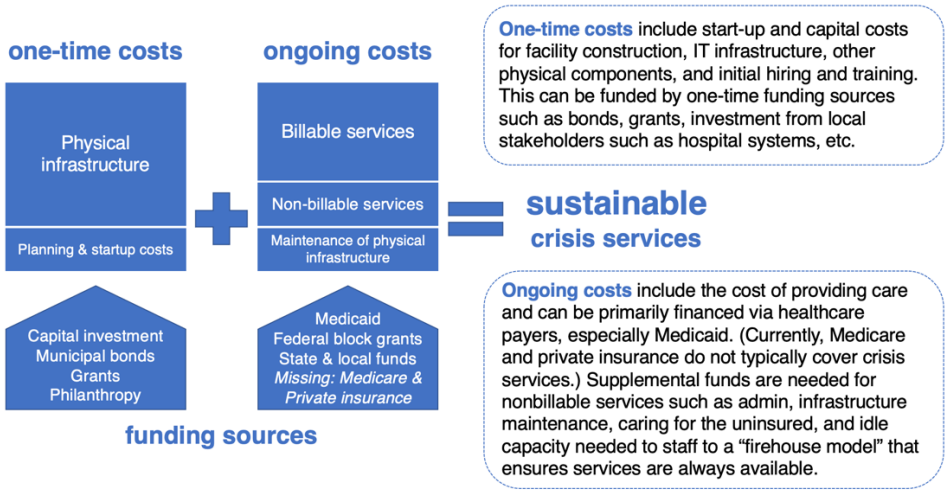
An adequate workforce is critical for development and expansion of crisis services, and legislators can employ multiple strategies to reduce barriers. Loan repayment programs should include crisis services as approved clinical sites, and GME funding should support training in crisis and other community behavioral health settings (which are often not hospital-based). Clinical licensure should be quickly and easily transferrable across state lines so that today's more mobile population can remain in the workforce. Peers – individuals with their own lived experience of behavioral health challenges – are an important member of the interdisciplinary team who are uniquely suited to engage with individuals in crisis; while many (but not all) state Medicaid programs reimburse for peer support services, Medicare and private plans typically do not.

Increasing Integration, Coordination, and Access to Care

SAMHSA's tripartite goal of "someone to call, someone to respond, somewhere to go" envisions a crisis system as easily accessible and well-coordinated as that which we expect for other health emergencies. Behavioral health care—and crisis care, in particular—must be integrated more seamlessly into health care delivery and payment systems in order to improve the access, quality, and experience of care for individuals experiencing a behavioral health crisis. Further, such integration can result in more cost-effective care and long-term savings.

Recent efforts such as 988 and the CMS mobile crisis planning grants have created positive momentum towards realizing the goals of "someone to call" and "someone to respond." The remaining piece – "somewhere to go" – requires investment in crisis receiving facilities that provide an alternative to emergency rooms, hospitals, and jails.

With more than 50% of every Medicaid mental health dollar spent on hospital care, crisis receiving centers provide an alternative that is both less restrictive and cost-effective. These facilities have been shown to reduce the cost of ED mental health care by more than 80%, and, when integrated into a well-organized crisis system, have reduced Medicaid total behavioral health spend by more than 40%. In addition, studies show that crisis receiving facilities are a key component of successful pre-booking jail diversion programs for people with mental health needs.



Funding Sustainable Crisis Services: Lawmakers should use upcoming legislative opportunities to dedicate funds toward the establishment of building of crisis receiving facilities, which can then be financed via braided funding models to provide sustable services over the long term.

Ensuring Parity Between Behavioral and Physical Health Care

A behavioral health crisis is a potentially fatal health emergency. Crisis care for mental health and substance use emergencies and should be primarily financed via healthcare payers, just as they do for medical emergencies.

Medicaid 1115, 1915(b), or 1915(c) waivers provide states a powerful tool to braid together multiple funding streams, maximizing efficiency and accessibility by pooling resources to create a common safety-net crisis infrastructure that can serve anyone in need, regardless of payer. The American Rescue Plan Act of 2021 further incentivizes states to leverage Medicaid by providing 85% federal match for MCT bundled payments. In contrast, Medicare and most private health plans provide little or no coverage for crisis services, and oftentimes care for their members is financed by taxpayer funded safety net mechanisms such as Medicaid, federal block grants, and state/local funds. These payers must be held accountable to provide parity coverage for behavioral health emergency care. The Centers for Medicare and Medicaid Services (CMS) Emergency Triage, Treat, and Transport (ET3) demonstration program provides parity Medicare reimbursement for EMS to transport to "alternative" destinations other than the ED, including crisis facilities. Models like this are a step in the right direction.

Updating Programs to Improve Availability, Cost Management, and Quality

Pre- and post-crisis outreach and follow-up can "break the cycle" by ensuring that the person is connected to the care they need to stay well in the community.

Connections believes that in order to properly address issues facing individuals in crisis and the behavioral health system today, a shift in approach is needed in order to focus on prevention, early identification, and robust post-acute care, along with shifting the current service model to a population health focused, crisis-prevention method of care delivery.

Crisis services are a "win-win" solution that achieves outcomes that are both clinically and fiscally desirable. By providing alternatives to EDs, hospitals, and jails, crisis services help communities achieve the vision outlined in the Supreme Court's *Olmstead* decision, which entitles people with mental health disabilities to receive the care they need in the most community-integrated (i.e., least-restrictive) setting possible. Because these less restrictive treatment options tend to be less costly, crisis services are also an effective tool for responsible stewardship of taxpayer funds and healthcare dollars. This convergence sets the stage for innovative provider-payer partnerships.

Connections sees alternative payment models (APMs) as part of the glidepath to support innovations in care by incentivizing the things that matter most. In these models, compensation is tied to outcomes that incentivize quality of care, patient experience, and affordability. We have been working proactively with health plans to develop a clinical model and funding model that supports this paradigm shift. Today in Arizona, > 75% of Connections' contracts are geographically capitated and value based. In our experience, these types of payment structures are feasible when applied to behavioral health services and should be incorporated in any comprehensive behavioral health care reform legislation.

Regarding the redesign of our nation's behavioral health care system, Connections supports efforts to improve data collection, to better identify where and how to allocate new funds to address existing issues and improve how efficiently new resources are allocated, to address disparities among underserved groups, and to improve service access to meet current unmet needs and the outcomes of individuals who end up using them, among others.

Next Steps

Our team would be pleased to share additional information and resources with your offices as you seek to craft a legislative package to address the many behavioral health care challenges currently faced by millions of Americans. We look forward to serving as a resource to the Senate Finance Committee as you collectively work toward achieving meaningful behavioral health care reform.

Again, thank you for your leadership and for the opportunity to provide feedback on these important issues. Please do not hesitate to contact us directly if you have any questions or would like additional information.

Sincerely,

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