The Fletcher Group, 601 Meyers Baker Road, Suite 238, London, Kentucky 40741, 606-657-4662, fletchergroup.org

RE: U.S. Senate Finance Committee Request for Information on Policy Proposals to Address Unmet Mental Health Needs

Background

Founded by former Kentucky Governor Ernie Fletcher, the Fletcher Group, Inc. (FGI) works with federal, state, local, and private partners to provide technical assistance with the goal of helping rural communities across the nation develop the quality and capacity of recovery housing. As a Health Resources and Services Administration (HRSA) Rural Center of Excellence for Recovery Housing, our approach integrates a customized ecosystem of services that lead to successful recovery outcomes for individuals with a history of substance use disorder (SUD) and that reduce the total cost of care. Since September 2019, FGI has provided technical assistance in thirty states representing over one hundred counties and service providers and completed environmental scans that include review of state and county data, participation in state and federal work groups, review of state and federal reports, and interviews with state partners.

Gaps in Access

Gaps in **access to mental health and substance use healthcare** include lack of screening for social and health support needs, lack of care navigation to access necessary services, lack of reimbursement for care navigation in managed care, and lack of access to a full continuum of care and closed loop referral system. We have found that silos exist in the continuum of care in rural communities as mental health and SUD services are often fragmented, uncoordinated, and insufficiently funded to positively impact an individual's health and wellbeing. These service gaps have significant negative impacts on population health and pushes costs to other systems, such as acute care, emergency room, first responders, and jails/prisons.

These pitfalls are exacerbated by the lack of housing across the continuum. Gaps in **access to housing** that appropriately meet the needs of persons with a substance use disorder, the lack of alignment between services and housing to support building recovery capital, and lack of an overall continuum that allows persons to graduate into permanent affordable housing is one of the largest systems challenges we hear most often. Coordinated entry sites are set up to meet the

needs of the most vulnerable, yet vouchers are limited, and local communities compete for limited resources, prioritizing certain populations over others. Populations of equal needs must compete for limited resources, an unnecessary competition in a holistic approach to addressing individuals experiencing a mental health or a substance use disorder.

Gaps in Workforce

The American Hospital Association completed a "systematic literature review on the state of the behavioral health workforce in order to better understand the challenges and opportunities facing hospitals and health systems, and begin to find new ways to build capacity for the future." Their literature review underscored a critical issue and revealed new findings – that is, to meet the growing need and demand for behavioral healthcare, hospitals and health systems must rethink, then redesign, the delivery of behavioral healthcare across the care continuum. In their publication they cite the disparities in the investment toward behavioral health and the impact on the workforce. They also suggest a framework to broaden, strengthen, and create a workforce with consideration for education and training, practice environment, financing, and recruitment and retention.

Complicating the shortage of mental health practitioners in the United States is the unequal distribution of this workforce. Data from 2015 revealed dramatic urban versus rural disparities in the supply of psychiatrists, psychologists, and psychiatric nurse practitioners. For example, only 6% of counties in the highly urban New England Census Division were without a psychiatrist, while 69% of counties in the highly rural West North Central Census Division of the country lacked a psychiatrist (Holly et al., 2018).

A comprehensive HRSA-funded assessment of supply, demand, and shortages of mental health providers found that small increases in the rurality of an area and small decreases in per capita income were both associated with increased shortages of mental health professionals. The shortage of mental health prescribers in rural and low-income areas was particularly severe (Thomas et al., 2009).

Payment, Metrics, Credentialing

- Develop national standards or guidelines that could help mitigate the impact of different state-to-state credentialing and licensing requirements, which can be a barrier for the provision of these services across state lines.
- Initiatives such as the Center for Medicare and Medicaid Innovation (CMMI) and the State Innovation Models Initiative (SIM) allow states to test innovative payment and delivery models and submit a plan to improve statewide population health. These initiatives include the Comprehensive Primary Care (CPC), Accountable Communities of Health (ACH), Healthy Neighborhoods, and Regional Health Collaboratives. These are initiatives we support for continued development and expansion to drive innovation in assisting states and communities to test models that improve health by addressing population health strategies.
- Expand payment options for recovery housing programs and services that address board and room as well as recovery support services as research demonstrates that these

programs achieve as good or better outcomes than established high-cost medical-based programs.[1,2]

- Our financial model is proposed in which several fee-for-service interventions are bundled into a recovery support service with a case rate delivered by the RH social recovery model. This approach is consistent with established Health Home programs and Chronic Disease Management models of care. In addition, the program may incorporate coordination with other medical services and care coordination that extends beyond medical services to encompass development of recovery capital for the individual to gain the knowledge, skills, and competence to maintain recovery following the chronic disease approach. A per diem rate is proposed in which an individual can engage with a RH for six to twelve months, which results in improved recovery outcomes. This proposed service model is obtained at a similar cost as residential programs with shorter duration of treatment and no better outcomes or poorer long-term outcomes. See the attached document for more information.
- Increase flexibility in Medicaid waivers and require states to update their state Medicaid plans.
- Create a pathway for interdisciplinary/interagency waivers.
- Extend flexibility to allow Medicaid MCO providers to participate in pooled funding arrangements with others in the community, such as state social service agencies, to more easily bring different funding sources together to have a greater impact on social determinants of health.
- Allow for workforce expansion by using an "incident to" scenario to allow for non-licensed care team members to perform services that contribute to SDOH. These services may be overseen by licensed professionals.
- Align HUD and CMS metrics policies to support partnerships in health and housing programs.
- Establish sustainable recovery housing and support services.
- There are significant barriers to establishing a workforce of sufficient size and quality to address SUD, expand who and how care is delivered by the workforce for example, peer support specialists and recovery coaches.
- Providers develop their business models based on available funding. Federal agencies could come together to develop financial frameworks that reimburse the medical, clinical, and social services that yield shared outcomes.

[1] Logan, T.,Cole, J., Miller, J. & Scrivner, A. (2020). *Findings from the Recovery Center Outcome Study 2020 Report.* Lexington, KY: University of Kentucky, Center on Drug and Alcohol Research

[2] Kaskutas, LA., Witbrodt, J., and French, MT. "Outcomes and Costs of Day Hospital Treatment and Nonmedical Day Treatment for Chemical Dependency." Journal Studies Alcohol 65: 371-282 (2004)