November 1, 2021

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

Delivered via email to mentalhealthcare@finance.senate.gov

Re: Request for Information to Address Unmet Mental Health Needs

Dear Chairman Wyden and Ranking Member Crapo,

Thank you for this opportunity to submit comment to you and other members of the Committee regarding the urgent and unmet needs of the mental health community. As the Chief Executive Officer of Fountain House, I am pleased to engage with you on policy issues enumerated below that will benefit the unique community we serve.

About Fountain House
Fountain House is a national mental health nonprofit fighting to improve health, increase opportunity, and end social and economic isolation for people living with serious mental illness. Drawing on more than 200 community-based social rehabilitative programs inspired by Fountain House and known as clubhouses - to reflect an insistence on belonging and acceptance - in nearly 40 states and with more than 60,000 clubhouse members nationwide, we are building a national movement for the dignity and rights for *all* of the 13 million people living with serious mental illness in our country.

Millions of Americans living with serious mental illness are denied access to care and support in the community, and end up cycling through our streets, shelters, emergency rooms, and jails. For far too long our punitive, ineffective, and costly approaches have taken away their capacity, dignity, and humanity. Fountain House takes a public health approach to serious mental illness. We address both the health and social needs of our members through an integrated model that connects our physical clubhouse – where members are engaged in an innovative therapeutic community rooted in Social Practice, and take steps in reclaiming their agency and dignity – with access to clinical support, housing, and care management. Since the pandemic, we have also built a virtual version of our clubhouse to provide connection.

Strengthening the Workforce
Fountain House encourages the Committee to think broadly as you consider policies aimed at strengthening the workforce of mental health providers. Psychosocial rehabilitation through the group setting model requires consistent management and leadership by providers. However, because most payment is derived through 1:1 billable services, management of community supports is not currently eligible for reimbursement by payers.

We also encourage you to consider policy that ensures that all workforce members are practicing at the top of their licenses. The pandemic has exacerbated an already serious mental health provider shortage in the US, which cannot be remedied quickly by relying on highly trained clinicians to fill in the gaps (it would take many years of education and training). The only feasible solution is to deploy people with lived experience from the community to provide critical support as an adjunct to more serious clinical expertise where we are maximizing what each person in the provider system can do.

Our model shows that the role of peers is incredibly important – and inspiring - to addressing the requirements of our members and other individuals with mental health needs. Fostering a community of people with similar lived experiences has multitudes of benefits and is especially critical for promoting health equity. As SAMSHA reports, research show that peer support provides important recovery benefits.

Combined, these impediments mean that the fee-for-service payment models, current scope of practice limitations, and licensing regulations restrict growth of this community support model that has proven highly effective.

Increasing Integration, Coordination and Access to Care

Fountain House has endorsed the bi-partisan Behavioral Health Crisis Services Expansion Act (S. 1902) and we strongly recommend that the Committee consider the provisions of this bill. S. 1902 would address many of the issues you have enumerated in your communication to the behavioral health stakeholder community including expanding the availability of services such as 24/7 national hotlines, mobile crisis services, behavioral health urgent care facilities, crisis stabilization and observational beds, and short-term crisis residential options. Additionally, the bill calls for data collection and evaluation of the current provision of services and programs offered, and it would help communities build up their behavioral health crisis response systems. These policies are critical to the goal of ensuring that people who require behavioral health care can access it in a safe and timely manner.

Crisis intervention models need to focus on what factors drive crises (e.g., mental health, social challenges), enlist a wide range of people (various mental health professionals, peers, etc.), and focus training on de-escalation. Research shows that a public health approach to mental health crises works, and that law enforcement is rarely required.

Most data systems do a poor job of addressing critical aspects of behavioral health, integrating social needs into patient records, and following the patient across settings.

Psychosocial rehabilitation is a valuable, evidence-based element of the care continuum. It often serves as a critical bridge between high-acuity care and long-term health & productivity for people with severe mental illness. Research has shown that participating in the clubhouse model facilitates positive recovery trajectories by promoting a sense of unity and belongingness for members. Randomized controlled trials have indicated that clubhouse members experience a significantly improved quality of life due to their involvement in the models.[i] [ii] The competitive employment aspect of the model specifically has also been linked to improved global quality of life, with the greatest positive influence being on members' levels of self-esteem.[iii] Overall,

aspects of the clubhouse model thought to account for these improvements include the focus on empowerment, autonomy, and person-hood instead of patient-hood. Clubhouses have further been proven to reduce severe psychiatric symptoms, improve self-esteem,[iv] and decrease internalized stigma, promoting greater recovery experiences,[v] thus reducing the need for psychiatric hospitalization. Randomized control trials of clubhouse programs have shown reduced hospitalizations for clubhouse members.[vi] Additionally, membership in clubhouses show lower drop-in rates and fewer hospitalizations,[vii] and clubhouse costs are substantially lower than partial hospitalization, thus clubhouse membership reduces overall cost of healthcare.[viii]

We urge the Committee to focus on the outcomes that matter the most to people living with mental illness. It is critical that our system moves beyond almost exclusive reliance on administrative data to measure provider performance. Utilizing this data does not capture the complexity of treating serious mental health diagnoses and the disabling social isolation that accompanies them, which requires markedly different treatment approaches than diagnoses such as heart disease, diabetes, or another chronic physical ailment. Yet success is measured with a system that does not adequately distinguish between them. To address this issue, we recommend that the Committee consider policies that would integrate patient-reported measures into performance assessments especially as they relate to social isolation/connection/loneliness; function and quality of life; and self-efficacy, agency, empowerment, and engagement.

Ensuring parity between behavioral and physical health care

As alluded to above, lack of payer parity between behavioral and physical health care continues to challenge the delivery of care to individuals who require mental health care. Statutory advancements in parity have not been well enough supported by regulatory and legal infrastructure in a manner that truly actualizes parity in the real world. Unfortunately, payers frequently fail to apply evidence-based standards to benefit determinations, causing enormous financial hardship for patients and people who have family members living with mental illness or resulting in many people to forego needed care due to expense of self-paying for it.

The 2019 ERISA Wit v. United Behavior Health ruling demonstrates the need for a more comprehensive approach to making mental health parity a reality. We urge the Committee to consider the precedent set by this ruling as you work to ensure real and lasting parity for individuals who require mental health treatment.

There is dramatic supply deficiency in terms of access to effective behavioral health programs at many levels of the system. Despite regulatory changes in the last decade, individuals who are covered by private health plans still face many hurdles when trying to identify an appropriate mental health provider. From workforce shortages to reimbursement challenges to payer coverage shortfalls, patients are often left without a viable path to getting the care they need.

Federal coverage programs also fall short. Medicare is not subject to mental health parity requirements and imposes additional limitations on mental health benefits. The Medicare 190 hospital days lifetime limitation does not serve patients seeking behavioral health care well and is easily exceeded for these chronic conditions; according to NAMI, no other health condition is subject to a similar cap. In addition to denying care to people who have eclipsed the coverage limit, we are also concerned that this limitation may deter individuals from seeking care if they

believe that they will exceed their lifetime coverage limit too early when, in fact, it's critical that individuals experiencing a severe mental health episode seek care as soon as possible. We urge the Committee to consider the provisions of the recently introduced, bi-partisan Medicare Mental Health Inpatient Equity Act, which would permanently repeal the Medicare 190-day lifetime limit for inpatient psychiatric care. Medicaid also poses arbitrary limits on treatment for mental health. The program excludes coverage for "institutions for mental disease" (IMDs). This exclusion, which has been in place for the duration of the existence of the Medicaid program, is a direct affront to Congress's work towards achieving mental health parity. We urge the Committee to work towards policy to eliminate this discriminatory limitation on access to care.

Furthering the Use of Telehealth

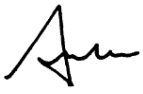
The COVID-19 pandemic has made clear the need for telehealth services for treatment of myriad conditions, including mental health diagnoses. While the flexibility afforded throughout this time has resulted in easier access to care, we urge the Committee to consider fully the needs of the community we represent when considering policy that would further expand telehealth. More research is required to determine what support is best provided via in-person treatment. We also want to ensure that individuals who prefer to access in-person treatment are not unduly forced into virtual treatment via a reimbursement structure that overly incentivizes this method of care delivery.

As we have previously mentioned, it is critical that people suffering from SMI feel part of a community, whether that community exists in person or virtually. We urge the Committee to consider policies that would enable coverage for virtual community-based psychosocial rehabilitation.

Conclusion

Equitable access and quality care begin by engaging representative people with lived experience in all aspects of research, policymaking, and program design. In addition to the recommendations we have made above, we strongly encourage the Committee to ensure that individuals from the community you are attempting to serve with this effort are engaged in a meaningful way. Defining the best approaches to integrating, coordinating & accessing mental health care requires a thoughtful framework that lays out a national quality strategy for mental health. It is clear that the Committee appreciates this dynamic and we thank you for your consideration of our comments. If you have any questions or would like more information, please contact Mary Crowley, Fountain House's Senior Vice President and Chief External Affairs Officer, at mcrowley@fountainhouse.org.

Sincerely,



Ashwin Vasan, MD, PhD
President and Chief Executive Officer
Fountain House

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