Thank you for the opportunity to provide information to the Finance Committee’s research on behavioral health inequities. Quest Center is a nonprofit organization dedicated to providing multidisciplinary and integrative healthcare services, community, and education to all people seeking a wellness-focused approach to living. We are located in Portland, Oregon and provide services in Multnomah and Clackamas counties.

We believe people thrive when their physical, emotional, spiritual, and social needs are effectively met. We offer a wide range of services for individuals to create a personalized treatment plan. Our services are offered in a manner that creates community among our clients that promotes continual healing.

If we can highlight one simple theme that has resonated throughout most of the question areas:

LOW RATES = LOW PAY. LOW PAY = LESS PROVIDERS. LESS PROVIDERS = LESS PATIENT ACCESS.

# Strengthening Workforce

What policies would encourage greater behavioral health care provider participation in these federal programs?

* First, and foremost, policies which encourage better reimbursement rates for behavioral health services is paramount.
* Low reimbursement rates (Medicare and Medicaid) result in low paying positions.
* Generally, behavioral health providers low earnings result in extended periods of time paying off debt from expensive educational degrees required for licensing in their chosen field. This leads to early burn-out and/or immediate departure from the non-profit health center they earned their licenses into private practice, resulting in a cycle which contributes to low reimbursements.
* Access for patients is decreased because of the low pay to BH providers. We pay our Medicaid non-licensed (have a masters but working for their 2000 clinical hours) BH providers lower than we pay administrative staff.
	+ Federal programs limit the types of providers able to give care. Medicare access to both MH and Substance Use Disorder treatment is limited by Medicare’s limited view of reimbursable providers. For example, Medicare does not credential Licensed Professional Councilors (LPCs) Certified Alcohol and Drug Counselors, Peer Support Specialists, and Peer Mentors, or LPCs, etc.
	+ Policies and of regulations in Medicare and Medicaid that would increase their credentialed workforce would significantly increase access to behavioral services in the United States, especially among older adults and marginalized communities.
	+ Federal policies that incentivize health centers to provide culturally appropriate care.
	+ Federal recognition of alternative and complimentary forms of care (acupuncture, naturopathy, etc.).
	+ Reduce administrative burdens, such as reporting unnecessary data and duplicative data entry.

What barriers, particularly with respect to the physician and non-physician workforce, prevent patients from accessing needed behavioral health care services?

* + Better pay, loan forgiveness for student loans if going to work for non-profit community health centers.
	+ Childcare and transportation
	+ Significant lack of culturally appropriate training.
	+ Difficult to find medical providers that are well versed in HIV and the populations most impacted by HIV, especially within the Medicaid and Medicare environments.
	+ Most difficult for Trans and gender diverse communities finding providers that are open and empathetic to their lived experience.
	+ Workforce shortages of providers reduces patient access through long wait times to see provider.
	+ Complexity of need and marginalized identity.
* We have patients who are Trans experiencing BH issues and are required to navigate a system that are inadequate does not recognize their needs.

What policies would most effectively increase diversity in the behavioral health care workforce?

* Diversifying the types of care would diversify the workforce.
* Access to educational opportunities within minority populations.
* Incentives for hiring
* Training in DEIJ work for predominately white organizations.
* Money and technical assistance for BIPOC organizations with limited infrastructure.
* Wider peer support training from within the communities.
* Broadening codes that include pay for Peer Support services within medical and BH payers, specifically in Medicare and Medicaid.
* More creative ways to certify non-licensed workers that values lived experience.
* Increasing reimbursement rates to increase provider salaries.
* Create and fund Culturally Informed and Responsive PRACTICE based evidence at both provider pre and post-graduation education levels and at the practice level.
* Monocultural evidence-based practices are steeped in white supremacy. Expand reimbursement modalities that extend beyond the narrow list of EVP that are currently offered.
* Require universities to engage in reparation practices in the form of partial tuition admission for BIPOC students.
* Require reparation practices with regard to salaries of BIPOC providers practicing within the state.
* Require ANY culturally specific services rendered by an individual who is part of the culturally specific community they are serving to be compensated for that labor in increased salary and/or student debt relief.

What federal policies would best incentivize behavioral health care providers to train and practice in rural and other underserved areas?

* + Financial incentives
	+ Improved reimbursement, especially for non-licensed BH workers.
	+ Opening telehealth services from higher density areas to practice in rural areas and other underserved areas outside of the providers county.
	+ Allowing non-credentialed individuals to remotely train in larger counties without having to relocate away from rural areas. Stay where they are needed to train when training opportunities don’t exist in those areas.
	+ Incentives help pay loans, tax credits, etc.
	+ Federal policies that provide rigorous protections for marginalized providers in those communities. Creating hiring incentives for subsidies in housing, provider office space, etc.

Are there payment or other system deficiencies that contribute to a lack of access to care coordination or communication between behavioral health professionals and other providers in the health care system?

* + Different EMRs don’t communicate effectively EMRs.
	+ Due to low reimbursement rates in both BH and others, practitioners simply don’t have the time to effectively communicate with a patient’s provider partners
	+ Duplication of efforts between siloed provider areas (BH, Medical, SUDx). Lack of communication.
	+ Having to share your story (via intake or new provider) requires patients to relive traumatic experiences repeatedly.
	+ High caseloads prevent coordination, people are busy!
	+ Compensate, reimbursement codes, for care coordination.
	+ There is an expectation that BH providers coordinate care within the reimbursement time allotment specifically dedicated to patient’s visit with provider.

Which characteristics of proven programs have most effectively encouraged individuals to pursue education and careers in behavioral health care?

* + Better pay to live in the cities and areas they serve.
	+ Internships (possibly paid) in SUD and MH programs.
	+ Incentivize health systems to value all levels of provider care along the continuum of care.
	+ Conduct onsite clinical supervision for all Medical and BH providers from peer support specialist to medical physician.
	+ Including interns and non-credentialed staff in higher level discussions and planning meetings.
	+ Early integration of all MH and SUD staff into the full breadth of the departments.
	+ Participation in program development and planning.
	+ Incentives for loan forgiveness if working non-profit community health organizations.

Should federal licensing and scope of practice requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?

* + Increase Medicare’s scope of practice to mirror States such as Oregon that has an expansive view of healthcare. In Oregon, two similarly situated patients’ healthcare is drastically diminished by the one insured by Medicare when compared to their counterpart covered by the Oregon Health Plan, especially in mental health and addiction care.
	+ Medicare, for all intents and purposes, does not cover intensive outpatient substance use disorder treatment. Similarly, mental health coverage is limited due to it’s restrictive panel requirements.
	+ Yes, more diversity in accepting positions currently not credentialed and unable to bill federal programs. Depending on the state, Expanded Medicaid under the ACA is provides better benefits to their clients.
	+ More focus on culturally specific programs and staffing.
	+ Medicare does not reimburse for case management. Often care coordination is included in case management.

What public policies would most effectively reduce burnout among behavioral health practitioners?

* + Higher reimbursement rates that would allow practitioners and organizations to hire more staff and carry smaller caseloads.
	+ Capping capacity patient loads. Too often larger BH systems “turn and burn” providers seeking their licenses by saddling them with enormous caseloads.
	+ Organizations being able to afford to give MH providers more wellness vacation days. Nonprofit organizations generally give good benefits for time off. Unfortunately, the unintended consequence to smaller organizations results in a loss of critical billing hours and necessary income to the organization.
	+ Recognizing vicarious trauma is common upon BH providers. Awareness campaigns and training programs for organizations to recognize and treat the trauma without reprisals.
	+ More resources available for higher acuity patients. Often, patients without the resources necessary for their care and left to providers beyond their training, thereby requiring additional time beyond the contracted time. Once the care is provided to the higher acuity patient, we are not contacted to bill beyond contracted and allowable reimbursement rates.
	+ More available wellness resources for providers. Paid wellness time off.
	+ Livable wage structure. Paid family leave. Build Back Better.

# Increasing Integration, Coordination, and Access to Care

What are the best practices for integrating behavioral health with primary care? What federal payment policies would best support care integration?

* + Funding and policies that support integrated community clinics, such as Quest Center, to have both primary and BH providers at the same clinic.
	+ At Quest, all provider staff have time made available in their schedules to attend twice monthly all clinical meetings for care coordination.
	+ Policy to make clinical meetings billable as part of the patient’s care.
	+ Parity of reimbursement rates.
	+ BH codes for wellness services provided by primary care providers.
	+ Setting best practices for EMRs to have both BH and Medical
	+ Expanding the Affordable Care Act’s (expanded Medicaid) Alternative Payment Methodologies (APM) through CCOs/ACOs for innovative programs such as Quest Center’s WISH (Wellness, Integrity and Sustainable Health) Non-Opioid Pain Management program, an integrated medical and behavioral health program designed to treat chronic pain opiate addiction through the use of non-opioid interventions. *Please see our attached informational and metric outcomes sheet for further details on the program*.
	+ Incentive programs, APM that incentivizes metrics to meet metrics by paying a bonus.
	+ Subsidies for nonprofits seeking to employ PMHNP or comparable. Typically, their salaries are beyond the reach of community health care clinics.
	+ Subsidies for specialized treatment training (Trans healthcare).

What programs, policies, data, or technology are needed to improve access to care across the continuum of behavioral health services?

* + Telehealth and video health. Standardizing telehealth at a national level. Private insurance companies change rules and groups frequently. Telehealth is currently dictated by private insurance companies, as such this decreases access to BH because they pick and choose who and when they will pay for telehealth.
	+ Barriers reduced by telehealth: transportation, childcare, disability that limits physical access, less travel time (easier for certain types of treatment)
	+ Federal programs that provide for stable housing, alcohol and drug free housing, transitional and permanent as patients move through their continuum of care.
	+ Expanding networks for referrals, such as Unite Us.
	+ More Peer Support Specialists, shared lived experience with patients, having PSS in hospital settings to support patients in communicating with patients.
	+ A support system for PSS that values their work, such as clinical supervision, training, adequate time off.

What programs, policies, data, or technology are needed to improve patient transitions between levels of care and providers?

* + Community support programs (PSS), good mobile apps to connect confidentially, and/or anonymously, if necessary, with professional peer support. For example, the Sound Off (sound-off.com) app for veterans to anonymously connect to MH care/suicide prevention.
	+ Again, better systems, such as Unite Us, that allows providers to easily make and track a referral as a patient enters the next level of care.
	+ Universal network of provider communication
	+ Clearinghouses for patient information that are efficient, protected, and useful.

What policies could improve and ensure equitable access to and quality of care for minority populations and geographically underserved communities?

* + Higher reimbursement rates.
	+ You must pay them a livable wage that includes ability to pay off school debt.
	+ Focus on educating and training individuals from those populations into BH fields.
	+ Increasing opportunities for BIPOC individuals to attend professional programs, beginning at the base community level. Campaigns to destigmatize mental health and increase community awareness on how to access culturally specific behavioral health services. If they don’t exist, focus on how to fill this all to often gap in healthcare equity.
	+ Incentives for providers to set up offices in geographically underserved communities.
	+ Ensuring that BH access points to care recognize marginalized populations. Training.

How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?

* + More research and funding on where these programs work and if they can be duplicated.
	+ Diversifying the teams so they represent the individuals in crisis.
	+ Remove the police from mental health emergency calls.

How can providers and health plans help connect people to key non-clinical services and supports that maintain or enhance behavioral health?

* + Increased access to SNAP and other federal programs.
	+ Peers, peers, peers.
	+ Health plans do not focus on the value of non-clinical services because they are not required to reimburse for those key support systems. Consequently, nonprofit community clinics must divert earnings away from patient care to fundraising.

# Ensuring Parity

How can Congress improve oversight and enforcement of mental health parity laws that apply to private plans offering coverage under the federal health programs? How can we better understand and collect data on shortfalls in compliance with parity law?

* + Federal government could use clearinghouse data (discreet method)
	+ More equitable pay regardless of the payor insurer. Patient care should not suffer because of an individual’s healthcare plan.
	+ More equitable reimbursement rates for group policies vs private individual policies.

How can Congress ensure that plans comply with the standard set by Wit v. United Behavioral Health? Are there other payer practices that restrict access to care, and how can Congress address them?

* + Commercial insurance Plans play by their own rules through the use of prior authorization, limiting of services, unnecessary paperwork. Congress should codify the Wit ruling.

Are there structural barriers, such as the size of the provider network, travel time to a provider, and time to an appointment, that impede access to the behavioral health care system?

* + Childcare, transportation, limited workforce, need for universal high speed internet services, and affordable devices.
	+ Yes, those are barriers. Especially if patient is in crisis. Waiting 3 months, let alone 3 days, is dangerous and leaves patients vulnerable.
	+ Yes. In general, transportation is problematic, transportation by Medicare is unreliable, time consuming, and often late causing patients to miss or reschedule appointments.

To what extent do payment rates or other payment practices (e.g. timeliness of claims payment to providers) contribute to challenges in mental health care parity in practice?

* + Payment Rate are too low.
	+ Payment rates are number one priority. In Medicare, cover substance use disorder treatment in accordance with how providers provide care.
	+ Low reimbursement rates make it challenging to hire and retain QMH Providers and Assistants
	+ Contracted providers operating outside of organization/agency practice settings ( private practice) under single case agreements with OHP must be paid in a more timely manner (currently timeline is 6+ months) or penalty of non-payment to be accrued and paid by CCO.
	+ Reduce bureaucratic and overly burdensome (barriers) requirements that hinder service connection and continuation (i.e. requiring the single case agreement provider, typically operating with zero overhead, to provide extensive and ongoing documentation, etc.).

How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicaid fee-for-service programs impact access to care and patient health?

* + Medicare’s rates for MH providers is abysmal. The low rates are directly responsible for creating barriers that lead providers away from accepting Medicare or Medicaid plans. Low rates = low pay. Low pay = less providers. Less providers = less patient access.
	+ Community health centers being able to independently pay its providers based on better reimbursement rates by federal and private payers. Quest increasing better working conditions by allowing providers to take adequate time for wellness care.
	+ Global authorizations can be too low considering the amount of utilization that Quest offers.
	+ Parity in Medicare would be a game changer, but would require Medicare to credential and authorize payments to a much larger pool of providers including QMHP and Assistants, CADCs, Peer Mentors and Specialists, etc.
	+ Currently, in Multnomah County and others in the Portland metro area, must use State funds to fund Medicare patients in need of Behavioral Health programs, especially SUD and Integrated MH and Medical pain management.
	+ Innovative programming created under the ACA APMs allow organizations to contract directly for their costs associated with the necessary utilization for the patient.

# Expanding Telehealth

How do the quality and cost-effectiveness of telehealth for behavioral health care services compare to in-person care, including with respect to care continuity?

* + During pandemic telehealth became a lifeline, however, from a provider perspective it is often difficult to read clinical body lang cues, etc. From the client perspective it is difficult to feel connected over a long period of time.
	+ With COVID, most codes achieved parity. Without legislation, those rates will likely fall once or if COVID ends.
	+ The unintended consequences of telehealth has been that service provision shift away from the organization and to the client.
	+ Cost burden shifts to clients, high speed internet and necessary devices.
	+ The use of supportive resources (administrative support, basic office supplies) has shifted from the organization to the both the employee working from home and the client/patient needing to access.
	+ Telehealth doesn’t work if lack housing and/or privacy.
	+ Telehealth is problematic if translation services or support/advocate person are necessary.
	+ Poor internet connectivity on either end of telehealth connection creates a poor environment for effective communication between providers and patients.
	+ Some platforms (MS Teams, WebEx) are more resource dependent than others resulting in poor connectivity.
	+ Telehealth also offers clear improvements as well:
	+ Allows for increased access and lowers barriers such as reduced travel time, waiting room tension,
	+ Increases engagement and minimizes no-show
	+ Less overhead to provider, shifts burden to patient.
	+ There is inherent value within in-person visits.
	+ There is no qualitative analysis gathered from those served regarding quality of care in either the form of in-person or telehealth means.

How can Congress craft policies to expand telehealth without exacerbating disparities in access to behavioral health care?

* + Better infrastructure for universal access to the internet and required devices.
	+ affordable internet access
	+ Policies and programs that promote patient access to necessary equipment/devices and low/free-high speed internet.
	+ Federal funding to allow healthcare plans to purchase necessary devices for patients.
	+ There needs to be equal access to both in-person and telehealth.
	+ Many behavioral health programs have patients that struggle with telehealth and require in-person. Quest Center works to troubleshoot the issues during COVID lockdowns, but without in-person visits, barriers exist.
	+ Fiscal and technologic assistance to those burdened by the cost and use of telehealth.

How has the expanded scope of Medicare coverage of telehealth for behavioral health services during the COVID-19 pandemic impacted access to care?

* + It helped, now mandate the rates permanently, currently being reviewed every 6 months by CMS. Permanency will allow providers to plan and fund ways to make TH better for patients.
	+ Removed restrictions from codes to bill both telehealth and in-person rates the same
	+ Increased access (for those with connectivity) and engagement.
	+ Since Medicare limits SUD treatment reimbursements to clinical staff, our intensive outpatient programs have not seen any increases.

How should audio-only forms of telehealth for mental and behavioral health services be covered and paid for under Medicare, relative to audio-visual forms of telehealth for the same services?

* + There should be no difference in reimbursement rates based on the delivery of services if the patient is helped. Service plans need to be created to suit the patient as long as the delivery is effective and demonstrated on their chart.
	+ Any interaction with a clinician should be billed the same way. Anything less decreases patient access to care.
	+ No difference in payment because the patient is benefitted. If they lack accessibility, but for the phone, that appointment by phone is as beneficial to patient as in person or video.

Are there specific mental health and behavioral health services for which the visual component of a telehealth visit is particularly important, and for which an audio-only visit would not be appropriate? For which specific mental and behavioral health services is there no clinically meaningful difference between audio-visual and audio-only formats of telehealth? How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?

* + In person or visual is particularly necessary for mental health assessments, looking for non-verbal cues and emotional body language.
	+ For SUD treatment in person treatment is crucial although in the short-term telehealth is better than nothing at all.
	+ If safety for the patient or others is of concern, visual is better, if possible, in person.
	+ In COVID, some MH patients withdrew from care because of fear of video and audio distrust, in these cases in-person is essential for patient care.
	+ Audio is least effective, loss of non-verbal cues and body language. Limited in telehealth, but better than audio alone.
	+ People with language or hearing barriers (deaf or hard of hearing) are even more disparaged by the burden placed on them in telehealth care.

How should Medicare pay for the practice expense portion of Medicare's telehealth payment for mental and behavioral health services? Should the practice expense resources needed for telehealth forms of these services be independently measured, or should Medicare rely on the practice expense values used for in-person forms of Medicare payment for the services?

* + Patient assistance is the priority. If a provider cannot see a patient in-person and that patient has financial or infrastructure barriers, the provider loses the patient and the associated revenue. Patient access is decreased.
	+ Larger practices typically have the resources and more able to cover the expenses than
	+ Often Medicare rates are so low, they don’t cover the cost of the provider, let alone practice expenses.

Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care (in addition to flexibilities already provided on a permanent basis in the SUPPORT for Patients and Communities Act and the Consolidated Appropriations Act, 2021)? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?

* + Yes, these should be made permanent because they works
	+ Telehealth is adaptable to peer support, one on one and group therapy, workshops
	+ Increase in access for patients to their providers
	+ The safeguard is the patient getting better, demonstrated in their chart. Limiting care is the appropriate choice if the person is not improving utilizing telehealth.

What legislative strategies could be used to ensure that care provided via telehealth is high­ quality and cost-effective?

* + Audits and compliance reviews are typically conducted and could be created for telehealth, minimum expectations and incentivize higher performance.
	+ Universal high speed internet access, access to devices by billing healthcare plans.
	+ Training guidelines and benchmarks to ensure providers have the necessary skills unique to telehealth visits.

What barriers exist to accessing telehealth services, especially with respect to availability and use of technology required to provide or receive such services?

* + Lack of access to high speed internet and necessary devices for the telehealth visit.
	+ Availability to a device or whether patient can afford the minutes on a limited plan.
	+ Not having access to a private space to meet with their providers. (Patients in shelters and group homes)
	+ Restrict telehealth ONLY companies from practicing within the state without demonstrating access (measurable) to OHP insured individuals.