Spectrum Healthcare Group

Request for Information – Behavioral Health Care Provider Response

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Proposal Cover Sheet

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Website and Media Overview

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Strengthening Workforce:

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

- Increased payment structures, increased grant and other diversified funding opportunities, increased recruitment efforts for prescribing providers as well as other licensed and unlicensed personnel, increased efforts toward value-based care in behavioral health arenas (alongside physical health arenas.)

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

- Barriers include a.) a lack of providers entering the workforce itself, b.) overall historical/cultural pushback from providers and employers when it comes to the leveraging of technology to deliver services, and c.) limitations around non-licensed personnel's ability to deliver services under the supervision of licensed personnel.

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

- Increased offerings of educational programming at all levels of post-secondary education, including emphasis on technician level staff, and other non-licensed behavioral health team members. Early recruitment.

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

- Increased grant funding and student loan payback options for rural and underserved areas.

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?

- Yes, for example there are reimbursable codes in the behavioral health space for care management to happen, however care-coordination codes are lacking at the prescriber level; also, there are not reimbursable codes for physical health providers to use to incentivize care coordination between disciplines.

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

- Effective educational and career programs are ones that are flexible (online courses and online learning resources, ability for students to self-pace through programs, and programs that expose students to the clinical environment quickly as opposed to at the

end of programs.)

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?

- Yes, the less restrictive the licensing and practice requirements are, the greater breadth of workforce becomes available. This can be done in a safe way, through the oversight of licensed professionals.

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

- Continuing to leverage technology (through telehealth solutions) creates a winning situation for patients, organizations, and practitioners. Practitioners are looking to work from home, with increased work-life balance, and flexible schedules.

Increasing Integration, Coordination, & Access to Care:

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

- There are various integrated models that range from bi-directional referrals to fully-structurally integrated. Evidence from SAMHSA indicates that a fully-structurally integrated model of care produces the best health outcomes. This model includes providing physical health and behavioral health services under one business umbrella in the same facility. Operationally this includes multidisciplinary collaborative meetings, shared culture, shared teams, shared spaces, and shared information. Federal payment policies that provide one-time payments for the expense related to initial integration are extremely helpful for agencies looking to begin integration. Federal payment policies that promote reimbursement for time spent in multidisciplinary collaborative meetings and parity between physical and behavioral health reimbursement are needed.

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

- Federal policies that restrict therapeutic services to be provided by an LCSW, (or any single certification) limit the availability of behavioral health services. This is particularly true in rural areas, where employing a therapist with this level of licensure can be difficult. Consequently, patients who have Medicare and commercial insurance are often placed on long waiting lists to receive therapeutic services. Updating federal policy to include acceptance of billing for Licensed Professional Counselors (LPC's) and Licensed Marriage and Family Therapists (LMFT's) would result in improving access to care for these patients.

Federal policies that restrict the ability to provide care management activities for patients in behavioral health have a similarly limiting effect. The role of the therapist is to assess and provide therapeutic intervention. The role of a care manager is to assist in coordinating care, provide care plan updates, ensure the social determinates of health needs of the patient are met, and to provide resources. Patients that have Medicare and commercial insurance are unable to access the care management level of care with current billing guidelines from CMS. Expanding this availability will require allowing bachelors prepared providers to perform care management activities that are reimbursable.

Finally ensuring that virtual and telehealth behavioral health services continue to be reimbursed by Medicaid, Medicare and commercial plans would ensure access to behavioral healthcare in all areas.

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

- When a patient is transitioning between levels of care, facilities utilize the Transitional Care Management (TCM) code set authorized by CMS. This code set covers a follow-up visit with a medical provider and one phone call of outreach. It has been Spectrum's experience that much more than this is required to ensure that a patient's whole health needs are met in this crucial time. As a result, we perform more outreach and engagement to include home visits if needed. Currently, these services are not reimbursable. Expanding the scope of the TCM code set to include more options for alternative levels of need (based on presentation and supported with documentation) would increase patient engagement during this transition.

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

- Often underserved communities do not have access to healthcare or behavioral health services. This causes significant negative health outcomes. To increase this access these areas will need funding to build infrastructure so that virtual appointments can be obtained. Investing in technology would ensure equitable access to care in rural and underserved communities. Utilizing a common and trusted area, such as a public library or school as a base would be advised.

  Additionally mobile care can be provided in these communities utilizing mobile clinics or home-based providers. This level of care has tremendous amounts of down time that is not reimbursable, as the providers of care must travel. This results in unsustainable programs long term. Implementing policy that promotes home-based care with a higher differential payment could fill this gap.

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

- The CAHOOTS model of crisis is at its core an integrated crisis response team. Models

of care that address the physical and behavioral health of a patient are backed by years of research and the data shows positive health outcomes. One aspect of the CAHOOTS model that is pivotal in ensuring that crisis intervention models are successful is the collaboration between community partners. When law enforcement, behavioral health agencies, hospitals, and social agencies work together the system of care is more accessible for follow-up care. Spectrum has found that the key to a successful crisis intervention model, is less about fidelity to a certain practice, and more about using the right team at the right time to stabilize patients in their homes whenever possible. Utilizing our own model of care, with crisis response specialists trained in physical and behavioral health interventions, we have a community stabilization rate of 65%. This results in diversion from hospitals and jails, in turn demonstrating significant cost savings to the system. This also results in patients learning how to stabilize without escalating to higher levels of care, showing improved outpatient engagement.

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

- Understanding local community resources and facilitating referral, specifically around social determinants of health. Providing warm hand-offs as frequently as possible also helps with all referrals.

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?

- Spectrum Healthcare Group recommends congress assign a federal agency such as HRSA or SAMHSA to create a parity reporting and scoring system similar to Medicare Stars. In this parity reporting and scoring context, health plans would be incentivized for complying with parity laws. Health plans would receive a score or rating based on their compliance with parity laws. Commercial health plans would self-report on their parity policies including standards for prior authorization, reimbursement rates, and coverage. Health plans would also report on key indicators such as the claims expenditures. The requirements could be increased gradually on an annual basis. The rating could be used by the plans in advertising and the ratings could be posted online by SAMHSA as well. There could also be a financial incentive which is earned when health plans report and meet a high standard. This money would be required to be used for developing mental health capacity within their network.

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?

- Most of the commercial health plans do not pay for substance abuse rehabilitation, but

they do pay for rehabilitation from medical conditions. Congress should require coverage for substance abuse rehabilitation services.

Most private health plans restrict access to low-cost mental health supports which are used with high levels of efficacy in Medicaid populations. These supports include peer and family support services, respite for families of children with severe mental health conditions, workforce development, and case management. Most health plans also refuse to cover services delivered by unlicensed professionals in licensed outpatient facilities. Congress could require health plans to cover these kinds of services.

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?

- There is a dearth of independently licensed behavioral health professionals in health professional shortage communities. Congress should continue to provide funding for the HRSA National Health Service Corps which provides support for professionals to serve in these areas. Additionally, congress should require health plans to cover services delivered by unlicensed professionals under the supervision of a licensed professional when they work for a licensed outpatient facility.

  Most rural communities in Arizona have limited or no public transportation. The Covid epidemic caused health plans to cover services delivered via phone and telehealth technology. The delivery of counseling and psychiatry services via these communication modes has been incredibly successful. Congress should require health plans to continue covering behavioral health services delivered via telehealth technology and phone.

  Some Arizona communities are in extremely remote areas of the state. For example, the Havasupai Tribe is in the bottom of the Grand Canyon. Their community can only be accessed by walking, helicopter, or donkey. This community had limited access to health care during Covid due to poor access to technology. Congress should allocate funds for building technology infrastructure for remote communities.

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 rates and practices have a tremendous impact on parity. Most behavioral health services are conducted effectively by people who do not have a medical degree. Most health plans substantially decrease rates for individuals who do not have a medical degree. There should be higher pay for these services. Timeliness of claims payments has not been an issue impacting our organization, however if claims were to not be paid in a timely manner, this would be extremely detrimental to operations.

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 has a higher need for mental health parity than Medicaid in the state of Arizona. Allowing Medicare to cover the following services would promote parity:
  - Services provided by licensed facility NPI provider types, such as supportive counseling, peer support, family support and education, case management, transportation, vocational rehabilitation
  - Coverage for residential treatment for substance abuse

  At Spectrum Healthcare Group, we have a lot of patients with complex medical needs in addition to substance abuse disorders. Allowing Medicare to provide these services and issuing grants for specialized organizations able to treat both needs would be helpful to these patients in their recovery. Many patients with substance use disorders also have unmet dental needs that impede their recovery. Coverage of dental needs in both Medicaid and Medicare would also be helpful.

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?

- Telehealth is a tremendous resource for patients who either cannot or will not come into an office for care. Often patients are apprehensive to receive behavioral healthcare services. Virtual care from the comfort of their home offers an avenue to start this. Additionally for patients who are unable to come to the office, receiving virtual care is certainly better than no care at all. Many behavioral health diagnoses have symptoms that make receiving care in a facility difficult, and virtual care can bridge that gap. Behavioral health care is easily provided using a virtual model of care, as there are very few physical components that require touching a patient. Spectrum has been providing telehealth services for many years with no perceived or actual decrease in quality of care compared to in-person.

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

- Expanding policy to provide reimbursement parity for telehealth and in-person care would accomplish this goal. Eliminating the previously instituted rural boundaries related to telehealth coverage and reimbursement would also move the needle. Finally, funding programs that provide much needed technology to underserved areas would ensure equitable access to virtual care.

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

- Access to care, through the pandemic has dramatically increased as a result of the removal of the telehealth restrictions. This allowed Spectrum to provide a wide range of services virtually for physical and behavioral health. These services would not have been received otherwise. There are many reasons a patient may be unable to attend in-person care, even outside of Covid. Spectrum has found that many patients are now comfortable with and asking for virtual care, rather than in person. Eliminating the ability to provide this would certainly result in decreased access to care, and consequently negative health outcomes. Spectrum is in favor of the continuation of the expanded scope of coverage for telehealth.

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?

- All forms of care can be considered equal when a patient is in need. It takes an equivalent amount of licensed and unlicensed staff time to provide audio-only or audio-visual forms of service. With that in mind the reimbursement should be relatively similar. We advocate for whatever kind of care the patient is needing, wanting, and is available – whenever and wherever that may be.

Are there specific mental health and behavioral health services for which the visual component ofa 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?

- Spectrum has provided services for individuals living with a serious mental illness for over 65 years. Our experience has taught us that no two people are alike. Some of our patients genuinely need in-person services, and some do not. This is determined on an individual basis, and patient preference is deferred to. With that in mind, there is no specific behavioral health service that would have a clinically significant need to have in-person, but patients may have preference either way. There is no denying that in-person can be better for many reasons, in many situations. Some specific examples include work in a home with a family, or assessment for adverse reactions related to antipsychotic medication. Once again, care that is accessible is preeminent.

How should Medicare pay for the practice expense portion of Medicare's telehealth payment formental 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?

- Virtual forms of care do not offer significant savings to a practice in terms of operational cost. This is largely due to technology implementation and upkeep, licensed provider time and the ongoing need for administrative functions regardless of patient location. Where virtual care *does* impact practice operations is as it relates to efficiency and service delivery reach.

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 theSUPPORT 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, the flexibilities provided for telehealth services have increased and improved access to care. Making them permanent would allow for continuation of this and the corollary positive health outcomes. Spectrum has found use for all services to be provided virtually and does not wish to see a restriction on these. Safeguards for beneficiaries should include patient choice whenever possible.

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

- Correlation of healthcare outcomes (HEDIS measures, value-based measures, etc.) with telehealth services.
- Establish best-practice guidelines for the delivery of telehealth services; providers that demonstrate best-practice receive higher reimbursement rates.

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

- Barriers include virtual technology in rural areas (i.e. cell coverage, wi-fi availability, etc.) Additionally, expense for implementation, training, and maintenance are not covered through traditional forms of reimbursement, making it cost-prohibitive for some behavioral health providers.

Improving Access for Children and Young People:

How should shortages of providers specializing in children's behavioral health care be addressed?

- Recruitment, starting in high schools
- Development of vocational programs specializing in skills needed to work with children
- Support for telehealth, incentives for those leveraging technology to deliver care

How can peer support specialists, community health workers, and non-clinical professionals, and paraprofessionals play a role in improving children's behavioral health?

- Creation/implementation of specialized training that isn't long or onerous (certificate programs.) Allowing for peer support/paraprofessional to support a member in a group or while receiving another service (and bill for it.) Establishing teen peer supports/advisory groups.

Are there different considerations for care integration for children's health needs compared to adults' health needs?

- Access to care is paramount – there is an opportunity to bring medical and behavioral health services to the homes or schools of children. Accessible care for children also requires accessible care for adults; the children's barriers to care often spawn from the barriers to care for adults (i.e. workforce issues, transportation issues, and other social determinants of health.)

How can federal programs support access to behavioral health care for vulnerable youth populations, such as individuals involved in the child welfare system and the juvenile justice system?

- Continue to fund services at the intersection point where children and youth are already present. Continue to fund the full continuum of services for children and families, while providing opportunities for new and innovative programming.

What key factors should be considered with respect to implementing and expanding telehealth services for the pediatric population?

- At times, providers seem to be less comfortable with telehealth for the pediatric population, than the children do (kids are probably more comfortable with screens than the average adult.) That said, specialized training around engaging youth in telehealth services could be useful. Availability of technology in rural communities is always a key consideration; this is another reason it might be helpful to partner with schools for service delivery.

RFI Guidance:
https://www.finance.senate.gov/imo/media/doc/092221%20Bipart%20mental%20health%20RFI.pdf