NATIONAL ASSOCIATION OF Community Health Centers

November 1, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Comments on the Request for Information (RFI) on Addressing Challenges Related to the Access of Mental Health Care and Substance Use Treatment

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the National Association of Community Health Centers (NACHC), thank you for the opportunity to provide input on the challenges and opportunities to addressing improved access to behavioral health care and substance use treatment.

NACHC is the national membership organization for federally qualified health centers (also known as FQHCs or health centers). Health centers are federally funded or federally supported nonprofit, community-directed provider clinics serving as the health home for nearly 29 million people, including 1 in 5 Medicaid beneficiaries and 1 in 3 people living in poverty. It is the collective mission and mandate of the 1,400 health centers around the country to provide access to high-quality, cost-effective primary and preventative medical care, as well as dental, behavioral health, pharmacy, and other support services that facilitate access to care to people located in medically underserved areas, regardless of insurance status or ability to pay.

By way of background, FQHCs provide primary care services in geographic areas and zip codes designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSA). Services are offered on a sliding fee scale and in a culturally competent manner. FQHCs are reimbursed for Medicaid and Medicare services through the Congressionally-mandated Prospective Payment System (PPS). For Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of providing Medicaid services in Fiscal Years 1999 and 2000, while Medicare FQHC services are paid for using a single national PPS rate that is adjusted for regional price differences. FQHC services are a mandatory Medicaid benefit, and the PPS is central to the financial viability of health centers. NACHC's response to this RFI seeks to ensure, in part, that any changes made in the way behavioral health services are reimbursed in Medicaid and Medicare do not undercut the provision of PPS reimbursement to FQHCs in delivering behavioral health services to their patients.

Due to the lingering stigma of behavioral health conditions, primary care is identified as a key entry point for behavioral health services. Health centers serve as key behavioral health providers in communities where this stigma persists, providing culturally and linguistically appropriate services that overcome barriers to care. Health centers accounted for nearly 12 million mental

health visits as well as increasing the number of behavioral health patients by approximately 26 percent from 2017 to 2019.[1] As the need for behavioral health services continues to grow, health centers will continue to be at the forefront of meeting this need and must be supported by policies that enable them to continue effectively serving their communities.

Strengthening Workforce

The behavioral health care workforce shortage impacts the ability of health centers to respond to the increased mental health needs of patients. In 2016, 56 percent of health centers reported at least one behavioral health staff vacancy, whether it be a licensed clinical social worker, psychologist, or mental health/substance abuse professional.[2]

Amend the definition and statute for FQHC core providers to include more behavioral health practitioners: NACHC supports broadening the types of practitioners eligible to provide behavioral health services by making it clear that these additional services are covered and reimbursed as FQHC services and billable as FQHC visits. This includes adding Licensed Marriage and Family Therapists (MFTs), Licensed Addiction Counselors, Peer Support Specialists, Community Health Workers (CHW), Licensed Professional Counselors (LPC), Mental Health Counselors (MHC), Psychiatric Nurse Practitioners (NPs), and Psychiatrists to the list of Medicare and Medicaid-covered providers, which can help health centers expand access to care. The currently limited list of reimbursable behavioral health providers is a particular barrier to expanding behavioral health care in rural areas.

Increasing Integration, Coordination, and Access to Care

***Require PPS payment for group encounters*:** Group visits are incredibly meaningful for patients, especially for those in substance use disorder (SUD) recovery. Some health centers face challenges if states refuse to pay the full PPS rate for behavioral health and other services delivered in a group setting. For example, many health centers offer group counseling to clinic users with substance use disorder and receive either fee-for-service rates covered under the Medicaid benefit or no payment whatsoever. Neither of these payment methodologies complies with the requirement to pay the FQHC PPS. To address this problem, NACHC recommends that CMS issue guidance to state Medicaid agencies clarifying that Medicaid is required to pay PPS to FQHCs for all group services when provided by an FQHC professional.

Adopt Medicaid expansion: For the millions of people living in the 12 states without Medicaid expansion, the choice not to expand has left them without affordable access to behavioral health care. Improving access to health care coverage has been shown to increase access to behavioral health services by reducing financial barriers to accessing care and increasing the number of behavioral health providers that accept Medicaid.[3]

***Screen for Social Determinants of Health (SDOH)*:** When addressing a patient's behavioral health needs, understanding their SDOH needs helps health care providers deliver appropriate,

[1] https://bphc.hrsa.gov/qualityimprovement/clinicalquality/behavioralhealth/index.html

[2] http://nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf

[3] https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-medicaid-coverage-gap

culturally competent care. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) enables providers to screen patients for SDOH, and is both a standardized social risk assessment tool consisting of a set of national core measures and a process for addressing the social determinants at the patient and population levels.[4] By using PRAPARE, providers can target clinical and non-clinical care – often in partnership with other community-based organizations – to drive care transformation, delivery system integration, improved health and lower costs. NACHC supports additional federal funding to help health centers cover the administrative costs of integrating SDOH screening tools into their clinics and the costs to cover the services needed for patients after they are identified by SDOH screening tools.

***Support multidisciplinary, team-based care through community health workers (CHW)*:** The scope of multidisciplinary teams should be broadened to include community health workers. CHWs serve as an intermediary between health and social services and the communities they serve. Health centers have utilized CHWs to address social determinants of health, simplify access to services and improve the quality and cultural competence of care delivery. NACHC supports additional funding for hiring and training of non-clinical staff like CHWs.

***Create integration bonus payment for CCBHCs and FQHC*s:** The Protecting Access to Medicare Act (PAMA) of 2014 authorized demonstration programs in up to eight states to improve behavioral health services by establishing and evaluating Certified Community Behavioral Health Clinics (CCBHCs). PAMA allows CCBHCs to establish formal relationships with other providers such as FQHCs to deliver certain services that might not be directly available through the CCBHC. When these relationships form, the FQHC is known as a designated collaborating organization (DCO).[5] NACHC recommends that Congress incentivize these formal partnerships for integration between CCBHCs and FQHCs by establishing a separate integration bonus payment available to both CCBHCs and FQHCs that partner together. The bonus payment should be in addition to the potential payment rates the CCBHC and health center each receive. When establishing these bonus payments, Congress should consider DCO relationships and should address any barriers to FQHCs in receipt of that bonus payment when serving as a DCO. This could strengthen integration and create the potential to provide a more comprehensive range of services.[6]

Require CMS to issue guidance on PPS payment to FQHCs dually certified as CCBHCs: Since the initial CCBHC demonstration period ended, CMS has not issued guidance that reminds states of their obligation to pay the full PPS rate when a health center delivers a service that overlaps with the CCBHC scope of services. NACHC believes this guidance is necessary to assure that states continue to pay the full PPS rate.

***Incentivize Collaborative Care Models*:** The Collaborative Care Model is a systematic approach to the treatment of mental health care that involves the integration of multiple health care and non-clinical providers to more proactively manage patients care.[7] Under current law, FQHCs can bill

[4] https://www.nachc.org/research-and-data/prapare/

[5] https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf

[6] https://www.thenationalcouncil.org/wp-content/uploads/2020/12/120920_CoE_NACHC_AdvancingHealthIntegration.pdf?daf=375ateTbd56

[7]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226460/#:~:text=The%20collaborative%20care%20model%20is,as%20chronic%20diseases%2C%20rather%20than

for collaborative care model services that are up to 80 minutes of work for the first month of services and 60 minutes for the following months, but are not allowed to bill for any additional service time over those allotted amounts. For example, one health center performs neuropsychological exams (at minimum 4 hours) and surgery clearance assessments (approximately 3 hours). The current billing model makes these services cost-prohibitive, and these restrictions and low reimbursement rates have prevented some health centers from hiring additional workers to support these certain services. NACHC recommends Medicare eliminate the service time restrictions and allow health centers to bill the add-on codes.

Expanding Telehealth

During the pandemic, health centers dramatically increased their use of telehealth. Congress, the Centers for Medicare and Medicaid Services (CMS), and state governments deserve immense credit for spurring flexible telehealth policies in both Medicare and Medicaid when the pandemic began. It is critical that these flexibilities continue after the federal public health emergency (PHE) ultimately expires, specifically as it relates to behavioral health. According to a recent NACHC study of health centers, 90 percent used telehealth for behavioral health services and 81 percent believed patients with behavioral health or substance use needs would see worse outcomes if these flexibilities were terminated.[8]

Make permanent Medicare telehealth flexibilities: At the onset of the pandemic, CMS relaxed existing (and severely restrictive) policies related to the ability of health centers to provide telehealth services to Medicare enrollees. However, these flexibilities will ultimately expire with the PHE absent Congressional action. NACHC supports multiple bills – including the CONNECT for Health Act (S. 1521) and the HEALTH Act (HR 4437) – that would recognize FQHCs as distant site providers, remove originating site restrictions, provide payment parity equal to in-person care and permit audio-only services.

Support state efforts to make Medicaid telehealth flexibilities permanent: Since the onset of the pandemic, all 50 states plus the District of Columbia and Puerto Rico have expanded telehealth in Medicaid for patients. While states have significant flexibility in how they choose to cover Medicaid telehealth services, the federal government has yet to provide clarity about the ability of states to make Medicaid audio-only telehealth permanent beyond the PHE and in doing so receive federal matching funds for such services. Some states pursuing audio-only legislation have been told that HHS and CMS' interpretation of existing law and regulations would result in termination of a federal match for Medicaid audio-only telehealth benefits with the expiration of the PHE. It is imperative that HHS and CMS clarify that there are no barriers to audio-only permanency.

Invest in telehealth infrastructure**:** Policymakers should prioritize effective access to telehealth services for all patients by ensuring that every community has access to broadband.[9] Increasing the availability of high-speed internet and associated platforms with appropriate technology will help remove structural barriers to telehealth access. NACHC also recommends grant funding to purchase equipment and other infrastructure changes that will be needed for health centers to implement and offer more telehealth visits.

[8] https://www.nachc.org/wp-content/uploads/2021/07/Audio-Only-Report-Final.pdf

[9] https://www.rand.org/blog/2021/03/the-doctor-will-call-me-maybe-the-uncertain-future.html

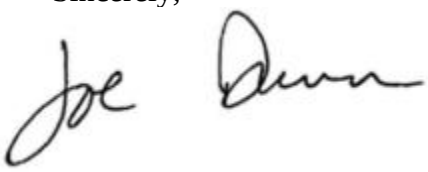
Improving Access for Children and Young People

Address the needs of the vulnerable youth populations: Children who are in foster care experience higher rates of chronic medical, developmental, and mental health issues[10]. When a child enters the foster care system, this can cause another traumatic event. These traumatic events are known as adverse childhood experiences (ACEs), and research has shown they can have lifelong impacts on mental and physical health[11]. NACHC recommends providing additional behavioral health services for children in the foster care system, including mental health screenings for youth when they first enter foster care and providing a comprehensive health assessment to identify what services might help address their behavioral health needs.

Addressing the needs of former foster youth: Young adults who age out of the foster care system experience high rates of homelessness, unemployment, and food insecurity. Providing services and resources to this population is critical, and NACHC recommends that CMS issue guidance that explains how FQHCs may best serve young adults who have aged out of the foster care system.

We appreciate the opportunity to provide feedback as you consider next steps. Should you have any questions about our comments, please feel free to contact me at jdunn@nachc.org or Jeremy Crandall, Director of Federal and State Policy, at jcrandall@nachc.org.

Sincerely,



Joe Dunn
Senior Vice President, Public Policy and Research
National Association of Community Health Centers

[10] https://oig.hhs.gov/oei/reports/oei-07-13-00460.asp

[11] https://www.americaspromise.org/opinion/giving-hope-youth-foster-care-and-their-families-too