Network of Behavioral Health Providers
9401 Southwest Freeway, #1242
Houston, Texas 77074

United States Senate
Committee on Finance
Washington, DC 20510-6200

November 1st, 2021

To The Honorable Ron Wyden, The Honorable Mike Crapo, and other Distinguished Committee Members:

Thank you for your time and dedication to serving people with behavioral health conditions, including taking the time to learn more about the issues and drawing feedback from the community. The US Senate Finance Committee is in a unique position to be able to make meaningful change for people living with behavioral health conditions.

The Network of Behavioral Health Providers (NBHP) is a collaborative of more than 40 public and private, nonprofit, and for-profit mental health and substance use treatment providers across the Greater Houston area. Our mission is to improve the delivery of and access to high-quality behavioral health services through education, collaboration, and advocacy. Cumulatively, our members employ over 5,000 behavioral health professionals and serve over 250,000 children and adults each year.

On behalf of NBHP, I will be providing comments on the following areas outlined in the US Senate Finance Committee RFI: Strengthening Workforce, Increasing Integration, Coordination, and Access to Care, Expanding Telehealth, and Improving Access for Children and Young People. You will find area outlined below as specified in your previous letter.

Strengthening Workforce

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

Texas' overall ability to meet the behavioral health needs of its residents is contingent upon the availability of a qualified, culturally- and linguistically-competent mental health and substance use treatment workforce. In October 2009, 173, or about 69% of Texas counties were designated either total or partial Mental Health Professional Shortage Areas (MHPSAs).[i] In July 2021, 253, **or more than 99% of Texas counties**, had that unfortunate designation, with Williamson County being the lone exception.[ii]

In addition, while research shows that a diverse health care workforce can improve health care access, satisfaction, and communication for patients of color, the behavioral health workforce remains overwhelmingly White, with just over 10% of practicing psychiatrists and 16% of psychologists being underrepresented minorities.[iii,iv] The shortage of, and lack of diversity among,

providers has compounded disparities in the diagnosis and treatment of behavioral health conditions. Studies cited by the American Psychiatric Association found that African-Americans are more likely to be diagnosed with schizophrenia, less likely to be diagnosed with mood disorders, and less likely to receive evidence-based mental health care than the general population.[v] They also found that Hispanics are more likely to express having communication issues with their health care providers and are more often undertreated.[vi]

Congress can help with these issues by making significant investments in the behavioral health workforce development, through: providing graduate medical education programs with funding to expand psychiatric residency slots; increasing funding for the National Health Service Corps Loan Repayment Program; providing funding to increase certification efforts for Mental Health and Recovery Support Peer Specialists; and instituting grant assistance programs for behavioral health professionals to cover supervision costs they incur for licensure.

Additionally, Congress can help address the workforce shortage by passing the following legislation:
- S. 1727/H.R. 3450, the Medicaid Bump Act, which would improve Medicaid reimbursement for behavioral health providers;
- S. 828/H.R. 432, the Mental Health Access Improvement Act of 2021, which would provide reimbursement for marriage and family therapist services under Medicare; and
- S. 2144/H.R. 2767, the PEERS Act of 2021, which would reimburse for services provided by Certified Peer Support Specialist Services under Medicare.

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

In the Spring of 2021, NBHP conducted a survey of over 250 behavioral health professionals in the greater Houston area and found that: Almost 40% of respondents entered the behavioral health because of an educational presentation (second only to having a loved one affected by a behavioral health issue); 80% of respondents who had postsecondary field placement/internship requirements received no stipend during the placement; and the most common barrier to educational and supervision completion was financial. The results suggest that workforce recruitment efforts ideally should combine both educational and preparation components, as well as financial incentives for educational and supervision completion.

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 integration?**

There are two integrated behavioral health and primary care models that have Current Procedural Terminology (CPT) codes associated with them that are billable and reimbursable under Medicare (and in some states, Medicaid). These models are the Primary Care Behavioral Health Model (PCBH), which uses the Health Behavior Assessment and Intervention (HBAI) codes; and the Collaborative Care Management Model (CoCM), which uses the Collaborative Care Management Model codes.

The HBAI CPT codes range from 96156, 96158, 96159, 96164, 96165, 96166 and 96168. In Medicare, these codes are billable and reimbursable for psychologists, but this is cost prohibitive

for primary care providers, as oftentimes utilizing an LCSW for these services allows for sustainable integrated behavioral health. The United States Congress should allow Medicare to reimburse for services provided by LCSWs in primary care settings under the HBAI codes.

Additionally, although the HBAI and CoCM codes are meant to only be used in an integrated behavioral health primary care setting, many managed care organizations continue to use a separate carrier to cover behavioral health services. Because of this, these codes often are reimbursable only by the behavioral health carve-out carrier. Primary care providers should not need to contract with a separate behavioral health insurance provider in order to offer integrated behavioral health in primary care. Primary care providers should be able to bill for services reimbursed under the HBAI and CoCM codes directly through the insurance company with which they contract.

Additionally, NBHP recommends that the following traditional mental health codes should be included in integrated behavioral health[vii]: 90791 (psychiatric diagnosis evaluation) and 90832 (psychiatric diagnosis evaluation with medical services).

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

The United States Congress should pass the following bills that would make changes in the federal Medicaid program and improve access to care for people with mental health and substance use disorders:

- S. 2315, the Medicaid Saves Lives Act, which would create a federal Medicaid-style program for individuals living in non-expansion states.
- H.R. 22611, the Increasing Behavioral Health Treatment Act, which would remove the Institutions of Mental Disease (IMD) exclusion that prevents Medicaid reimbursement to certain inpatient psychiatric facilities;
- S. 1821, the Humane Correctional Health Care Act, which would remove improve access to treatment for incarcerated people with behavioral health conditions. Like the suggestion above, this would eliminate Medicaid eligibility exclusions for coverage of people in these scenarios.
- S. 285, the Medicaid Reentry Act of 2021, which would help justice-involved individuals with behavioral health issues connect with needed community services prior to release; and
- S. 2069, the Excellence in Mental Health and Addiction Treatment Act of 2021, which would expand the Certified Community Behavioral Health Clinic demonstration waiver program.

<u>Expanding Telehealth</u>

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

Several studies have found that tele-behavioral health therapy across the continuum of care is as effective as face-to-face intervention.[viii] Telehealth has been proven to improve access in terms of time to service and comprehensiveness of service.[ix] Studies also have shown reduced wait times, reduced time to treatment, and an increase in the number of patients receiving indicated treatments.[x] Additionally, telehealth has been proven to reduce the number of hospital visits, hospital admissions, and length of hospitalizations.[xi] Lastly, studies also suggest that telehealth

services can save patients both time and money related to travel, as well as reduce provider no-show rates.[xii,xiii] Tele-behavioral health services are extremely high quality and cost-effective and help improve continuity of care.

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

Telehealth has been utilized during the pandemic at an unprecedented rate across the nation. For instance, the number of nation-wide Medicare beneficiaries receiving telemedicine increased from approximately 13,000 before the pandemic to nearly 1.7 million beneficiaries in April 2020.[xiv]

- **Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?**

Yes, Congress should absolutely make permanent the COVID-19 flexibilities for providing tele-behavioral health services.

A recent study found that 4.5 million Texans began using telehealth during the pandemic.[xv] This is due in large part to the temporary emergency rules for telehealth that Texas Governor Greg Abbott issued as a result of the federal flexibilities. Some of these emergency rules included: making providers eligible for payment from state-regulated insurance plans for medical visits they conduct electronically at the same rate they would receive for in-person visits (pay parity);[xvi] allowing psychiatrists to establish the physician-patient relationship over the phone;[xvii] allowing professionally licensed counselors to provide outpatient chemical dependency treatment services electronically; and requiring Medicaid managed care organizations to reimburse for audio-only behavioral health and substance use disorder treatment services delivered by federally qualified health centers[xviii]. Unfortunately, the pay parity flexibility expired in September 2021, reducing an important incentive for the provision of telehealth services.

These flexibilities have all drastically aided in expanding access to behavioral health care in Texas. High utilization rates of telehealth during the pandemic have proven that Texans do utilize and are satisfied with receiving care through telemedicine. Nearly all respondents to a study – 94% - said they would continue to use telehealth services after the pandemic, and 45% said that they now trust telehealth options as much as in-person visits.[xix] Making the above-mentioned flexibilities permanent would be tremendously beneficial to millions of vulnerable Texans.

Improving Access for Children and Young People

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

A few strategies to address the children's behavioral health care provider shortage are similar to the suggestions above regarding addressing the behavioral health care workforce shortage in general. These strategies include student loan repayment programs, offering four-year residency programs as an alternative to the typical five-year postgraduate training, and/or addressing administrative issues like codes and reimbursement rates to better align with the additional complexity that comes with working with a pediatric population.[xx] Additionally, colleges and universities could implement

discounted education tracks for undergraduate and graduate level students interested in pursuing children's behavioral health practices, especially for in-state students. Finally, community health workers could be utilized in settings such as schools and provide many important services to children.[xxi]

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

Peer support specialists, community health workers, and non-clinical professionals and paraprofessionals can play a critical role in improving children's behavioral health. They can serve as navigators or liaisons on and off school campuses, between teachers and mental health professionals. They can help coordinate communication between teachers and mental health professionals about a student with a behavioral health condition, and thereby improve the child's experience at school. They also can assist with de-escalating behavioral situations involving children and help them get back to class in a timely fashion.

Community Health Workers (CHWs) are often individuals who were raised in a community and then choose to go back into that community to work and provide services. Ensuring that these individuals are in schools can improve student access to people who look like them, which can help with positive health identity in students and can aid in the integration of more diverse behavioral health providers in schools. Community health worker positions are on-the-job trainable positions that will not require years of education to be qualified[xxii].

CHWs can help families gain access to and assist with a variety of resources, such applying for Medicaid. They also can help in school environments by performing services such as monitoring behavior patterns in children, helping administer a behavior modification plan, and leading support groups. Finally, CHWs can assist with implementation of Tier 1 (Prevention) and Tier 2 (Identify groups of students that have a potential emotional disturbance) services of the Multitier System of Support[xxiii] framework for schools, which is supported by the Texas Education Agency,[xxiv] as well as the Safe and Secure School[xxv] components, which also is supported by the Texas Education Agency[xxvi].

- **Are there different considerations for care integration for children's health needs compared to adult's health needs?**

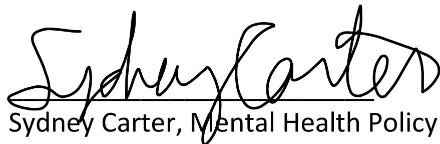
Yes, there are different considerations for care integration for children's health needs compared to adult's health needs. An example of this is how providers must pay respect to children's rights and parental guardian consent when a child is being seen by a professional and while receiving services. Additionally, a child needs to be assessed as a "whole child,"[xxvii] meaning an assessment must take place with consideration to the child's family and living environment. There are also other factors that play into considering the "whole child," such as cultural implications of admitting to, asking for, and receiving treatment for a mental health condition in the family dynamic, and any stigma that applies.

- **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?**

Up to 70% of youth in the juvenile justice system suffer from mental health disorders.[xxviii] For a large majority of those children, their first mental health screening occurred only when they had already become involved in the juvenile justice system[xxix]. Once children enter these systems, it is extremely difficult for them to get out. There is a massive need for funding for more community-based prevention efforts to keep children from entering the child welfare and juvenile justice systems in the first place. A few potential solutions could be hiring additional school counselors, implementing programs that "slow the pipeline" of children at risk transitioning to child welfare and juvenile justice system, and providing funding for after school programs and summer school programs for children. There could also be reimbursement for providers who co-locate their services, and those who build referral pathways with school districts, to aid in the efforts to prevent children from entering these systems.

Thank you for giving NBHP the opportunity to provide these comments. Please do not hesitate to contact us if you have any questions or need any additional information. NBHP would be honored to be a resource to the Committee in whatever way we are able. Again, thank you so much for your time and dedication to this important topic.

Sincerely,



Sydney Carter, Mental Health Policy Fellow, NBHP | scarter@nbhp.org

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[xi] Ibid.

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