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Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

Delivered via email to Statementsfortherecord@finance.senate.gov.

Statement for the Record: Full Committee Hearing: Protecting Youth Mental Health: Part I - An Advisory and Call to Action – Tuesday, February 8, 2022, 10 AM, 215 Dirksen Senate Office Building

Dear Chair Wyden and Ranking Member Crapo,

Thank you for this opportunity to submit this comment to you and other members of the Committee regarding the urgent and unmet needs of the community living with serious mental illness, which currently numbers 14 million in the US, many of whom are youth and young adults. Fountain House is pleased to engage with you on policy issues enumerated below that will benefit the unique community we serve. We believe that directing funding to clubhouses that provide evidence-based psychosocial rehabilitation, through programs such as the Community Mental Health Services Block Grant and other funding mechanisms, would prove effective at supporting the rights and recovery of those living with serious mental illness and substance use disorders and reduce Medicaid costs.

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. The majority of Fountain House members are BIPOC who are disproportionately affected by racism and systemic/structural barriers. Fountain House leads a national network of regional affiliates in San Antonio, TX, Phoenix, AZ, Sarasota, FL, Seattle, WA, Bellevue, WA, Everett, WA, Concord, CA, Ann Arbor, MI, Cleveland, OH, Queens, NY, Jamaica, NY, Staten Island, NY, New York, NY, and Bronx, NY and draws 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 of the 14 million people living with serious mental illness in our country while also providing necessary support and resources to the individuals we serve.

Millions of Americans living with serious mental illness (SMI) are denied access to care and support in the community because mental health support systems in the United States were not built to address the wide-ranging needs of people with SMI, especially people who cannot afford care. These individuals then end up cycling through our nation's streets, shelters, emergency rooms, and jails, at great expense to local, state, and federal budgets. In addition, we know that people with SMI face social and economic isolation¹ that has profound mental and physical

health consequences.ⁱⁱ For far too long our punitive, ineffective, and costly approaches have taken away their capacity 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, proven therapeutic community called social practice designed to support them to take steps in reclaiming their agency and dignity – with holistic access to clinical support, housing, care management, education, and more. Since the onset of the COVID-19 pandemic, we have also built a virtual version of our clubhouse to provide connection and expand our reach to others who can benefit. We are pleased to report that preliminary data suggests this helps to better engage both younger adults and a more demographically diverse cross-section of people living with SMI.

Simply put: Fountain House’s approach works. Our members are hospitalized and experience crises at rates significantly lower than others living with serious mental illness, resulting in 21% lower Medicaid costs for the highest-risk population. Of the 40% of our members experiencing homelessness or unstable housing when they arrive at Fountain House, 99% are housed within a year. Of the 24% of Fountain House members with a history of incarceration and justice involvement, rates of recidivism are less than 5%. Our members complete their education, find paid work, and achieve health and wellness goals at significantly higher rates than people living with serious mental illness who don’t have access to our programs. Our country has growing and intersecting crises of homelessness, police involvement, incarceration, and rising mental health needs, which require programs like Fountain House to be accessible and available to all.

As this Committee recognized during its February 8, 2022 hearing, millions of young Americans are struggling under a mental health epidemic amounting to a national crisis, which will require both coverage of and access to physical and mental health care to solve. As this Committee works to produce a bipartisan bill this summer that can serve as a step forward in solving this nation’s mental health crisis, we urge you to recognize that there are 14 million people in the United States living with serious mental illness (SMI). Traditional care delivery models fail to address many of the underlying needs of people with SMI, and these failures result in unnecessary morbidity, mortality, healthcare costs, and other social service costs to society. We encourage states to use new Medicaid and behavioral health funding to support comprehensive models of psychosocial rehabilitation that break down social isolation and improve quality of life. Congress and the federal government should support these aims so that trained behavioral health staff can serve as social practitioners and offer the following services to the populations they serve:

- transitional employment;
- health and wellness programming;
- culinary food service and medically managed meals;
- housing assistance;
- care management; and
- supported education.

Based on the needs of our community, we support the following proposed Appropriations Report Language:

The Committee directs the Center for Medicare and Medicaid Services (CMS) to provide a report the Committee within 180 days of enactment that addresses how CMS will encourage the following:

- How the Center for Medicare and Medicaid Innovation intends to develop new payment models that supplant fee-for-service models with more global-oriented payment models that reward value associated with breaking down social isolation for people living with SMI;
- How the Center for Clinical Standards of Quality will develop, specify, test, and integrate into payment models patient-reported outcome measures that address social isolation and loneliness; and
- How the Center for Medicaid and CHIP Services will encourage state Medicaid agencies to contract with payers that offer comprehensive psychosocial rehabilitation services, as described above.

The Committee directs an additional \$40 million to be allocated to the Patient-Centered Outcomes Research Institute (PCORI) to specifically support a funding announcement related to social drivers of health for people living with serious mental illness.

In addition, the Committee directs the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide a report to the Committee within 180 days of enactment that addresses how SAMHSA will clarify expectations that rehabilitation services should comprehensively address rehabilitation, including psychosocial rehabilitation as described above.

Strengthening the Workforce

As Senator Crapo recognized during this Committee's February 8, 2022 hearing, strengthening the mental and behavioral health workforce will prove vital, especially in the face of widespread stress, fatigue, and burnout of providers and workers in the mental health field. And, as the Senate HELP Committee heard during its February 1, 2022 hearing to examine mental health and substance use disorders focusing on responding to the growing crisis, serious workforce gaps in the mental health community have been left unaddressed by broader efforts to strengthen the US workforce. Fountain House encourages Congress to broaden its thinking as it considers policy and structural changes aimed at strengthening the workforce of mental health providers.

Senator Cortez Masto's line of questioning regarding peer support services during this Committee's February 8, 2022 hearing recognized the vital role that peers play in recovery for people with SMI. The role of peers is incredibly important to social practice that works to address the requirements of our members and other individuals with mental health needs. Fostering a community of people with similar lived experiences is critical for promoting health equity. As SAMSHA reports, research shows that peer support provides important recovery benefits. Creating and resourcing additional pathways for peers and other mental health paraprofessionals to enter the field would play a critical role in addressing staffing gaps nationwide, contribute to innovation and more well-evidenced models of care, and create new employment opportunities for people from lower-resourced backgrounds to enter the helping profession and serve people with SMI. After entering the field, we recommend that there be clear pathways for peers to remain and grow in the mental health workforce to serve people with SMI. One way of ensuring continuity and robust availability of peer supports is to create standardized training programs for peers, which can contain advancement opportunities in and of themselves in addition to promoting a general understanding of the opportunities in the field.

We urge Congress to consider the ways in which health care payments limit growth of the mental health workforce, especially those who serve people with SMI. 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 under traditional fee-for-service payment models.

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 most feasible solution is to deploy people with lived experience from the community to provide critical support as an adjunct to more serious clinical expertise so we are maximizing what each person in the provider system can do.

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 bipartisan 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 enumerated in your communication to behavioral health stakeholders including expanding the availability of services such as 24/7 national hotlines, mobile crisis services, behavioral health urgent care facilities, crisis stabilization beds, and short-term crisis residential options. The bill also 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 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, such as the services that social practitioners provide in clubhouses, 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 living with SMI. 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 members experience a significantly improved quality of life due to their involvement in the model.^{iii iv} 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.^v Overall, aspects of the clubhouse model believed to account for these improvements include the focus on autonomy and personhood instead of patient-hood. Clubhouses have further been proven to reduce severe psychiatric symptoms, improve self-esteem,^{vi} and decrease internalized stigma, promoting greater recovery experiences.^{vii} Randomized controlled trials of clubhouse programs have shown reduced hospitalizations for clubhouse members.^{viii} Additionally, membership in clubhouses shows lower drop-in rates and fewer hospitalizations,^{ix} and clubhouse costs are substantially lower than partial hospitalization, thus clubhouse membership reduces overall cost of healthcare.^x

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 which requires markedly different treatment approaches than diagnoses such as heart disease, diabetes, or other chronic physical ailments. Yet success is measured with a system that does not adequately distinguish between behavioral and physical health. 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 supported well enough 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 having 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, bipartisan Medicare Mental Health Inpatient Equity Act, which would permanently repeal the Medicare 190-day lifetime limit for inpatient psychiatric care. Medicaid also imposes 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 many conditions, including mental health diagnoses. While the flexibility afforded 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 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 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 this opportunity to respond to this Committee's discussion draft. If you have any questions or would like more information, please contact Jennifer Wang, Senior Director of National Policy and Advocacy at jennifer.wang@fountainhouse.org.

Sincerely,



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