BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION IN RURAL HEALTH FACILITIES

POLICY BRIEF AND RECOMMENDATIONS TO THE SECRETARY

JUNE 2022

NACRHHS

National Advisory Committee on Rural Health and Human Services

EDITORIAL NOTE

During the 89th meeting of the National Advisory Committee on Rural Health and Human Services (hereinafter referred to as "Committee"), members explored behavioral health and primary care integration in rural health facilities, using the experiences of providers in rural counties of Arizona. Typically, the Committee travels to a rural part of the country to hold its meeting and to visit local providers, allowing members to hear directly from stakeholders. Prior to the Public Health Emergency, the fall 2021 meeting was scheduled to be held in Arizona; but because of the pandemic, the meeting was held virtually.

Representatives of the planned Arizona site visits spoke to the committee via Zoom. Committee members were divided into two groups and visited with either representatives of Gila River Health Care or the Mariposa Community Health Center, and these discussions helped the committee formulate this policy brief. Summaries of the two discussions can be found in the Appendix.

ACKNOWLEDGEMENTS

The Committee acknowledges the assistance and contributions of those who helped plan the meetings as well as those who presented to the members. These individuals were: Dr. Daniel Derksen (Arizona Center for Rural Health); David DeVoursney (Substance Abuse and Mental Health Services Administration); Dr. Shannon McDevitt (Health Resources and Services Administration), Ing-Jye Cheng (Centers for Medicare and Medicaid Services): Patricia Tarango (Arizona Department of Health Services); Jami Snyder (Arizona Health Cost Containment System); Dr. Yoendry Torres (Pascua Yaqui Tribe), John Gale (University of Southern Maine); as well as Dr. Anthony Santiago from Gila River Health Care, and Dr. Eladio Pereira from the Mariposa Community Health Center, and their respective staff.

The Committee also extends its appreciation to Samia Ismail for coordinating the activities of this meeting, summarizing the Committee's findings, and drafting this policy brief.

POLICY RECOMMENDATIONS

Access

Recommendation One: The Committee recommends that the Secretary support targeted outreach and enrollment efforts to rural communities to enroll appropriate rural residents eligible for Medicare Dual-Eligible benefits, Medicaid, CHIP, and the national and state-based Health Insurance Marketplaces to enhance access to behavioral health and primary care by ensuring more rural residents have insurance coverage.

Recommendation Two: The Committee recommends that the Secretary support behavioral health start-up grants or loans to help offset the initial costs of integration, including integration of electronic health records, acquisition of telehealth equipment, and recruitment of behavioral health providers into primary care practices in rural communities.

Workforce Recruitment and Retention

Recommendation Three: The Committee recommends that the Secretary support targeted, rural-specific grant awards within its Title VII and VIII health professional training programs to increase the number of clinicians practicing in rural areas.

Recommendation Four: The Committee recommends that the Secretary expand the number of Rural Residency Planning Grants and Teaching Health Center Awards to support rural primary care and psychiatric residencies.

Recommendation Five: The Committee recommends that the Secretary fund grants to increase the number of DEA-waivered providers who are approved to prescribe buprenorphine in rural practices.

Recommendation Six: The Committee recommends that the Secretary support research to assess the impact of expanding the range of behavioral health providers eligible for Medicare reimbursement, including but not limited to, marriage and family therapists and mental health counselors.

Telehealth, Technology, and Broadband

Recommendation Seven: The Committee recommends that the Secretary work with Congress to maintain the Medicare regulatory and reimbursement flexibilities from the pandemic beyond the Public Health Emergency and the brief extension included in the 2022 Budget, particularly those of benefit to rural communities and relevant to the provision of behavioral health services. This includes allowing RHCs and FQHCs to serve as telehealth distant sites, permitting beneficiaries to receive telehealth services at home for a broader range of behavioral health services, including but not limited to, MAT induction and tele-prescriptions for SUDs. Also, providing reimbursement to clinical psychologists and licensed clinical social workers for virtual communications services, and exercising enforcement discretion on the use of non-HIPAA compliant remote communications technologies.

Recommendation Eight: The Committee recommends that the Secretary work with the Department of Commerce, the Federal Communications Commission, and the U.S. Department of Agriculture to coordinate broadband investments to address access gaps in rural communities.

Reimbursement and Sustainable Revenue

Recommendation Nine: The Committee recommends that the Secretary conduct an ongoing campaign to educate rural primary care and behavioral health providers on how to apply the Medicare behavioral health integration codes.

Recommendation Ten: The Committee recommends that the Secretary develop a payment model through the CMS Innovation Center to focus on an integrated behavioral health-primary care payment methodology to expand access, coordinate care, and enhance outcomes through a range of primary care providers including Federally-Qualified Health Centers and Rural Health Clinics.

I. INTRODUCTION

Policy makers have long understood the benefits of integrating behavioral health and primary care services as a way to improve access to, increase coordination of, and reduce the costs of care. In addition to improved clinical outcomes and financial benefits, behavioral health and primary care integration can also reduce travel time for rural residents, and reduce fear of stigma in seeking behavioral health assistance. One of the major challenges to integration in rural communities is the lack of clinical services providers, especially mental health and substance use disorder specialists. For rural providers that would like to integrate services, the lower volume of patients make it difficult to sustain. Recognition of these challenges led the Committee to examine rural behavioral health and primary care integration, and how federal programs can best support those efforts in rural America. Through its background work, and from hearing presentations from experts and stakeholders at the state and national levels, the Committee narrowed its focus to four main concerns: barriers to access, workforce shortages, lack of broadband access, and reimbursement issues that rural providers encounter when incorporating behavioral health services in rural primary care settings.

II. BACKGROUND

Behavioral health is term used to cover a wide range of conditions and disorders related to both mental health and substance use and includes life stressors, crises, stress-related physical symptoms, and health behaviors. If left untreated, these mental health conditions or instances of substance use may begin to disrupt daily life and can also exacerbate medical illnesses. The term *primary care* describes the care provided to a patient, the system of care delivery, and the clinicians providing the care. In addition to addressing physical conditions, primary care providers often encounter psychological and social conditions that they are less prepared to manage. Because they are usually an individual's first point of contact with a health care system, primary care providers are often the first to notice behavioral health problems that, ideally, should be addressed by a specialist.

The Centers for Disease Control and Prevention (CDC) reported in 2017 that rural residents in the United States are more likely than urban residents to die prematurely from each of the five leading causes of death: heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.[1] These

patients often experience mental health disorders, such as depression, as a comorbidity to these chronic conditions.[2] Among the 10 most common patient-reported reasons for a primary care visit were symptomatic conditions including cough, back pain, abdominal symptoms, headache, and fatigue. However, clinicians report that after upper respiratory tract infection and hypertension, the next most common reason for a visit was depression or anxiety.[3]

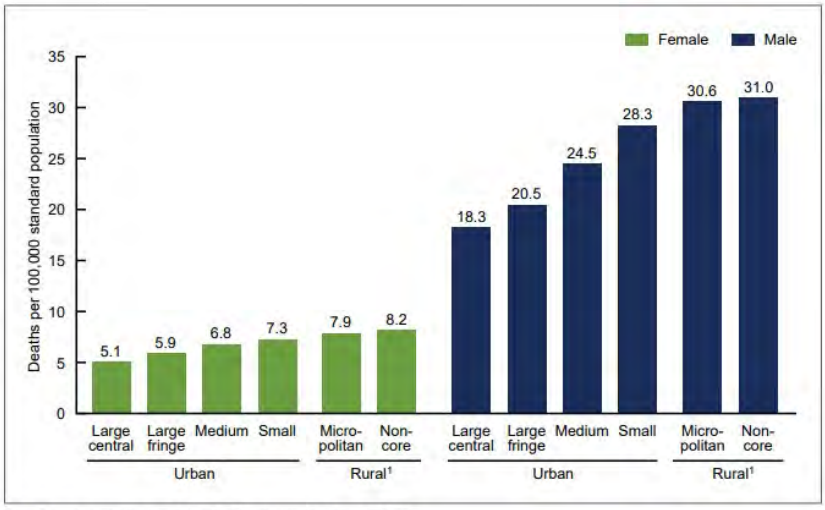
Rural Mental Health

Before the COVID-19 pandemic, approximately one in five people in the United States reported any mental illness diagnosis,[4] with the prevalence slightly higher in rural areas.[1,5] However, for rates of serious mental illness increase significantly with rurality, ranging from 4.8 percent of people in large metropolitan counties to 5.9 percent in nonmetropolitan counties.[4]

Similarly, the proportion of deaths by suicide increase substantially by rurality among both men and women. In 2019, the rate of rural men 75 and older who died by suicide was 39.9 per 100,000, almost three times higher than the national rate of 14.2 per 100,000.[6] For women, the rate was 5.1 deaths by suicide per 100,000 women in large central counties vs 8.2 per 100,000 in non-core rural counties, **Figure 1**).[7]

For men in high-risk occupations like farming and ranching, the rate of deaths by suicide is 43.2 per 100,000 compared to the average across all other male-dominated occupations of 27.4 per 100,000. Similarly, rates of death by suicide among American Indian/Alaskan Native (AI/AN) population, 54 percent of which live in rural areas of the country, are more than twice the national average.[8]

These statistics suggest that opportunities for rural people to access mental health treatment and preventive care are either not readily available or not utilized effectively. Exacerbating the issue, 60.6 percent of Mental Health Professional Shortage Areas (MHPSAs) are in rural areas.[9]



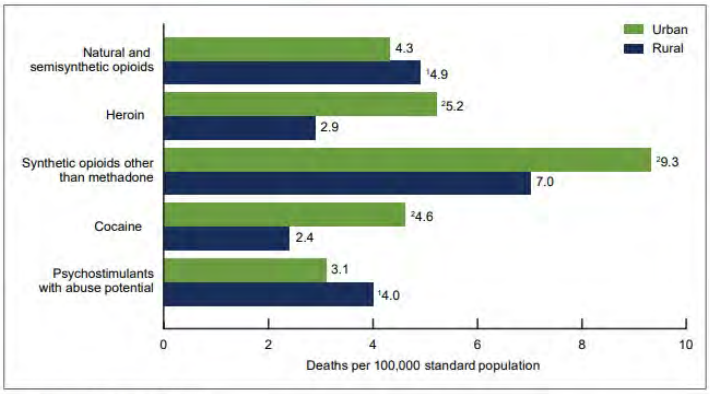
[1]Rates for rural county groups are higher than for urban county groups, $p < 0.05$.
NOTES: Suicides are identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Counties were classified using the 2013 National Center for Health Statistics Urban–Rural Classification Scheme for Counties available from: https://www.cdc.gov/nchs/data/series/sr_02/sr02_166.pdf. Access data for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db362-tables-508.pdf#4.
SOURCE: NCHS, National Vital Statistics System, Mortality (NVSS-M).

Figure 1: Age-Adjusted Death by Suicide Rates, By Sex and Urbanicity of County of Residence, United States, 2018

Rural Substance Use

Substance use disorder (SUD) is a general term that encompasses the misuse of any legal or illegal (e.g. illicit) substance, except caffeine.[10] The rates of illicit drug use and prescription drug overdose are higher in urban areas, however, the prevalence of specific legal and illegal drug use differs by the degree of rurality.[11,12] Generally, adults in nonmetropolitan counties are more likely than adults in metropolitan counties to use methamphetamine (1.0 percent vs 0.7 percent, respectively) or die from a methamphetamine overdose (4.0 per 100,000 vs 3.1 per 100,000).[11,122]

Among subtypes of SUD, opioid use disorder (OUD) is the fastest growing nationwide with overdose deaths caused by synthetic[i] opioids, such as oxycodone, rising 71 percent from 2013 to 2017.[13] Of the 70,000 deaths caused by drug overdoses in 2017, over two-thirds were opioid-related.[133] In particular, rates of overdose deaths involving natural (e.g. morphine and codeine) or semisynthetic opioids were significantly higher in rural than in urban communities (**Figure 2**).[12] Between 2014-2015, 86.3 percent of nonmetropolitan adults who met the criteria for SUD involving illicit drugs were not receiving treatment for that condition.[14]



†Significantly higher than urban rate, $p < 0.05$.
‡Significantly higher than rural rate, $p < 0.05$.
NOTES: Drug overdose deaths were identified using *International Classification of Diseases, 10th Revision* underlying-cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Deaths involving specific drugs or drug types were identified using multiple-cause-of-death codes: natural and semisynthetic opioids, T40.2; heroin, T40.1; synthetic opioids other than methadone, T40.4; cocaine, T40.5; and psychostimulants with abuse potential, T43.6. Deaths involving more than one drug (e.g., a death involving both heroin and cocaine) were counted in both categories. In 2017, at least one specific drug was identified in 88% of drug overdose deaths. Decedent's county of residence was classified as urban or rural based on the 2013 NCHS Urban–Rural Classification Scheme for Counties. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db345_tables-508.pdf#4.
SOURCE: NCHS, National Vital Statistics System, Mortality.

Figure 2: Age-Adjusted Drug Overdose Death Rates, by types of Drugs Involves and by Urban and Rural Residence, 2017.

Certain rural subpopulations may face compounding behavioral health inequities due to their age, race, ethnicity, disability status, sexual orientation, gender identity, and/or occupation, in combination with their geographic location. Though there are data describing the disparate health outcomes of some of these communities, there are few studies of the behavioral health outcomes of rural LGBTQ+ people and rural people of color. From available data we do know that SUD trends among rural teenagers and older people mirror those of rural adults.

Teenagers in nonmetropolitan counties are more likely than their metropolitan counterparts to use methamphetamine (0.3 percent vs 0.2 percent)[15] and are slightly more likely to have used opioids than

[i] Natural opiates include morphine, codeine, and thebaine. Semi-synthetic opioids are opioids created in labs from natural opiates. Semi-synthetic opioids include hydromorphone, hydrocodone, and oxycodone (the prescription drug OxyContin), as well as heroin, which is made from morphine.[12]

urban adolescents. The elderly in rural areas are also disproportionately affected by OUD. The proportion of mental health and substance use-related emergency department visits involving people 65 and older increased with rurality, from 18.2 percent in urban counties to 27.9 percent in small rural counties.[16]

Between 2014-2015, 86.3 percent of nonmetropolitan adults who met the criteria for SUD involving illicit drugs were not receiving treatment for that condition.[17] During the same time period, 75.9 percent of nonmetropolitan adults who satisfied the criteria for OUD were not receiving treatment.[20]

Rural Primary Care

In rural areas, emergency departments, primary care clinicians, and other generalist providers often provide behavioral health diagnoses and treatment. In 2017, less than 20 percent of nonmetropolitan adults received treatment for depression from a mental health provider; instead, 43.7 percent of adults in these areas visited a general practice physician for depression symptoms.[5] In particular, Medicare beneficiaries in rural areas have at least two-thirds of their mental health visits with a general practitioner (including primary care physicians, nurse practitioners, or physician assistants) whereas only 44.5 percent of Medicare beneficiaries in urban areas do the same.[13]

Federal Support Toward Behavioral Health and Primary Care Integration

Several agencies within the U.S. Department of Health and Human Services (department or HHS) support programs and direct resources to encourage providing behavioral health and primary medical care in integrated settings, though these are not necessarily rural-specific. In May 2021, a multi-agency committee was chartered by the HHS Secretary to create more efficient, collaborative, and innovative approaches to advance the department's behavioral health agenda and priorities. This initiative will include a focus on behavioral health and primary care integration. HHS' programs and resources that link to either primary care or behavioral health are spread across the department. Several, however, hove great potential to encourage integration of behavioral health and primary care services.

Centers for Medicare and Medicaid Services (CMS) CMS supports both primary care and behavioral health through the administration of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), as well as its oversight of the Health Care Marketplace. Payment policies have the potential to encourage integrated care if well structured. CMS has taken important steps in this direction through the introduction of new Medicare billing codes for behavioral health integration.[18] Medicaid and CHIP payment policies are set at the state level, giving each state the ability to also create incentives for behavioral health and primary care integration. CMS has also created incentives for behavioral health and primary care integration within some of the value-based payment models that emphasize care coordination, including Accountable Care Organizations and the Medicare Shared Savings Programs. In recent years, CMS has been gradually expanding the services Medicare will cover under telehealth, with tele-mental services being one of the highest areas of utilization. With the expanded telehealth billing flexibilities under the pandemic-driven Public Health Emergency (PHE) declaration, the use of telehealth, and tele-mental health specifically, has expanded dramatically. Lawmakers are deciding the extent of the flexibilities once the PHE expires.

Health Resources and Services Administration (HRSA) HRSA administers programs that focus on improving health care for Americans who are geographically isolated and economically or medically vulnerable, and is also the home of the Federal Office of Rural Health Policy (FORHP). Improved access to primary care and behavioral health services is also an area of emphasis across the agency's programs. One in five rural residents receives care from a community health center, grantees organizations that are part of HRSA's Health Center program, which has made considerable investments in integrating behavioral health and primary care services. HRSA is also the HHS lead in health workforce training.

FORHP focuses on behavioral health services through the Rural Communities Opioid Response Program (RCORP) which is expanding access to opioid treatment by funding networks of rural health care providers to coordinate those services. In FY 22, HRSA began funding a new cohort of RCORP grants to focus on the integration of substance use treatment services into the behavioral health and primary care sectors. In addition, FORHP's Rural Health Outreach program includes a heavy focus on behavioral health services, and these programs are often leveraged by rural communities to focus on behavioral health and primary care integration.

HRSA's Maternal and Child Health Bureau administers the Pediatric Mental Health Access program, which promotes behavioral health in pediatric care through telehealth. This program serves both rural and urban communities. HRSA's Maternal Depression and Related Behavioral Health Disorders Program trains primary care practitioners to identify maternal mental health conditions early, and integrating behavioral health into primary care and maternal health care settings.

HRSA's workforce programs focus on training an array of health care providers to work in underserved and rural areas. This includes programs focused on the behavioral health workforce. Through the National Health Service Corps and the Nurse Corps, HRSA provides loans and scholarships to encourage clinicians to practice in rural and underserved areas.

Indian Health Service (IHS) Investments in fostering behavioral health and primary care integration are also made through the Indian Health Service (IHS) and its provision of services to American Indian and Alaska Native (AI/AN) people through the IHS directly, and through its Tribal Health Programs. The federal government has a unique government-to-government relationship with 574 federally recognized tribes. In both its direct care program and tribal health programs, IHS focuses on integrated care. In recent years, there has been a pronounced focus on addressing the opioid epidemic facing many tribal communities. The IHS has heavily leveraged telehealth technology to meet health care needs, particularly in terms of behavioral health. However, the IHS faces ongoing challenges related to recruiting and retaining clinicians and the need for new or expanded facilities.

Substance Abuse and Mental Health Services Administration (SAMHSA) SAMHSA serves as HHS' lead agency in reducing the impact of substance use disorders and mental illness on America's communities. Through state and local grant funding, SAMHSA supports a diverse portfolio of behavioral health care services. This includes the Community Mental Health Services Block Grant, the Substance Use Prevention and Treatment Block Grant, Tribal and Behavioral Health Grants, all of which play a key role in supporting behavioral health services in rural communities. SAMHSA also coordinates with HRSA to support the Center for Integrated Health Solutions (CHIS), a national training and technical assistance center that promotes the development of integrated primary and behavioral health services. CIHS

provides clinical practice tools and resources for integration of mental health, substance use, and primary care. While not a standard part of their programing, the Center has included rural in its efforts to focus on behavioral health and primary care integration in the past. Finally, SAMHSA has invested its efforts toward addressing the impact of the opioid epidemic through additional targeted programs, such as the Tribal Opioids Treatment program.

III. DISCUSSION AND RECOMMENDATIONS

ACCESS TO CARE

Multiple barriers prevent people in rural areas from accessing behavioral health services, including provider shortages, lack of insurance, costs of care, and, especially for tribal organizations, and linguistic and cultural barriers. Distances to service facilities and transportation difficulties may lead rural patients to seek mental health diagnoses and care from local, generalist providers. At the same time, providers must keep their clinics financially viable, despite the low patient volumes in rural areas. As HHS continues to focus on integration of services, these challenges must be considered.

Lack of Insurance. Rural areas have traditionally had higher rates of uninsured relative to urban areas, and though rural uninsured rates have fallen since the passage of the Affordable Care Act, Americans living in rural areas still lack health insurance at higher rates than those in urban areas.[19] Rural areas continue have uninsured rates for nonelderly adults are roughly 2-3 percentage points higher than urban areas.[20]

Lack of Mental Health Specialists. Among nonmetropolitan counties in 2015, 27 percent lacked a social worker, 47 percent lacked a psychologist, 65 percent lacked a psychiatrist, and 81 percent lacked a psychiatric nurse practitioner (**Figure 3**).[21,22] Compared to urban counties, rural counties frequently have less than half as many of these behavioral health care professionals proportional to the population (**Figure 4**).[219,20]

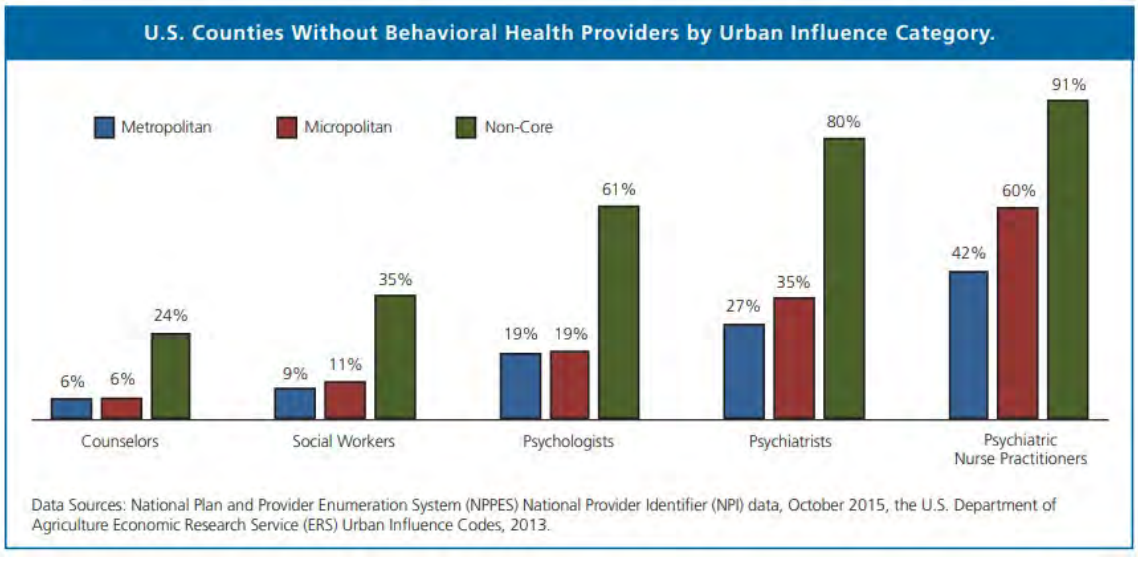


Figure 3: U.S. Counties without Behavioral Health Providers by Urban Influence Category. Note that nonmetropolitan counties include both non-core and micropolitan counties.

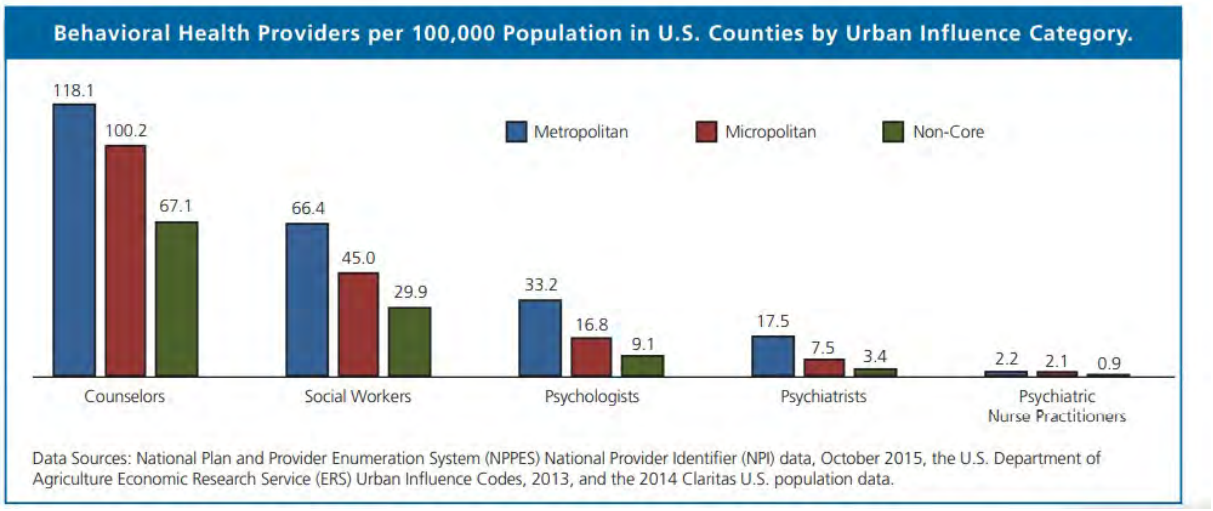


Figure 4: Behavioral Health Providers per 100,000 Population in U.S. Counties by Urban Influence Category. Note that nonmetropolitan counties include both non-core and micropolitan counties.

Lack of SUD specialists. In addition to the lack of behavioral health clinicians, rural areas also experience a shortage of specialists equipped to provide treatments for SUD and OUD. From 2014-2015, 86.3 percent of nonmetropolitan adults who met the criteria for SUD involving illicit drugs were not receiving treatment for that condition.[i] During the same period, 75.9 percent of nonmetropolitan adults who satisfied the criteria for OUD were not receiving treatment.[20] Although any physician, nurse practitioner, or physician assistant can apply for a waiver from the Drug Enforcement Agency (DEA) to prescribed buprenorphine, more than half of rural counties (56.3 percent) still lacks an approved provider. Almost one-third (29.8 percent) of rural Americans compared to 2.2 percent of urban Americans live in a county without a buprenorphine provider.[23]

Despite these challenges, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and private practice clinics in rural areas have stepped up to offer SUD services. RHCs have faced challenges in meeting this due to confusion by some Medicare survey agencies that the provision of SUD services falls outside primary care and is instead a "specialty" service. These determinations are variable from region to region and the Committee is concerned that such variability will reduce access to SUD care, while also inhibiting efforts to integrate behavioral health and primary care services. RHCs and FQHCs in particular face the added hurdle of being unable to bill for services from some types of behavioral health professionals, such as marriage and family counselors, licensed professional counselors, and licensed mental health counselors under Medicare.[24]

Distances to care. Lack of rural behavioral health providers puts a strain on other providers and forces people to travel long distances to find care. This inconvenience may lead to people foregoing the care altogether. Medicare beneficiaries from rural counties travel 70 miles and 90 minutes on an average round trip to receive behavioral health services, compared to 34.6 miles and 52.6 minutes for Medicare beneficiaries from urban counties.[25]

Access: Federal Programs and Recommendations

CMS is the federal agency responsible for providing insurance coverage through the public programs of the Centers for Medicare and Medicaid Services (CMS), which includes CHIP. Given the gaps in access to integrated behavioral health and primary care, rural providers will benefit from getting as many of their patients as possible into health insurance coverage. This will be true not only for enrolling eligible rural individuals and families into Marketplace insurance plans, but also ensuring that those who are eligible for public coverage are able to take advantage of that opportunity. This would include identifying any low-income Medicare beneficiaries who may also be eligible for Medicaid.[26] The same would also be true for children potentially eligible for Medicaid or CHIP.

> **Recommendation One:** The Committee recommends that the Secretary support targeted outreach and enrollment efforts to rural communities to enroll appropriate rural residents eligible for Medicare Dual-Eligible benefits, Medicaid, CHIP, and the national and state-based Health Insurance Marketplaces to enhance access to behavioral health and primary care by ensuring more rural residents have insurance coverage.

HRSA's programs focus on improving health care for Americans who are disadvantaged and encourage integration of services. HRSA's Health Center program offers ongoing expansions of behavioral health services into existing and new health center service sites. HHS has opportunities to build on these efforts by considering support for other providers such as RHCs, Critical Access Hospitals (CAHs), and other rural primary care providers.

> **Recommendation Two:** The Committee recommends that the Secretary support behavioral health start-up grants or loans to help offset the initial costs of integration, including integration of electronic health records, acquisition of telehealth equipment, and recruitment of behavioral health providers into primary care practices in rural communities.

Access is also a primary factor that SAMHSA. As mentioned above, SAMHSA is dedicated to reducing the impact of substance use and mental illness on America's communities through the Community Mental Health Services Block Grant, the Substance Use Prevention and Treatment Block Grant, Tribal and Behavioral Health Grants, each of which include a component supporting behavioral health services in rural communities. In addition, SAMHSA and HRSA support the Center for Integrated Health Solutions to provide training and technical assistance that promotes the development of integrated primary and behavioral health services.

Most recently, in May 2021, a multi-agency committee was chartered by the HHS Secretary to create more efficient, collaborative, and innovative approaches to advance the department's behavioral health agenda and priorities. This initiative will include a focus on behavioral health and primary care integration. HHS' programs and resources that link to either primary care or behavioral health are spread across the department. The challenge for HHS comes in identifying ways to support integrated services even if the bulk of the funding is much more specifically targeted to agency-specific programs.

WORKFORCE

Over 60 percent of rural America is classified as a MHPSA and the difficulty in recruiting behavioral health clinicians is an obstacle shared by many rural primary care facilities looking to integrate behavioral health and primary care.[9] The additional responsibilities of providing behavioral health screening and services only exacerbates burnout among rural primary care providers. Provider burnout is prevalent in rural communities and often results in the clinician leaving the practice location.

Among the strategies to alleviate staff burnout, include utilizing community health workers, peer support specialists, and behavioral health aides. Creating virtual partnerships with nearby behavioral health providers, and arranging professional and personal support to mitigate burnout have also been found to be effective.[24,27] Creating a cohesive working environment between behavioral health and primary care staff is another strategy found to be successful by CAH-based RHCs in preventing high turnover and creating a more efficient integrated operation.[242] However, the encouraging findings of at least one study showed that "a rural practice location has a positive effect on physician well-being."[27]

Some CAH-based RHCs report that offering financial support in the form of rent assistance, loan repayment, and competitive salaries and benefits can make recruitment efforts more successful, though RHCs may find it difficult to afford recruitment incentives.[21]

Workforce: Federal Programs and Recommendations

The federal government, through HHS offers an array of support aimed at alleviating rural workforce shortages. Within the department, HRSA administers the training programs for behavioral health and primary care and, their grant announcements emphasize team-based care. Federal and state initiatives such as the National Health Service Corps, Nurse Corps, the State Loan Repayment Programs, or state-run loan forgiveness programs, are the most well-known and could help incentivize more behavioral health providers to serve in MHPSA.[286] The Committee heard from state representatives that long-term solutions are need to alleviate the shortage of nearly all provider types, including behavioral health clinicians, family medicine, internal medicine, psychiatry, OB/GYN, general surgery, preventive medicine, and other specialties. The challenge for rural, however, is that smaller and rural-focused academic training programs often have to compete against larger urban-focused training programs. Given that rural communities have a greater shortage of needed behavioral health providers, the Committee believes a more targeted approach may be needed to expand the pipeline to support integrated behavioral health and primary care services in rural communities.

> **Recommendation Three**: The Committee recommends that the Secretary support targeted, rural-specific grant awards within its Title VII and VIII health professional training programs to increase the number of clinicians practicing in rural areas.

Two other programs within HHS, the Rural Residency Training Program and Teaching Health Centers program administered by HRSA, offer an emphasis on physician residency programs that wholly or primarily train in rural communities, place residents in rural locations for greater than 50 percent of their training, and focus on producing physicians who will practice in rural communities. Their focus is training physicians, but the Committee contends these programs could be expanded to support more new rural residency programs or Rural Training Tracks (RTT) for other provider types that work in family medicine, internal medicine, and psychiatric settings, to support expansion of the health care workforce in rural areas. This would include creating Graduate Medical Education slots at hospitals in MHPSAs and in integrated settings.[28]

Recommendation Four: The Committee recommends that the Secretary expand the number of Rural Residency Planning Grants and Teaching Health Center Awards to support rural primary care and psychiatric residencies.

In addition to training more practitioners to enter the rural behavioral health workforce, primary care providers should be encouraged to apply for a DEA waiver to prescribe buprenorphine. This would expand the number of practitioners able to provide specialized SUD and OUD care to rural people, while drawing on the existing infrastructure of rural health primary care providers and practices. There is a great need for SUD and OUD care in rural areas. As of 2016, 60.1 percent of nonmetropolitan counties lacked a DEA-waivered provider, more than twice the amount of metropolitan counties (26.2 percent).[29]

Recommendation Five: The Committee recommends that the Secretary fund grants to increase the number of DEA-waivered providers who are approved to prescribe buprenorphine in rural practices.

Another area the Committee is concerned about is that under Medicare there is currently are statutory restrictions on who can bill for behavioral health services, which is limited to physicians, psychiatrists, psychologists, licensed clinical social workers and psychiatric nurse practitioners.[242] The Committee is aware that some states allow other clinicians such as marriage and family therapists and licensed professional counselors to bill for services under Medicaid, provided it is linked to an appropriate state scope of practice. However, given the shortage of behavioral health providers in rural areas, the Committee believes there may be benefit in expanding the pool of available clinician types. At the same time, the Committee recognizes the need for a better understanding of the impact these clinicians have had in meeting rural needs in those states where they are licensed and able to bill for services under Medicaid.

Recommendation Six: The Committee recommends that the Secretary support research to assess the impact of expanding the range of behavioral health providers eligible for Medicare reimbursement, including but not limited to, marriage and family therapists and behavioral health and primary care counselors.

TELEHEALTH, TECHNOLOGY, AND BROADBAND

Given the magnitude of the behavioral health problems among rural residents, where it is available, telehealth is an effective tool in increasing access to services, and use of this technology only increased during the pandemic. Before 2019, tele-mental health services constituted the most billed telehealth service in Medicare.[30] Due to the pandemic and the issuance of the PHE, some regulatory flexibility in billing for telehealth services was granted. Prior to the pandemic, Medicare saw approximately 8,000 tele-mental health visits every week. That grew to more than 200,000 per week during the pandemic.[31] During the PHE, telehealth acceptance and use both increased exponentially, with Americans' interest in using telehealth increasing from 11 percent in 2019 to 76 percent in May 2020.[32] Given that rural communities were already using telehealth to enhance access to behavioral health services prior to the pandemic, the Committee believes it will continue to be an important tool. However, the scale of that

use will be affected by what federal and state policymakers do in terms of maintaining the PHE flexibilities.

> **Recommendation Seven**: The Committee recommends that the Secretary work with Congress to maintain the Medicare regulatory and reimbursement flexibilities from the pandemic beyond the Public Health Emergency and the brief extension included in the 2022 Budget, particularly those of benefit to rural communities and relevant to the provision of behavioral health services. This includes allowing RHCs and FQHCs to serve as telehealth distant sites, permitting beneficiaries to receive telehealth services at home for a broader range of behavioral health services, including but not limited to, MAT induction and tele-prescriptions for SUDs. Also, providing reimbursement to clinical psychologists and licensed clinical social workers for virtual communications services, and exercising enforcement discretion on the use of non-HIPAA compliant remote communications technologies.

The Committee believes telehealth will be an essential tool for integrating behavioral health and primary care in rural communities. However, the Committee notes that the simply availability of telehealth in a rural clinic is in, and of itself, not integrated care. Other factors, such as ongoing coordination between the rural clinicians and the specialists providing services via telehealth technology, and ensuring that support staff have adequate IT familiarity, are crucial to maximizing the potential of telehealth to meet the needs in rural areas.

Chief among these factors is the access to high-speed, reliable broadband internet. According to a 2020 report from the Federal Communications Commission, 22.3 percent of rural Americans lack fixed broadband coverage compared to 1.5 percent of their urban counterparts.[33] This disparity is heightened for those living in tribal lands, where 27.7 percent of people report lacking reliable broadband internet.[332] The Committee encourages efforts that will ensure all rural communities have the necessary access to broadband internet.

> **Recommendation Eight**: The Committee recommends that the Secretary work with the Department of Commerce, the Federal Communications Commission, and the U.S. Department of Agriculture to coordinate broadband investments to address access gaps in rural communities.

REIMBURSEMENT

Underlying the workforce and telehealth components of behavioral health integration is the issue of reimbursement. That is, is it financially feasible for a rural primary care clinic to integrate behavioral health services? Although there are Medicare codes that incentivize behavioral health integration and telehealth utilization, the overarching, fragmented nature of the fee-for-service (FFS) payment model can create roadblocks to achieving integration.[34] Because FFS works by reimbursing physicians and behavioral health clinicians for services rendered to the patient, non-billable tasks such as acquiring and setting up telehealth technologies, training providers, case management, care coordination, promoting cohesion between behavioral health and primary care staff, and integrating electronic health records, are not funded.[34] Additionally, Medicare is not currently authorized to reimburse licensed professional

counselors, licensed behavioral health and primary care counselors, and marriage and family therapists.[24]

Reimbursement: Federal Programs and Recommendations

CMS supports both primary care and behavioral health through the administration of Medicare, Medicaid and the Children's Health Insurance Program as well as its oversight of the Health Care Marketplace. The Committee believes that, if well structured, the payment policies promulgated by CMS have the potential to encourage integrated care. The Committee recognizes that CMS has taken important steps in this direction through the introduction of new Medicare billing codes for behavioral health integration[18]

> **Recommendation Nine**: The Committee recommends that the Secretary conduct an ongoing campaign to educate rural primary care and behavioral health providers on how to apply the Medicare behavioral health integration codes.

As noted above, CMS has also created incentives for behavioral health and primary care integration within some of the value-based payment models that emphasize care coordination. Examples include, but are not limited to, the Accountable Care Organizations and the Medicare Shared Savings Programs, and, the demonstration projects administered by the CMMS Innovation Center such as Comprehensive Primary Care (CPC), and Comprehensive Primary Care Plus (CPC+) programs.[35,36]

Behavioral health integration into an existing primary care practice was an allowable activity under CPC and a required activity under CPC+, and between the two models over 2,800 primary care practices began providing some behavioral health services in their facilities. However, RHCs were ineligible from participating in these demonstrations and rural representation among the awardees in both cohorts was between 8 and 9 percent.[354,365] Future demonstrations should consider the unique barriers to behavioral health and primary care integration that rural health care facilities face.

> **Recommendation Ten**: The Committee recommends that the Secretary develop a payment model through the CMS Innovation Center to focus on an integrated behavioral health-primary care payment methodology to expand access, coordinate care, and enhance outcomes through a range of primary care providers including Federally-Qualified Health Centers and Rural Health Clinics.

IV. CONCLUSION

In order to improve behavioral health, and reduce rates of mental illness and suicide prevalent in rural areas, it is critical that accessible and affordable behavioral health services be provided in MHPSAs. Integrating behavioral health services with primary care is one potential solution that can mitigate the stigma associated with seeking behavioral health care, increase patient satisfaction, and decrease patient spending on behavioral health conditions. Alleviating workforce shortages, establishing permanent telehealth regulations, and optimizing reimbursement policy can help make pursing behavioral health and primary care integration a viable opportunity for rural facilities nationwide.

APPENDIX A – Gila River Health Care

Gila River Health Care (GRHC) is a tribally owned health care system of the Akimel O'otham (Pima) and Pee Posh (Maricopa) tribes and serves a population of 29,000 patients. GHRC's four sites are Hu-Hu-Kam Memorial Hospital, Komatke Health Center Campus, Hau'pal (Red Tail Hawk) Health Center Campus, and Hau'pal Health Center. The Gila River Indian Community (GRIC) is an Indian reservation lying adjacent to the south side of the city of Phoenix. The Gila River Indian Reservation was established in 1859, and the Gila River Indian Community was formally established by Congress in 1939. The community is nearly 600 square miles and is home to members of both the Akimel O'odham (Pima) and the Pee-Posh (Maricopa) tribes. Despite being within the Phoenix Metropolitan Area the GRIC is primarily a rural community.

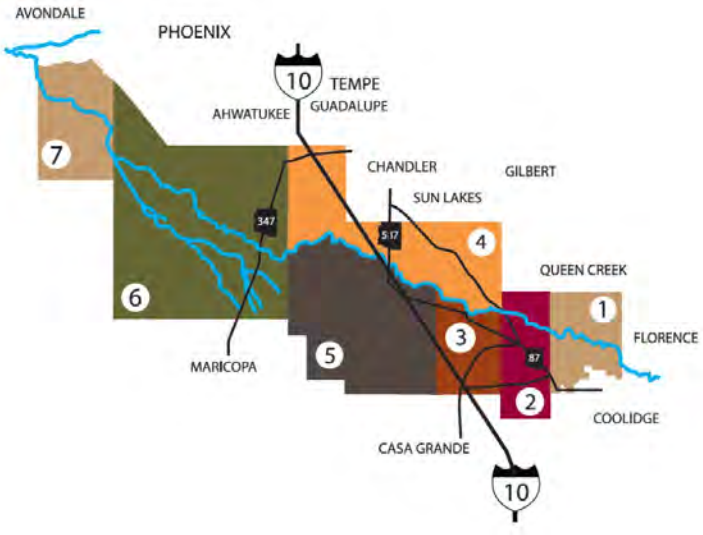


Figure 5: A map of the Gila River Indian Community

During the Committee's virtual site visit, they heard from a variety of MCHC staff and clinicians who are involved in providing integrated behavioral health services. These panelists included:

- Anthony Santiago, MD
- Viji Murugavel, MD
- Priscilla Foote, LMSW
- Michael Berkshire, DO
- Kerry Van Volkinburgh, LPC

GHRC has been undergoing efforts to integrate services for over 10 years and has found success after overcoming some initial barriers. One of these barriers was that, originally, primary care staff were responsible for the intake process and that process took too long. Another challenge was that patients that went to the primary care office to see the psychiatrist wanted all the behavioral health services through primary care, which was not sustainable. Through this experience, GHRC found that primary care offices need a counselor on-site that can do the initial behavioral health and primary care screening for things like depression, anxiety, domestic violence, and adverse childhood experiences. Other best practices they implemented in response to barriers they faced were offering primary care services in behavioral health clinics to assist with unmet health needs and hiring case managers and care coordinators to help patients navigate the health care system.

All of the panelists mentioned the nature of their relationship with the GRIC and other considerations they must give to behavioral health, given the tribal population that they serve. Some of their patients have generational trauma due to a history of mistreatment. This can make it difficult to build trust between providers and patients and give them care. To address this, the community invests in the care of the people and takes ownership of services. Community leadership helps provide insight and direction for GHRC to ensure that their care strategy is appropriate.

APPENDIX B – Mariposa Community Health Center

Originally founded in Nogales, Arizona, the Mariposa Community Health Center (MCHC) has been providing primary care to the rural border community living within Santa Cruz County since 1980. Over the years, this clinic has converted to a federally qualified health center, added four additional locations in three other cities throughout Southern Arizona, and expanded their care provision to include dental, pharmaceutical, and behavioral services. MCHC first began offering integrated behavioral health and primary care services upon receiving supplemental funding to do so in 2003. Since 2015, they have been granted additional awards to begin offering medication-assisted treatment, hiring multiple full time behavioral health support staff and clinicians (including a licensed clinical social worker), and contracting with a health care analytics company to increase their service capacity.

Figure 6: Mariposa Community Health Center locations.

During the Committee's virtual site visit, they heard from a variety of MCHC staff and clinicians who are involved in providing integrated behavioral health services. These panelists included:

- Dr. Eladio Pereira, Chief Medical Officer
- Dr. Frank Bejarano, Director of Behavioral Health
- Dr. Phil Williams, Associate Medical Director
- Dr. Tanya Henry, General Pediatrician
- Yvonne Padilla, Staff Accountant

Currently, MCHC integrates services by offering on-site behavioral care to patients with mild, moderate, and severe behavioral health needs. These visits are typically limited to 4-6 sessions that last approximately 30 minutes each. Urgent issues that arise during primary care visits can be discussed with the next available behavioral health provider, but most patients who indicate a behavioral health need are encouraged to schedule a same-day visit with a behavioral health clinician. All of the panelists stressed the importance of colocation and practicing warm hand-offs between primary care/pediatric staff and behavioral health staff to the success of their operation. They also emphasized the value of building connections with nearby behavioral health facilities that patients can be referred to if MCHC cannot address their behavioral health conditions within the capacity of their practice.

While MCHC initially began offering integrated services to address the unmet behavioral health needs in the community through their primary care practice, they are now planning to transition into a fully licensed behavioral health facility in 2022. This will allow them to continue expanding the scope of their MH and SUD care for their patient population. MCHC's presentation and discussion on the process they undertook to build a successfully integrated care environment was illuminating for the Committee; however, it demonstrates the need to create sustainable revenue channels for integrated facilities beyond the limits of competitive grant funding in order to encourage more primary care clinics to integrate behavioral health services to some degree.

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