

**Health Resources and Services Administration  
Office of Rural Health Policy**

**National Advisory Committee on Rural Health and Human Services**

**Fall Meeting  
Held Virtually  
October 25-27, 2021**

**Meeting Summary**

The 89<sup>th</sup> meeting of the National Advisory Committee on Rural Health and Human Services was October 25 – October 27, 2021. It was a virtual meeting due to the Covid -19 pandemic.

The meeting topics are Behavioral Health and Primary Care Integration in Rural America & The Rural Emergency Hospital Designation. Arizona Health and Human Service representatives will be conveying the state perspective related to the topics.

The committee members in attendance: Jeff Colyer, Committee Chair; Steve Barnett, DHA, CRNA, FACHE; Robert Blancato, MBA; Kari Bruffett; Wayne Deschambeau, MBA; Molly Dodge; Meggan Grant-Nierman, DO, MBA; George Mark Holmes, PhD; Joe Lupica, JD; Michelle A. Mills; Brian Myers; Kellie M. Phillips, MSN, RN; Patricia Schou; Robert L. Wergin, MD, FAAFP; James Werth, Jr., PhD, ABPP; Loretta Wilson.

Ex-Officio members in attendance: P. Benjamin Smith, MBA, MA; Lacey Boven; Aleta Myer; Darci Graves, MPP, MA; Diane Hall, PhD, MSED.

Present from the Federal Office of Rural Health Policy (FORHP): Sahira Rafiullah, Executive Secretary; Tom Morris, Associate Administrator-FORHP, Steve Hirsch, Administrative Coordinator. Truman Fellows: Patrick Grady and Samia Ismail.

**Monday, October 25, 2021**

Dr. Jeff Colyer, Chair of the Committee, convened the meeting.

**WELCOME AND INTRODUCTIONS**

**Jeff Colyer, MD  
Committee Chair**

Dr. Colyer welcomed the committee members and stated the committee will examine the challenges and opportunities of integrating behavioral health and primary care services in rural America. Additionally, the committee will examine The Rural Emergency Hospital Designation.

At the close of the meeting the staff will draft a policy brief and recommendations for review and submission to the Secretary of Health and Human Services. The National Advisory Committee on Rural Health and Human Services consists of a wide range of rural health and human service experts from across the country. There are also ex officio members from the Administration for Community Living, Centers for Disease Control and Prevention, Administration for Children and Families, Indian Health Service, Substance Abuse and Mental Health Service Administration, and the Centers for Medicare and Medicaid Services.

Dr. Colyer thanked representatives from the Office of Rural Health Policy for organizing the meeting: Tom Morris, Steve Hirsch, Sahi Rafiullah, Michael Fallahkhair, Jocelyn Richgels, Patrick Grady, and Samia Ismail.

Dr. Colyer welcomed Kellie Phillips and Michelle Mills to the committee.

## **ARIZONA/SOUTHWESTERN ORIENTATION**

### **Joe Lupica, JD Committee Member**

Joe Lupica shared his disappointment that the meeting had to be virtually. He had looked forward to hosting the committee and is hopeful that there can be an in-person meeting in the future. Arizona is a diverse state culturally, economically, and ethnically. It really is the old west that everyone has seen in the movies. The movies planted the idea of the western spirit deep in the national consciousness. Arizona is a rural state, but Phoenix is the nation's fifth largest city. There are fifteen definitions of rural and Arizona is rural by any definition. The official state historian is Marshall Trimble, who is a wonderful storyteller. Wyatt Earp was a real person who took part in the gunfight at the O.K. Corral and became a legend. Arizona is home to the Grand Canyon, but another natural feature is Monument Valley, and it is beautiful. Monument Valley is part of the Navajo Nation, and they are gracious enough to open it to visitors. John Ford shot ten movies in Monument Valley. Phoenix was in the opening shot of Psycho, Alfred Hitchcock's masterpiece.

Each year in the past decade, Phoenix has grown by 90,000 to 100,000 people. Arizona has an expanding economy including technology, bioscience, and manufacturing centers. The universities lead the country in term of innovation. Quality of life in Phoenix makes it easy for companies to recruit people to the area. During the pandemic, the media reported that people moved from the more restrictive states to the State of Arizona where people can be outdoors. The five Cs of Arizona are copper, cattle, citrus, cotton, and climate. The United States copper boom began in Arizona and there were mining engineers who made fortunes. Arizona is still number one in copper in the United States. There are two hundred golf courses in metro Phoenix. Mr. Lupica thanked the committee for choosing Arizona as the focus of the meeting.

### **Daniel Derksen, MD Director of the Arizona Center for Rural Health**

Dr. Daniel Derksen thanked the committee for inviting him to give an overview of the State of Arizona. Arizona has fifteen Critical Access Hospitals, thirty-eight Rural Health Clinics, and twenty-three Federally Qualified Health Centers in 175 sites. There are also Indian Health Service hospitals and clinics, and some rural communities have private practices. Each of the fifteen counties is about the size of a land mass of a medium size New England state. Coconino County is one of the largest counties as far as land mass. There is a distance between sites and that makes it difficult for individuals seeking care.

The Arizona Center for Rural Health's mission is to improve the health and wellness of rural and vulnerable populations. Some of the Health Resources and Services Administration (HRSA) supported programs include: Rural Hospital Flexibility Program (HRSA), State Office of Rural Health (State-HRSA), HRSA-Central Arizona Area Education Center (CAAHEC), The University of Arizona Center for Rural Health (AzCRH) Navigators Initiative, Arizona Department of Health Services (ADHS), Substance Abuse and Mental Health Services (SAMHSA), The University of Arizona Center for Rural Health-AzCRH: First Responders and Medical Assisted Treatment (MAT) Mentors Initiatives, and ADHS-CDC-AzCRH: COVID Disparities and Overdose Data to Action (OD2A) Initiatives.

The population of Arizona is 7.3 million with sixty percent of the residents in Maricopa County. The fifteen counties in the state span 114,000 square miles. In 2010, there were nineteen percent of Arizonans uninsured as compared to eleven percent in 2021. COVID-19 was the top cause of death in 2020-21, followed by heart disease, cancer, accidents, and Chronic Obstructive Pulmonary Disease (COPD). Sixty percent of Arizonans over the age of twelve are fully vaccinated. The highest rate of COVID-19 is in the counties with the lowest vaccination rates. There has been an increased vaccination uptake in the rural areas due to the COVID-19 Disparities Initiative. The most vulnerable populations are, American Indian, Hispanic Latino and African American populations in COVID-19 transmission and death rates.

The University of Arizona Area Health Education Centers program mission is to enhance access to quality health care by improving the supply and distribution of health care professionals through academic community partnerships in rural and medically underserved areas. In 2022, there will be a new Tribal Area Health Education Center. Other regional centers nearby are willing to give a proportion of their coverage area to assist with the health workforce. Scholarships and loan repayment will be another way to attract workforce. Arizona meets only the forty-two percent of primary care physicians needed and ranks 44<sup>th</sup> in the United States for primary care physicians per population of 100,000.

Copper Queen Community Hospital in Bisbee, AZ, has had challenges transferring people who need higher levels of care. Even though the number of hospital beds that are COVID-19 related has declined, the hospital occupancy is still high due to routine needs and surgical procedures that were postponed at the health center due to the pandemic.

MOVE-UP is the mobile outreach for vaccination and education for underserved populations lead by Dr. Rosales. The clinic is vaccinating workers who are coming across the border to deliver produce or help do the farm work.

There have been improvements in the uninsured rate from nineteen percent in 2014 to eleven percent in 2020. Medicaid expanded through the Affordable Care Act, and Arizona Health Care Cost Containment System (AHCCCS) is the result of expanded Medicaid. Employers laid-off workers due to COVID-19 and businesses closed so many people lost insurance benefits. Medicaid provided coverage to 2.3 million who lost benefits.

Dr. Derksen shared there are close to one hundred tuition scholarships for medical students that have agreed to come back to Arizona and practice primary care in Health Professional Shortage Areas (HPSA). The training of the health workforce and support through loan repayment is an important incentive for recruitment.

Dr. Derksen stated he appreciates the committee and that they are shaping and creating a vision as they advise the Secretary of Health and Human Services. He stated that it is essential to remember that the focus can not only be on access to care but also the quality of service and reducing disparities that are evident between rural and urban populations.

## Q&A

**Steve Barnett** asked how much cross over there is between tribal community members and public health care organizations. Are there boundaries or restrictions that prevent people accessing care in the place of their choice?

**Dr. Daniel Derksen** responded that there is a need to educate people about health care locations and choices. The uninsured rate is eleven percent, and half of the individuals (400,000 people) would be eligible for Medicaid or Marketplace coverage. Part of the Affordable Care Act is no copays or deductibles up to 300% of the Federal Poverty Level for American Indian populations so there should not be high rates of uninsured in the twenty-two federally recognized tribes across the state. It is a problem when people need specialty services and do not have Medicaid or the Marketplace benefits.

**Bob Wergin** stated that Dr. Derksen was instrumental in teaching health centers to attract people to train and work in rural areas. There seems to be political pushback. What do you think the future is for teaching health centers?

**Dr. Daniel Derksen** responded that the future is bright. There is twenty billion a year spent through Medicaid and Medicare Graduate Medical Education (GME). It would be great for the teaching health center concept to include nurse practitioners and physician's assistants. Teaching health centers have strong bi-partisan support for funding. The public health service Title 7 and 8 that support primary care and nursing can help build the rural health teaching infrastructure.

**Pat Schou** said there are OB shortages throughout rural. How are you addressing that?

**Dr. Daniel Derksen** said that he married an OBGYN doctor who was instrumental in New Mexico setting up a rural OBGYN infrastructure based on a midwife support. Midwives managed much of the primary care and provided tertiary care at facilities in Albuquerque. There are two counties in Arizona with huge geographic areas and no OB GYN services. The maternal

mortality rate is worse than some third world countries. There is no reason with the technology and things learned through the pandemic that this should happen. Prenatal and postnatal care needs to be easily available and there must be a labor and delivery system and transport system that can get people the help they need as quickly as possible. There must be differential payments because there is not enough volume in rural areas. The teaching health center model could bring together the pieces needed to make this happen.

## **BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION FEDERAL PROGRAMS**

**David DeVoursney**  
**Division Director, SAMHSA**

David DeVoursney thanked the committee for inviting him to address the group and acknowledged the committee has a wide range of expertise. He commended the committee for focusing on behavioral health issues and the critical issue of integration of primary care and behavioral health. Substance Abuse and Mental Health Services Administration (SAMHSA) view integration bidirectionally and the importance of integration between behavioral health and primary care settings. Primary care is most often the access point to health care and some behavioral health needs can be addressed through primary care physicians. It is important that patients with behavioral health needs beyond the scope of primary care receive specialty services.

It is essential to integrating primary care into specialty behavioral health care. People in the specialty behavior health system often have chronic conditions including obesity, substance abuse, and diabetes. This has a significant impact on their quality of life and on average they die ten years earlier than their demographic peers.

SAMSHA's available resources are:

- Center of Excellence for Integrated Health Solutions
- Block grants
- Promoting Integration in Primary and Behavioral Health Care
- Certified Community Behavioral Health Clinics
- Other grant programs and resources

Mr. DeVoursney said considerations in rural settings include the importance of primary care in rural behavioral health care: differing patterns of service utilization, and the need for better models that recognize workforce constraint.

The Center of Excellence for Integrated Health Solutions is available at: <https://www.thenationalcouncil.org/integrated-health-coe/>. It provides evidence-based resources and tools and support for organizations working to integrate primary and behavioral health care. The website includes webinars and training events, a resource library, ECHO style training, capacity development, and learning collaboratives.

SAMSHA Grant Programs Include:

- Mental Health and Substance Abuse Block Grants
  - MHBG - \$757.5 million FY 2021 and \$1.5 billion in supplemental funds
  - SABG - \$1.85 billion in FY 2021 and \$1.5 billion in supplemental funds
- Promoting the Integration of Primary and Behavioral Health Care Grants
  - Twenty-four grants to states at up to \$2 million/year for 5 years
  - States must implement a plan to partner with organizations to implement integrated physical and mental health (including SUD) service provision in primary healthcare or behavioral health settings
- Certified Community Behavioral Health Clinic Expansion Grants
  - Currently 402 grants across forty-two states and Guam with grants of up to \$2 million/year for 2 years
  - Designed to ensure access to comprehensive coordinated behavioral health services
  - Include primary care screening and monitoring as a requirement
- Other activities Minority AIDS Programs; Training and Technical Assistance Centers; State Opioid Response and Tribal Opioid Response Grants; Providers Clinical Support System; and Screening, Brief Intervention, and Referral to Treatment.

David DeVoursney shared rural challenges that include workforce shortage and reliance on primary care:

- Data from the National Plan and Provider Enumeration System shows that 65% of non-metropolitan counties do not have a psychiatrist and 47% do not have a psychologist.
- Non-metropolitan areas on average have 5.8 psychiatrists and 13.7 psychologists per 100,000 people compared with 17.5 psychiatrists and 33.2 psychologists per 100,000 people in metropolitan areas.
- The 2012–2014 National Ambulatory Medical Care Survey indicates that 29% of mental health visits in non-metropolitan areas were with a psychiatrist and 54% were with primary care physicians.
- Although primary care providers may be comfortable treating more common mental disorders like anxiety and depression, they have less capacity to provide treatment for conditions like schizophrenia and bipolar disorder.
- Primary care providers also are unlikely to have the capacity to coordinate care for individuals with serious mental illness (SMI) that are facing challenges with social determinants of health, such as housing or employment challenges.

David DeVoursney indicated considerations for Rural Integration and Behavioral Health Care include:

- Rural primary care providers have time constraints for patient visits
- Rural practices may have trouble building in workflows for practices like the Collaborative Care Model or Screening Brief Intervention and Referral to Treatment
- A need for an access point for specialty behavioral health care for patients
- There is a need for the development and adaptation of models to support people with serious mental illness and complex behavioral health conditions in rural areas

- Different models of staffing and consultation to leverage peers and other non-traditional providers is important as is consultation
- Telehealth is important, but is not a panacea
- Pharmacotherapy for opioid use disorder continues to be a priority
- For clients in specialty behavioral health settings, access to primary care services is critical
- Transportation burden is higher for clients with significant physical and behavioral health needs

David DeVoursney thanked the committee for their time and attention.

**Dr. Shannon McDevitt**  
**Office of Policy and Program Development, HRSA**

Shannon McDevitt said she was glad to join the committee and hopeful the information shared will assist them in preparing the report for the Secretary of Health and Human Services. She stated that she knows the committee is familiar with the health center programs. 1,400 health centers operate 13,500 service delivery sites. The health centers provide services for 28.6 million patients.

Health centers provide patient-centered, comprehensive, integrated care by offering a range of services that include:

- Primary medical, oral, and mental health services
- Substance use disorder and medication-assisted treatment (MAT) services.
- Enabling services such as outreach, case management, health education, interpretation services, and transportation.

One in four patient appointments with health centers were virtual in 2020. The top five services offered via telehealth are primary care, mental health services, substance use disorder, chronic conditions, and nutrition and dietary counseling. Ninety-nine percent of health centers offered virtual visits in 2020, compared to forty-three percent in 2019. The health centers employed more than 255,000 fulltime equivalent employees (FTEs) in 2020. Mental health and substance abuse use disorder staff increased and there was a decrease in dental and vision staff.

The Fiscal Year (FY) 2020 Budget request includes \$5.6 billion, a net decrease of \$44.7 million due to sequestration, for:

- Supporting 1,400 health centers, providing care to 29.8 million patients
- \$50 million: Expanding prevention and treatment services to people at high risk for HIV transmission, including Pre-Exposure Prophylaxis (PrEP)-related services, outreach, testing, and care coordination for an additional 140 health centers for a total of approximately 440 health centers
- \$50 million: Optimizing Virtual Care through a one-time funding to support up to twenty-five health centers to develop, implement, and evaluate innovative, evidence-based strategies that:

- Optimize the use of virtual care to increase access and improve clinical quality for underserved communities and vulnerable populations
- Can be adapted and scaled across the Health Center Program

Health Resources and Services Administration (HRSA) also looks forward to working with Congress to advance the President's goal of doubling the federal investment in community health centers, which would help reduce health disparities by expanding access to care.

HRSA supports the integration of mental health and substance abuse technical assistance opportunities. Technical assistance modalities include communities of practice, a site visit-program assessment technical assistance, community outreach technical assistance through social media, one-on-one coaching, and webinars.

Primary Technical Assistance Topic Areas:

- Medication-Assisted Treatment (MAT)
- Screening Brief Intervention and Referral to Treatment (SBIRT)
- COVID-19
- Tele-Behavioral Health Services
- Depression Screening
- Social Determinants of Health
- Workforce Recruitment and Retention
- Care Coordination and Case Management
- Dissemination of Evidence-Based Practices

HRSA's visions include:

- Every high-need community has access to the health centered model of care.
  - The goal is to increase access to the health center model of care in the nation's highest need communities and populations.
- All health center patients have access to patient-centered services that address both clinical and social barriers to health.
  - The goal is to increase access to a comprehensive range of services for health center patients.

The Workforce Health Professional Education & Training (HP-ET) Readiness Program is to enhance health centers' capabilities to recruit, develop, and retain their workforce by exposing health and allied health profession students, trainees, and residents to education and training programs at health centers. The Readiness to Train Assessment (RTATTM) Progress as of February 28, 2021, indicates 8,500 individual responses from over 1,000 responding health centers. This represents over sixty-seven percent of health centers nationally. Primary Care Association (PCA) workforce staff will use the initial Readiness to Train Assessment Tool (RTAT) results to provide training and technical assistance (T/TA) to health centers to assess and improve their readiness to engage in health professional education & training and provide T/TA to health centers to develop and implement strategic workforce plans.

Health Center Program Resources Include:

BPHC website  
<https://bphc.hrsa.gov/>

Weekly e-newsletter: Primary Health Care Digest  
Sign up online to receive up-to-date information

Health Center Controlled Networks (HCCNs), National Training and Technical Assistance Programs (NTTAPs), and Primary Care Associations (PCAs):  
<https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/>

### **Ing-Jye Cheng** **Chronic Care Policy Group, CMS**

Ing-Jye Cheng thanked the committee for the opportunity to share information about the efforts that CMS's is working on to support the treatment and prevention of behavioral health and substance use disorder across the country, and particularly in rural areas.

Ing- Jye Cheng stated that she would speak about the Federal efforts of CMS associated with Medicaid and Children's Health Insurance Program (CHIP), the Medicare Program, and Medicare models that are being developed to assess new payment structures.

Medicaid is the single largest payer for mental health services in the United States and is playing a larger role in the reimbursement of substance use disorder services. In 2019, Medicaid and CHIP covered two hundred million behavioral health services, including 150 million mental health services and about 43 million substance use disorder services. About three percent of mental health and ten percent of substance use disorder services were emergency department visits.

CMS has identified eighteen quality measurements for Medicaid and CHIP. It has five measures for children and thirteen measures for adults. The behavioral health care quality measures set is an important effort to know how to better target funding and improved behavioral health.

The Centers for Medicare & Medicaid Services (CMS) Improving Behavioral Health Follow-Up Care Learning Collaborative supports state Medicaid and Children's Health Insurance Program (CHIP) agencies' efforts to improve access to follow-up care. These are important services for people who visit an emergency department or are hospitalized for a mental health or substance use condition. Three webinars are available on Medicaid.gov. Timely care for children and adults with behavioral health related emergency department visits and hospitalization leads to decreased suicidal ideation, reduced hospital readmissions, and improved medication adherence.

Centers for Medicare and Medicaid Services (CMS) supports Substance Abuse and Mental Health Services Administration (SAMHSA) to support states with the Certified Community Behavioral Health Clinics (CCBHC) Initiative. The CCBHC ensures access to addiction and mental health services which includes a 24/7 crisis response and medication-assisted treatment (MAT) for addiction. The clinics provide partnerships with law enforcement and schools to

improve care and prevent hospital readmissions. There are over 430 CCBHC's in over forty states.

Medicare makes separate payments to physicians and non-physician practitioners for Behavioral Health Integration (BHI) services. In recent years, Medicare has updated the physician fee scheduled policies to improve payment for care management services including behavioral health integration. CMS developed additional codes to capture shorter increments of time spent with a patient. The Psychiatric Collaborative Care Services Model (CoCM) provides care management support for patients receiving behavioral health treatment and psychiatric inter-specialty consultation.

Maternal Opioid Misuse (MOM) model is the next step in the Centers for Medicare & Medicaid Services' (CMS) multi-pronged strategy to combat the nation's opioid crisis. The model aims to address fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through state-driven transformation of the delivery system surrounding this vulnerable population. The hope is that supporting coordination of clinical care integration, the model will improve the quality care and reduce the cost of providing care to mothers and babies. The need for care integration coordination is particularly important in rural areas. West Virginia is adding staff under this model to enhance care coordination and community health connections across the state. The focus is on rural residents finding transportation and making sure there is telecommunication technology available.

The Value in Opioid Use Disorder Treatment Demonstration Program's purpose is to increase access and physical and mental health outcome of beneficiaries. It is a national program and participants include Federally Qualified Health Centers (FQHCs), opioid use treatment programs, and rural health clinics. The demonstration will continue through December of 2024 and rural areas in thirty-six states that have participants in the model.

## Q&A

**James Werth** stated he is the CEO of a health center. Providers are not reimbursed for telehealth visits by Medicare. Given the data available, the largest percentage of behavioral health providers in rural areas are licensed professional counselors (LPCs). Medicare will not reimburse for LPC's to provide behavioral health treatment. CMS could help improve access in rural areas by allowing for reimbursement for LPC's.

**Ing-Jye Cheng** said that CMS has been examining what types of employers are providing behavioral health services and how to best pay for services at the top of everyone's licensure. Certain providers cannot be reimbursed directly through the Medicare program. LPC's are in that category. CMS recognizes they are an important part of the care team but there is not administrative discretion in that area. CMS has been creative in creating pathways to expand payments in the past. Ing-Jye Cheng stated that she would follow-up on the topic.

**Bob Wergin** asked how to get a sustainable payment model for integrative behavioral health cost covered? What would you recommend for the smaller systems to get paid adequality to cover the costs?

**Ing-Jye Cheng** replied that it is a challenging question. Community access hospitals have been a focus of CMS for decades because they represent an important piece of the safety net in rural areas. Another piece of statute is looking at rural emergency hospitals that do not have a large capacity and must be resourced differently. There are not recommendations at this time, but different models are being assessed to find a way to target payments differently in terms of behavioral health integration related to practitioners and less on the facility side.

**David DeVoursney** responded that partnerships between rural health providers and Federally Qualified Health Centers (FQHC), offers better care services for people and becomes a better business relationship. He also suggested communicating these problems with states to make sure they understand the challenges and to find out if there are supports to consider through managed care or Medicaid.

## **STATE PERSPECTIVES ON BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION**

**Patricia Tarango**  
**Bureau Chief, Arizona Department of Health Services**

Patricia Tarango shared that she is the Bureau Chief, with the Bureau of Women and Children's Health Division of Prevention Services. The Department of Health Services is home to The Maternal Child Block Grant and the Primary Care Office for the State of Arizona. The department of health services does not have an active role in policy development related to reimbursement for clinical, dental, or behavioral health services. Data gathering, assessment, and capacity building including partnership development for the implementation of evidence-based strategies is part of the department's responsibility. Ms. Tarango told the committee that she would share information about the Arizona Health Improvement Plan and other initiatives related to behavioral health needs in Arizona.

Substance Use Disorder statistics in the State of Arizona show a steady increase of opioid deaths. In 2019, heroin deaths declined by twenty-four percent. There is a disparity among African Americans in Arizona having the highest number of opioid related deaths. There is a greater number of males that are dying of opioid use. In Yavapai County, there is the highest death rate per 100,000 people.

The Arizona Maternal Mortality Review Committee is a thirty-one-member volunteer committee that looks at the deaths that occur within one year of birth in Arizona. In 2016 and 2017, among all pregnancy associated deaths 28.4% had mental health conditions and 38.1% had a substance use disorder. For pregnancy related deaths 25.8% had mental health conditions as a need for care.

From 2014 to 2018, there has been an increase in Neonatal Abstinence Syndrome and substance exposed newborns. American Indian/Alaska Native newborns have the highest rate of Neonatal Abstinence Syndrome (NAS), and Asians have the lowest rate in Arizona. The highest rates for NAS are among infants who had Medicaid as the payer. Medicaid pays for fifty-one percent of the births in Arizona.

The Arizona Department of Health Services has a contract with Hushabye Nursery that provides short-term medical care to infants suffering from Neonatal Abstinence Syndrome. The nursery provides education and counseling to families. The Hushabye Opioid Pregnancy Preparation and Empowerment (HOPPE) program assists mothers during pregnancy, so they have a safe place to stay and access to care and support. There are challenges for families who are from rural communities and need to stay in the Phoenix Metro area for services.

According to SAMHSA, 40.3% of adults with mental illness in Arizona do not receive any treatment from public system or private providers. Suicide is the eighth-leading cause of death in Arizona and the rate of suicide per 100,000 people was 24% in 2017. Suicide impacts more American Indian individuals and is higher among males in Arizona. The suicide rate is three times higher for veterans than non-veterans in Arizona. The highest rate of teen suicides from 2017-2019 was among the American Indian/Alaska Native population at 56.2%. The adolescent suicide rate in rural Arizona was 27.7% compared to 11.3% in urban Arizona.

Barriers to access to care include lack of insurance, lack of providers in certain geographical areas, cost of care (even with insurance), and cultural and linguistic barriers (especially true for mental and behavioral health). There is the need for a diverse workforce that has lived cultural experiences and the ability to speak the local language. Arizona has the thirteenth highest overall poverty rate and poverty rates in rural counties can be as high as 26.9%. Lack of reliable transportation and border patrol check points can also impede access to care.

Arizona has fifteen large counties and eleven are rural. Each of the 126 primary care areas have unique geographical boundaries and are comprised of various census tracts. There are communities with no primary care physicians. Travel distance to the nearest primary care physician can be as high as seventy-eight miles in rural areas. Ten percent of Arizona's population resides in a rural area and only four percent of behavioral health providers are in those areas.

Health Professional Shortage Areas in Arizona include:

- 220 Primary Care HPSAs
- 211 Dental HPSAs
- 213 Mental Health HPSAs

Access to Care Strategies:

- Federal & State Incentive Programs
  - Multiple Clinical Disciplines
- Sliding Fee Scale/Safety Net Clinics
- Technical Assistance

The Arizona Health Improvement Plan (AzHIP) is part of the public health accreditation process. The 2021-2025 priorities in the plan are mental wellbeing, health in all policies/social determinants of health, rural and urban underserved health, and pandemic recovery. The Department of Health Services is partnering with the area Health Education Centers to increase the number of rural minorities entering health care professions.

The Arizona Department of Health Services initiatives to support mental wellbeing are training in the Mental Health First Aid Program, suicide prevention efforts, increased resources for addressing Adverse Childhood Experiences (ACEs), and Arizona Health Improvement Plan (AzHIP).

Recommendations for the committee to consider:

- Expand funding to State Primary Care Offices to support data and assessments
- Increase funding cap for the State Loan Repayment Program
- Continuation of the NHSC SUD Workforce Loan Repayment Program and the Rural Community Loan Repayment Program
- Funding/Technical Assistance
  - Community Health Center primary care/behavioral health care integration models navigation services
  - Non-clinical services to support mental and behavioral health
  - Continued investment in state level maternal health with emphasis on maternal mental health
- Telehealth
  - Support continued use of approved/expanded telehealth codes during pandemic for primary care, dental and behavioral health services
  - Expand support for the Telehealth Resource Centers
- Teaching Health Centers & Workforce Diversity Investments

### **Jami Snyder**

#### **Director, Arizona Health Care Cost Containment System**

Jami Snyder stated the focus of her presentation would be on the efforts to sustain and maintain an integrated care model at the policy, payer, and provider level. There is a need to integrate care at all three levels.

In 2016, The Division of Behavioral Health Services integrated into the state Medicaid program and that was the foundation to integrate care at the policy level. The health providers are responsible for offering the full continuum of acute care services and behavioral health services. This was not the case in Arizona historically. In 2018, children and adults accessing general mental health and substance use services obtained a fully integrated health plan.

The Target Investments Program pays for integrated care in a clinical setting. It is a five-year, \$300 million dollar program that offers incentive payments to participating providers including: primary care practices, behavioral health organizations, acute and psychiatric hospitals, co-located justice clinics. The payments are based on meeting milestones that support integration and whole person care. The goals include reducing fragmentation between physical and behavioral health providers, increasing efficiencies in integrated service delivery, and improving health outcomes for targeted populations.

The Participant Support Quality Improvement Collaborative (QIC) consists of providers working together using timely, actionable information with a performance management system. The collaborative features a peer learning forum to share best practices and disseminate the practical content needed to achieve the TIP performance measure targets. The Quality Improvement Collaborative is in partnership with Arizona State University College of Health Solutions and Center for Health Information Research (CHiR). The QIC provides dashboards for providers on quality measures performance, assistance with quality improvement actions, technical assistance, and peer learning. The Targeted Investments Program is a plan to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. Opportunities of the program are behavioral health co-location in primary care and payment for behavioral health services in primary care.

Whole person care is the next logical step in integrated care. The establishment of the Closed Loop Referral System is an automated IT tool to allow clinicians to identify a social service need and connect them to a community-based organization that can offer the social services. Arizona Health Care Cost Containment System monitors when patients received treatments to track member health outcomes.

The Arizona Health Care Cost Containment System provides thirty-million dollars a year for rental assistance and subsidies. In FY 2020, there was a thirty-one percent reduction in emergency department visits and forty-four percent reduction in inpatient admissions and a savings of \$5,500 per member per month. This is more effective than any clinical intervention offered. It is incumbent as a Medicaid agency to expand integrated whole person care and social determinant needs.

**Dr. Yoendry Torres**  
**Director of Centered Spirit Behavioral Health, Pascua Yaqui Tribe**

Dr. Yoendry Torres thanked the committee for inviting him to speak about integrated health care. The new health and social service building is a huge step forward for The Pascua Yaqui Tribe (PYT) Centered Spirit Program because it puts medical services, behavioral health, and the social services department in the same building.

The Pascua Yaqui Tribe Centered Spirit Program Tribe's Mission is to provide professional, confidential, and culturally compatible behavioral health services for Pascua Yaqui Tribal members and their families. Promoting healing, personal growth, and healthy living for the Pascua Yaqui Tribal members and their families in the communities served. The Pascua Yaqui Centered Spirit Program values focus on the culture and traditions of the Yoeme clients and their extended families. The circle of support includes various agencies and divisions and extended families. The program offers traditional, alternative, and western medicine as well as educational, professional, and personal growth opportunities.

The Centered Spirit Program is part of the Pascua Yaqui Tribe Health Division. Services are open to enrolled Pascua Yaqui members and their immediate family in the Tucson and Guadalupe areas. Programs include prevention and supportive employment, adult services, child and family services, medication assisted treatment, residential treatment, transitional treatment, crisis, and

referral. Individual, couples, family, and group therapy are available. Other services offered are methadone/suboxone maintenance, youth life skills, psychiatric evaluation and medication follow-up, and crisis evaluations for emergency situations.

Dr. Yoendry Torres noted that the challenges to health integration include:

- Billing and reimbursement
- Multiple electronic health record systems
- Staff and leadership reluctance
- Communication between programs
- Training current providers
- Increased and new job functions due to shortages
- Provider recruitment – limited tribal providers
- Medical director recruitment

Benefits of Health Integration Include:

- Increased revenue that will help fund other tribal departments and services
- Career development and advancement opportunities for staff
- Increased community member access and convenience to behavioral health and primary care
- Improved coordination of care and potential health outcomes
- Potential to narrow the tribe health disparities gap

Tribal social services have a counselor on location so if there is a situation that happens with a family or in the community, there is a counselor who can meet with the social worker and go to a home or location to provide emotional support and do evaluations for families.

## Q&A

**Dr. Jeff Colyer** asked what will success look like as you look forward one or two years and how do you communicate it to policy makers?

**Jami Snyder** said that the number one measure success is improving member health outcomes. In the last two years of the targeted investments program, there have been a series of performance metrics focusing on incremental improvement. A demonstration that shows member outcomes are improving in the integrative care model is necessary. Integrative care extends beyond clinical and connects individuals to critical social services.

**Patricia Tarango** responded she would like to see an increased number of mental health providers who are participating in the State Loan Repayment Program. Most of the participants are in federally qualified health centers or at Indian Health Service sites. Another success in Arizona would be to see a decrease in maternal mortality by addressing mental health issues and substance use disorder.

**Steve Barnett** stated that the three panelists are doing a very impressive job with the integration of primary care and behavioral health coordination and applying the whole person concept.

**Loretta Wilson** asked Dr. Yoendry Torres what type of providers he is having difficulty recruiting. Are they medical doctors or other professionals? Can you use nurse practitioners?

**Dr. Yoendry Torres** responded that there is a challenge to recruit psychologist and mental health professionals so they cannot provide psychological testing. They have had a challenging time trying to hire a Director of Behavioral Health. The director position required a doctorate degree and people were not applying for the position. Nurse practitioners were invited to apply for the position, but they still have not found someone to fill the position.

## **PUBLIC COMMENT**

No Public Comment.

**Tuesday, October 26<sup>th</sup>, 2021**

## **PROVIDER PANELS**

### **GILA RIVER HEALTH CARE PROVIDER PANEL**

**The Subcommittee Members Present at the Meeting:** Steve Barnett, DHA, CRNA, FACHE; Robert Blancato, MBA; Kari Bruffett; Wayne Deschambeau, MBA; Molly Dodge; Michelle A. Mills; Robert L. Wergin, MD, FAAFP; James Werth, Jr., PhD, ABPP.

**Present from the Federal Office of Rural Health Policy:** Tom Morris, Steve Hirsch, and Patrick Grady.

**Gila River Health Care Panelists:** Anthony Santiago, MD; Viji Murugavel, M.D.; Priscilla Foote, LMSW; Michael Berkshire, DO; Kerry Van Volkinburgh, LPC.

**Dr. Anthony Santiago**  
**CEO**  
**Gila River Health Care**

Dr. Anthony Santiago shared that Gila River Health Care did aggressive COVID-19 testing to quarantine those infected and avoid the virus spreading. There were 325,000 COVID-19 tests performed by the Gila River Health Care team.

The Gila River Indian Community (GRIC) is an Indian reservation in the State of Arizona, lying adjacent to the south side of the city of Phoenix, within the Phoenix Metropolitan Area in Pinal and Maricopa counties. Gila River Indian Reservation established in 1859, and the Gila River Indian Community formally established by Congress in 1939. The community is home for members of both the Akimel O’odham (Pima) and the Pee-Posh (Maricopa) tribes.

The reservation has a land area of 583.749 square miles (1,511.90 km<sup>2</sup>). There are seven districts along the Gila River and its largest communities are Sacaton, Komatke, Santan, and Blackwater. Tribal administrative offices and departments are in Sacaton.

Gila River Health Care is a tribally owned enterprise of the Pima, Maricopa, and Pee Posh tribes. It serves a population of 29,000 patients. The main site location is Hu-Hu-Kam Memorial Hospital Dental Clinic. Komatke is the other GRHC dental location. The Hu-Hu-Kam Dental Clinic has ten operatories, and the Komatke Health Clinic has twelve operatories. They also operate three mobile dental units with two chairs each for a total of six Mobil Dental Unit (MDU) chairs.

At the hospital, services provided include general medical and surgical care for inpatient, outpatient, and emergency room patients. Supporting these core services is medical imaging, pharmacy, dental, behavioral health, and medical transportation. In addition, GRHC operates two dialysis clinics – one on the east side of the reservation and the other on the west side of the reservation. Two other clinics serve the communities of Laveen and Mariposa - the Komathe Health Center and the Ak Chin Health Clinic, respectively.

There is difficulty recruiting staff and competing for health care professionals. The central region of Arizona has fifty-two licensed hospitals and there are 9,635 licensed beds. Hospital occupancy has been at ninety-five percent and currently sixty percent of the regional hospitals are on caution or diversion. Gila River Health Center, as a critical access hospital, has partnerships with systems for higher levels of care, but there is a need to have those services available in-house.

The community has cultural strengths, but also historical and systemic traumas that inform how tribal members view health equity, health care, and medical research.

**Viji Murugavel, M.D.**  
**Primary Care Medical Director**  
**Gila River Health Center**

Viji Murugavel stated that she has been at Gila River Health Center for thirteen years. Gila Health Care offers medical services such as urgent care, behavioral health, internal medicine, and pediatrics. There are also associated health services including dialysis, case management, inpatient services, and pharmacy. Administrative services include free patient transportation, health information management, and patient benefits.

The primary care clinics are already collaborating with the behavioral health departments. Behavioral health patients often come to the same day clinic for medication refills if they miss an appointment. Addiction medicine specialists hold clinics in primary care facilities and can function as the primary care physician for patients.

The health center tried integrating behavioral health into primary care years ago and faced challenges. Primary care staff were responsible for the intake process that took over an hour. Another challenge was that patients went to the primary care office to see the psychiatrist and wanted all the behavioral health services through primary care, and it was not viable. Primary care offices need a counselor on-site that can do the initial screening like in schools.

There are counselors in the post COVID-19 clinic to perform patient screening and decide the type of treatment needed to connect the patient to the correct services. It can take two or three visits with the counselor before the patient will agree to seek further behavioral health services. The post COVID-19 clinic addresses the behavioral health, medical, and rehabilitation needs of the post COVID-19 patients.

## **Behavioral Health and Primary Care Innovation**

### **How to Overcome Barriers:**

- Integrate behavioral health counselors into primary care clinics for basic mental health screenings – depression, anxiety, domestic violence, ACEs.
- Offer primary care services in behavioral health clinics to assist with unmet health needs.
- Hire case managers and care coordinators to help patients navigate the health care system.
- Partner with university systems to train medical students, APPs, and other support staff in rural and tribal medicine to help with recruitment and retention. Expand to a native acute care hospital with residency programs.
- Grant Funding to provide services in the community setting – mobile units, smaller satellite clinics in district service centers.
- Fee-for-service reimbursement model does not help or enhance chronic-disease management and population health, which involves ongoing monitoring, coaching on self-management and behavior change. Provide flexible, up-front funding for chronic-disease care infrastructure, involving capitation per-member per-month payments, payment for group sessions or multiple services offered in a single visit or bundled payment

**Priscilla Foote, LMSW**  
**Chief Behavioral Health Officer**  
**Gila River Health Care**

Priscilla Foote thanked the committee and stated she would highlight behavioral health issues in the community. Behavioral health services have about two-hundred employees. Three of the services are outpatient, including: individual, group, and family counseling. There is tobacco tax funding that funds a school counselor program to provide behavioral health counselors to work in coordination with existing counselors in the community schools. Behavioral health services also operate the Tribal Regional Behavioral Health Authority. The Tribal Regional Behavioral Health Authority Program (TRBHA) funds case management and it serves those who are part of the Medicaid program. It allows a network of providers outside of the community to access networks.

Thwajik Ki is a residential program for the treatment of substance use disorder. The program focuses on the whole person – body, mind, and spirit. Dual diagnosis patient's care is based on level of stability and appropriateness for level of care. Treatment is for a minimum of sixteen weeks but can be longer depending on the progress of the individual.

Baby Smarts is a parenting program for Gila River families. The program provides parenting education, screenings, and support to parents and families to promote the healthy development of their children from pregnancy to age five. The two main components of the program are parenting support groups and home visits.

The suicide prevention program was set up as an initiative by Tribal Leadership and it includes a workgroup of multidiscipline departments throughout the community that come together and partner for suicide prevention. It includes training initiatives and advocating for all tribal employees to receive education on suicide prevention.

The community invests in the care of the people and takes ownership of services. Community leadership helps provide insight and direction. There is collaboration between schools, Tribal Social Services, the court system, and a youth council. Grant funding and program initiatives do not fit with national and federal guidelines. There must be more time for tribal community input. Sometimes grants require tribal resolution and the process takes time.

The H.O.P.E. program promotes support and educational awareness of LGBTQ. The group assists with initiatives, for example, using pronouns and preferred names in electronic health records.

**Michael Berkshire, DO**  
**Chief Medical Officer**  
**Gila River Tribal Behavioral Health Authority**

Michael Berkshire said that he has been with Gila River Tribal Behavioral Health Authority for fourteen years and has witnessed considerable growth. There are thirteen behavioral health providers. Three addiction providers who are internists and the remainder are child/adolescent and adult psychiatrists. The hospital and behavioral health center are across the road from one another, and coordination is difficult because of being in different buildings. There is a stigma for people going to a separate behavioral health center in the small community.

Progress in integration began about a decade ago with implementation of depression screening in primary care and throughout the organization. Patients receive screening and get the appropriate services. Thwajik Ki Residential Facility has a physician assistant that does psychiatric evaluations, and there is a physician that provides medication assisted treatment and primary care needs. There is a nurse case manager that engages people who have health care needs and are going to the emergency room and not getting chronic management treatment.

There are 104 patients enrolled with serious mental illness. The typical diagnosis is mood disorder and substance use disorders. The vast majority are in behavioral health residential facilities that are in the Phoenix or Tucson area. The length of stay is sixty to ninety days, but people are transferring from one to the next group home. This makes it difficult for continuity of care and it is also a problem that the facilities are located so far from the community. The case managers follow-up and they see the psychiatrist at Gila River Health. The ability to use telehealth or phone appointments are accommodating for patients who have transportation issues or want to have more privacy.

The primary care department and behavioral health department are working together to assist patients discharged after COVID-19 hospitalization. The counselor can screen and do assessments in the clinic which is helpful so that patients do not have to return for a future appointment.

**Kerry Van Volkinburgh, LPC**  
**Gila River Health Care Oasis**

Kerry Van Volkinburgh shared that a crisis response team is part of the emergency department. The goal to have 24/7 coverage. If there is not a person onsite there is a contract through another provider to have a crisis team available. The Healthy Steps Program provides early childhood development support. Families are most likely to access this support in the primary care department. There is also screening and care coordination referrals for the Baby Smarts Program.

There is a relation between trauma and stress, so early intervention in the schools, pediatrics, and with the youth council is critical. To build relationships and trust and cross the bridge from medical to behavioral health is much more effective when schools, pediatrics, families, and the entire community work together.

## **Q&A**

**Bob Wergin** asked how do providers that are from outside of the community adjust to cultural barriers?

**Dr. Anthony Santiago** replied that one of the biggest challenges is embracing medical advances and clinical research. It is a barrier at a community level and there are legitimate reasons for that. It prevents communities from participating in clinical trials.

There are cultural barriers for providers so there is in-depth orientation and ongoing cultural sensitivity training. Retaining staff long enough to gain knowledge and the trust of patients is vital.

**Bob Blancato** said that Priscilla spoke about the positive nature of community involvement and another speaker spoke about needing more of a community presence. Could there be clarification?

**Dr. Anthony Santiago** responded that Priscilla Foote was responding to the integration of community leadership. Dr. Murugavel was responding to the community, not as organized leadership but community members at large. There are barriers with preventative medicine due lack of trust health trust.

**Kari Bruffett** asked how the reimbursement models do not support population health and integrating medical and behavioral health? Is there something that the committee could recommend at the federal level?

**Dr. Viji Murugavel** there needs to be a shift of focus to support the marginalized population. This population is trying to get basic needs met and there is so much focus on new devices or new medications. The payment structure is for the for-profit or the corporate health care institutions. Many non-profit organizations are fee-for-service. Making patient's appointments, arranging their transportation, and preparing their medical records are services that are not financially reimbursed. Providers must rely on support staff because they must focus on their job responsibilities. There needs to be care coordination. Patients have procedures cancelled because there are so many silos, and patients are not able to navigate the system on their own.

## **MARIPOSA COMMUNITY HEALTH CENTER PROVIDER PANEL**

**The Subcommittee Members Present at the Meeting:** Jeff Colyer, Committee Chair; Meggan Grant-Nierman, DO, MBA; George Mark Holmes, PhD; Joe Lupica, JD; Brian Myers; Kellie M. Phillips, MSN, RN; Patricia Schou; Loretta Wilson.

**Present from the Federal Office of Rural Health Policy:** Michael Fallakhair, Samia Ismail, Sahi Rafiullah, and Jocelyn Richgels.

**Mariposa Community Health Center Panelists:** Frank Bejarano, MD; Tanya Henry, MD; Yvonne Padilla, James "Philip" Williams, MD.

### **Santa Cruz County, AZ**

Santa Cruz is a county in southern Arizona, United States. The county seat is Nogales, which is located on the border with Mexico. The county was established in 1899, and borders Pima County to the north and west, Cochise County to the east, and the Mexican state of Sonora to the south.

Santa Cruz County, a Nonmetro county, includes the Nogales, Arizona Micropolitan Statistical Area. As of the 2010 census, there were 47,420 people, 15,437 households, and 11,992 families living in the county. The population density was 38.3 inhabitants per square mile (14.8/km<sup>2</sup>). There were 18,010 housing units at an average density of 14.6 per square mile (5.6/km<sup>2</sup>).

### **Mariposa Community Health Center**

The Mariposa Community Health Center was founded in 1980 in response to the tremendous unmet need in Santa Cruz County. Initially established as a clinical division of the Santa Cruz County Health Department, the vision was to establish a unique model of care that integrated primary medical care with traditional public health services. The Health Center was originally staffed by a pediatrician and nurse practitioner and was in a small building near downtown Nogales. The Health Center was a private, not-for-profit corporation in 1985. The new organization was based on a model public-private partnership, whereby the Health Center provided virtually all public health services by contract with the county health department. Staff members and the board of directors supported the development of a main campus with state-of-the-art buildings and equipment in Nogales, plus satellite clinics in Patagonia, Rio Rico and Tubac. As a one-stop shopping model of care delivery, we provide comprehensive primary medical and dental care supported by lab, digital x-ray, and mammography, ultrasound, telemedicine, a full-service pharmacy, an integrated behavioral health program, plus an extensive

health promotion/disease prevention department. Over three hundred staff members support Mariposa and our mission of service in the community.

**Dr. Frank Bejarano**  
**Director of Behavioral Health**  
**Mariposa Community Center**

Dr. Frank Bejarano thanked the committee for the opportunity to share information about Mariposa Community Health Center Behavioral Health. He shared that primary behavioral health service also evaluate the physical health conditions of the patient.

Behavioral health services include:

- Patient adherence to medical treatment
- Symptom management & expression
- Health-promoting behaviors
- Health-related risk-taking behaviors
- Overall adjustment to medical illness
- Self-management planning, motivational interviewing, cognitive behavioral therapy
- Mindfulness, self-acceptance, relaxation skills
- Assist PCPs with brief psych consults, brief crisis management

The health and behavioral health assessment and interventions focus on psychosocial factors important to the treatment and management of physical health problems. The assessment considers psychological, behavioral, emotional, cognitive, environmental, and interpersonal factors. Physical health problems and medical health issues that would benefit from behavioral health consultations include diabetes, hypertension, obesity, substance abuse, treatment plan non-compliance, and sleep disturbance. Other behavioral health issues that affect medical health are tobacco use, depression, anxiety, substance use issues, domestic violence, housing issues, lack of income, psychosis disorders, learning disabilities, and anger management issues.

There are differences between primary care integration with behavioral health and specialty behavioral health services. Integrating primary health and behavioral health allows patients who are seeing their primary care physician, walk-in appointments for behavioral health appointment. Specialty behavioral health care is by appointment only.

**Dr. Tanya Henry**  
**General Pediatrician**  
**Mariposa Community Health Center**

Dr. Tanya Henry said she would share coordination information of a primary care provider assisting with behavioral health needs. A provider identifies the behavioral health need of the patient and if it is not an urgent need, the patient is referred to a behavioral health specialist. The health center assists patients with making appointments. If the patient is suicidal or has urgent needs such as abuse or an emotional crisis, a behavioral health provider will come to the physician's office to see the patient directly. If the behavioral health provider is busy, the patient will go to one of the centers other locations to see a behavioral health provider.

**Yvonne Padilla**  
**Staff Accountant**

## **Mariposa Community Health Center**

Yvonne Padilla said that in 2003 Mariposa Community Health Center hired Dr. Bejarano and began implementation of behavioral health services. The health center received supplemental funds for the program with the 330 Community Health Center grant. In 2015, the health center received the Expanded Services award to expand dental and behavioral health services. Dr. Jeff Swain joined the staff as a behavioral health counselor.

In 2017, the health center received the Accesses to Mental Health and Substance Abuse Service Award. This granted Supplemental funding to expand services at the health center. The funding added direct hire staff and/or contractors to support mental health service expansion. The health center hired care coordinators and contracted with Arcadia Analytics population health software for expansion of services.

In 2018, the health center received the substance use disorder and Mental Health Services funding. The Medication-Assisted Treatment Program was created to enhance implementation and expand access to quality integrated substance use disorder and/or mental health services.

In 2019, Mariposa Community Health Center received the first round of the Integrated Behavioral Health Services Award to increase access to high quality, integrated behavioral health services. Margarita Elias joined the staff as a Behavioral Health Counselor. The health center received the Integrated Health Services funds through 2021.

In 2021, the health center received American Rescue Plan Act Funding for Health Centers. A portion of funds were allocated to hire a Project Manager for behavioral health. The center is in the process of hiring a psychiatric nurse practitioner, behavioral health consultant, and a care coordinator (IMBH)

In 2022, the health center contracted with Terros Health for assessment and program-building support to the health center.

### **Leslie Pou Certified Coder Mariposa Community Health Center**

The integrated service must have a medical diagnosis as primary and behavioral health as secondary. Anything below fifteen minutes is not a billable service.

Requirements to bill each Current Procedural Terminology (CPT) Code include:

- **96158** - Health behavior intervention, individual, face-to-face; Initial 30 minutes.
- **96159** - Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service).
- **96167** - Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes.
- **96168** - Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service).

- **96170** - Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes.
- **96171** - Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service).

**Dr. James “Philip” Williams**  
**General Pediatrician**  
**Mariposa Community Health Center**

Dr. Williams thanked the committee for their including Mariposa Community Health Center in the meeting and stated that he has been employed by the health center for 11 years. He shared a case study with the committee about a 14-year-old female patient. The school nurse contacted Dr. Williams and reported that teachers and counselors are very worried because the student is not engaged with other children or teachers, cries frequently at school, and “seems miserable. There was no known prior diagnosis of psychiatric illness. Her family had recently moved to Arizona. She has seventeen siblings, but only three of the siblings moved to Arizona with the family. The parents moved to the area to work and there was not any other family in the area. The child’s parents had not noticed a change in her mood after moving to Arizona even though her siblings had noticed a difference in her mood.

Dr. Williams stated that the behavioral health specialist is down the hall so they can meet with the patient immediately. The counselor did a thirty-minute evaluation, and the patient had a follow-up with both him and the behavioral health specialist. The patient did not come to the follow-up visits, so the care coordinators became involved and conducted home visits to determine the barriers. Transportation was an issue, so they provided transportation for the patient’s upcoming visits. The patient’s general anxiety screening and PHQ were both elevated. She was diagnosed with major depressive disorder and anxiety and started on an antidepressant. The clinical pharmacy team contact the patient weekly to make sure there are not side effects. The integrative behavioral specialist was always part of the team visits.

**SUBCOMMITTEES RECONVENE**

**Issues to Discuss for Policy Recommendations:**

- Various Financing/Payment Models – inability to integrate services is due to payment restraints
- Promote community-based training - integrated models
- Teaching Health Centers – As a solution to recruitment, retention, and providers issues
- Grant timelines – 30 to 45 days for a rural center or tribal center to get things approved is difficult.
- Grants need to have solid business planning so they can be sustainable. Policy to incentivize business plan of integration of behavioral health.
- Training programs – scale to meet the need.
- Health Career Opportunity program.

- Group visit reimbursement model - Center for Medicare and Medicaid Services has been expanding billable codes so there could be a group therapy code added for example.
- Rural Health Center regulations – allow for more true integration especially for independent RHCs. Regulatory changes for sharing of staffing and equipment among facilities. Keep public health emergency waivers in place for telehealth - Grants for equipment and infrastructure.
- Certified Community Behavioral Health Center – reverse integration -bringing primary care into that setting. Same challenges but the idea is encouraging.
- Social determinants of health and poverty in rural areas
- Adverse Childhood Experiences (ACES) – addressing the root of the problem.

## **PUBLIC COMMENT**

No public Comment.

**Wednesday, October 27<sup>th</sup>, 2021**

## **BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION TOPIC CONSIDERATIONS**

**John Gale**  
**Senior Research Associate**  
**University of Southern Maine**

John Gale said he had been working with clinics with a system of care focus for over twenty years. His first effort of installing and developing an integrated service dates to 1985 in the health clinic of the University of New England College of osteopath medicines. One of the benefits of integrating behavioral health services in Rural Health Centers (RHC) is the advantages in payment policies. Behavioral health services and medical health services are parallel and should be arm-in-arm and it is important to continue to advance integration.

Rural residents face barriers to behavioral health services including access to care, travel distances, and lower numbers of specialty services. Rural residents rely more on primary care providers to meet behavioral health needs. RHC's could help provide behavioral health services to rural communities because there are 4,800 rural health clinics serving people in forty-five states. RHC's receive Medicare cost-based reimbursement for behavioral health services provided by doctoral-level clinical psychologists (CPs) and licensed clinical social workers (LCSWs). Rural Health Centers are reimbursed funds from Medicaid for additional masters-trained behavioral health clinicians such as licensed professional counselors (LPCs)

There not a specific way to achieve integration so it is important to consider the function of integration instead of the model. No one model is the correct model for every setting.

There is encouraging evidence for integration, particularly for depression, including:

- Integrated care achieved positive outcomes (improvements in symptom severity, treatment response, and remission response) (AHRQ 2008)
- Improvements in outcomes did not increase as levels of provider integration or integrated process of care increased (AHRQ 2008)
- Clinicians and consumers are satisfied with integrated care (AHRQ 2008)
- Neither the use of evidence-based practices nor measures of trust or collaboration among network agencies were significantly associated with client service use or client outcomes during clients' first year of entering the program (HUD/HHS/VA Collaborative Initiative to Help End Chronic Homelessness)

Provider and Practice Level Barriers Include:

- Differing practice styles
- Differing practice cultures and languages
- Selecting integration model based on practice context
- Difficulty in matching provider skills with patient needs
- Management and supervision of behavioral health staff
- Tension between direct patient care services (reimbursable) and integrative (non-reimbursable) services
- Differing coding and billing systems
- Heavy reliance on physician services
- Provider resistance

Patient Level Barriers Include:

- Stigma
- Limitations on third party coverage for BH care
- Impact of high deductibles and co-payments on utilization of services
- Limitations on access to behavioral health services
- Patient preferences regarding settings in which they receive behavioral health care

Integrated care initiatives should be patient centered, expand access to care, decrease burden of illness, and optimize care. Integrated care focus should be clinical issues and not administrative issues. The focus is not only on integrating care within practices/facilities but also across practices and care settings.

Critical Access Hospital Based Rural Health Care Behavioral Health Integrative Care Models Include:

- Abbeville Area Medical Center, Abbeville, SC: An independent CAH with two RHCs providing BH services. Employs two LISWs, a board-certified psychiatrist, and an administrative assistant. Staff provide traditional counseling and medication management services.
- Adventist Health Clear Lake, Lake County, CA: A faith-based system with eight RHCs. Employs three psychiatrists, five LCSWs, and a PNP. Case managers address social determinants of health.

- Aspirus Ironwood Hospital, Ironwood, MI: Employs two CPs, a psychiatrist, and a PNP, with patient demand that exceeds staff availability. Providers offer counseling, psychotherapy, and psychiatric medication management.
- Bingham Memorial Hospital, Blackfoot, ID: Employs a psychiatrist, four CPs, and licensed counselors. Services include medication management, counseling, and BH screenings.
- Lakewood Health System, Staples, MN: Employs five LCSWs, four CPs, a psychiatric nurse practitioner, and a licensed practical nurse, along with a team of case managers and other support staff.
- Livingston HealthCare, Livingston, MT: Employs a psychiatrist, a psychiatrically trained PA, two LCSWs, and a nurse care coordinator. Psychiatrist and PA provide medication management/consultation, LCSWs offer short-term individual psychotherapy and counseling; and nurse care coordinator offers case management.
- Ozarks Community Hospital, Gravette, AR: Operates 12 RHCs and two clinics in Missouri, Arkansas, and Oklahoma. RHCs house at least one LCSW. Five psychologists divide their time between the RHCs.
- Pagosa Springs Medical Center, Pagosa Springs, CO: An 11-bed CAH with an on-campus RHC. Employs two LCSWs, an LPC, and a CP. For urgent needs, its clinician's complete emergency evaluations via telepsychiatry with an external provider.
- Regional Medical Center, Manchester, IA: Operates an RHC on the hospital campus and four satellite clinics. It employs three LMHCs, a licensed independent clinical social worker (LICSW), and a psychiatric nurse practitioner.
- Weeks Medical Center, Lancaster, NH: Operates four RHCs and employs three LADACs, two LICSWs, two PNPs and support recovery workers and master's level mental health counselors.
- Western Wisconsin Health, Baldwin, WI: An independent CAH that operates two RHC and employs one psychiatrist, two PNPs, one CP, and six LCSWs and licensed counselors to provide short-term outpatient counseling, BH screenings, and medication management.

Behavioral health services provided by CAH-based RHCs can be financially sustainable, particularly when considering their impact on system performance rather than as a standalone "profit center." Although study participants reported that behavioral health services were sustainable, only nine percent of all CAH-based RHC's provide them. RHC providers are satisfied with behavioral health services provided in their clinics and believe they help to overcome stigma and other barriers that discourage patients from accessing needed services. It is important that RHC's understand third-party behavioral health payment policies and regulations prior to developing these services.

**Dr. Jonathan Neufeld**  
**Program Director**  
**Great Plains Telehealth Resource and Assistance Center**

Dr. Jonathan Neufeld thanked the committee for inviting him to speak to the committee. He is the director of one of the fourteen telehealth resource centers and located at the University of Minnesota in Minneapolis. The mission of the resource center is to provide technical assistance and support and serve a safety net.

In 2020, people could not get to clinics due to COVID-19. Telehealth services assisted with the difficulties due to COVID-19. There is no data to determine the percentage of telehealth visits that transpired due to the pandemic. Telehealth is not primarily a rural phenomenon. The urban areas were much better situated to develop telehealth services and did it at twice the rate of rural areas.

There are strengths and challenges of using telehealth to address health care challenges. Even at the absolute best, there will be small numbers of providers doing telehealth well. There are studies that share information about programs that are developing innovative services and are successful. Most organizations do not have the resources to develop these types of services currently. It is a challenge to do it well. Ninety percent of RHC's are not doing behavioral telehealth so it is important to find out why.

Telehealth is a set of tools and does not fix anything alone. Telehealth can be an effective tool if used correctly. The skillset and the motivation of the practitioners using the tools, projects the outcome. The telehealth technologies are fundamental to learn but not sufficient in providing services alone. The individual encounter is not telehealth's only strength. Telehealth cannot do as much as an in person encounter but it does all access when it is not possible to have an in person visit.

It is a huge burden to understand telehealth reimbursement. There must be standardized coding and billing. Codes do not specify the location of the provider and patient during the appointment. For example, was the provider at the office and patient at home during the telehealth visit. It also does not specify if it was a telephone appointment or virtual visit. Telehealth can be is valuable when someone cannot go to a health provider's office, but it does not replace in-person visits when it is necessary.

Chronic Care Management Codes (CCM) and Collaborative Care Management Codes (CoCM) is a new way of organizing care and paying for care. Per patient per month payment is going to open the kind of innovation necessary. The monthly payment includes any type of communication or any team member meeting the needs of the patient during a month.

Telehealth does not increase health equity by itself. It can be a great tool to increase equity, but incentives and structures must already be in place to push the system to use telehealth to increase equity. Telehealth cannot improve access when there are not enough doctors to see, or reimbursement is not adequate to attract providers.

Audio services only function as the lowest barrier access point and the minimum viable product that can deliver individualized healthcare services. They extend the reach of healthcare services as broadly as possible but are not sufficient to provide the full range of services.

Measuring the quality of tele-behavioral health services can focus on technical quality (audio/video), patient satisfaction with care, improvement in access/cost, and clinical outcomes.

## Q&A

**Jim Werth** asked if the speakers could share what they would recommend to the Secretary of Health and Human Services.

**Dr. Jonathan Neufeld** replied that considering the Chronic Care Management (CCM) style reimbursement models and standardizing and aligning them.

**John Gale** responded that the recommendations he would suggest are:

- Encouraging CMS and Medicare to expand reimbursement options for counselors and clinicians.
- Expanded use of telehealth to provide access to services provide technical assistance and support to RHCs.

## DISCUSSION OF POLICY RECOMMENDATIONS

- HHS coordination with Commerce, USDA, and the FCC on the allocation of broadband resources to address rural gaps. Option: HHS should analyze billing for Integration codes to assess rural-urban differences and consider more public promotion of these codes?
- HHS should work with Congress to continue current telehealth billing flexibilities.
- HHS should develop a new payment model through the CMS Innovation Center focused on integrating payment for behavioral health and primary care services with a focus on including rural participants.
- HHS should require that Notices of Funding Opportunity should have at least 75 days of availability to give under-resourced rural and tribal communities time to develop applications.
- HHS should expand the SAMHSA State Integration Grants and give priority points for those focusing on rural and tribal efforts.
- HHS should consider developing community-specific grants to support the initial costs of integration for tribal clinics, RHCs and CAHs.

## FUTURE TOPICS

The committee discussed topics to consider for upcoming meetings. There was a consensus that the Program of All-Inclusive Care for the Elderly (PACE) and Emergency Medical Services (EMS) would be the two considerations.

Dr. Colyer stated EMS would be appropriate topic to consider for the Spring meeting because Covid-19 exacerbated the shortage issues.

## **PUBLIC COMMENT**

**Elisa Rosier, MD, FAAP**  
**Owner of Pacific Pediatrics, LLC**  
**Pediatric Medicine in Alaska**

I am a pediatrician in rural Alaska. I have been here 12 years and plan to stay here for the next decade or two. I practice on the fourth largest island in America, Prince of Wales Island. So, there's Hawaii, Kodiak (also in Alaska), Puerto Rico and then Prince of Wales. We have a population of fifty-five hundred residents. There's awesome fishing and hunting here. It is a beautiful land, and I am grateful to live here.

But our internet on the island is limited. Our healthcare is limited. I am the only pediatrician on the island.

I own my own practice. It is an LLC. Because I am a for-profit entity, I am not eligible for all the rural telehealth funding opportunities. I have asked two non-profits to partner with me, but they have said no because they have limited administrative staff and are concerned about the added paperwork burden. I do have an organization, The Denali Commission, will match any funding monies that I get.

I run a very lean business. I am personally and professionally debt-free and can guarantee that any funding monies will be well spent.

Telehealth has been an awesome addition to my practice. Through telehealth, I have been able to offer services to my patients that have historically been unavailable to my patients because of our location.

Thanks!



[WWW.NCPA.ORG](http://WWW.NCPA.ORG)

October 20, 2021

National Advisory Committee on Rural Health and Human Services  
C/O Steven Hirsch

Administrative Coordinator  
Federal Office of Rural Health  
Health Resources and Services Administration  
5600 Fishers Lane, 17W59D  
Rockville, Maryland 20857

**Re: Meeting of the National Advisory Committee on Rural Health and Human Services**

Dear Committee Members:

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide comments to National Advisory Committee on Rural Health and Human Services, which advises the Secretary of the U.S. Department of Health and Human Services on matters of rural health. NCPA recognizes the importance of the work of the Committee and wishes to provide information on policy initiatives which might be of interest to the Committee in future discussions.

NCPA represents America's community pharmacists, including 19,400 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care (LTC) settings. Together, our members represent a \$67 billion healthcare marketplace, employ 215,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers. NCPA submits these comments on behalf of community and long-term care pharmacies.

NCPA is encouraged by the willingness of the Committee to consider new and innovative policy initiatives – such as a new classification of rural providers - to enhance the quality of care in these underserved areas. Thirty-eight percent of independent community pharmacies are located in an area with a population of less than 10,000. These community pharmacies are providing vital services to very rural areas. Thirty-six percent are located in areas with a population between 10,000 and 50,000<sup>1</sup>. Collectively, 74 percent of independent pharmacies are serving areas with a population less than 50,000<sup>2</sup>. These pharmacies are vital participants in the health care system and share a desire to serve patients with quality care. Unfortunately, Pharmacy Benefit Managers (PBMs) are forcing these pharmacies to close as the current reimbursement structure does not cover the costs of operation.

NACRHHS Comment  
October 20, 2021  
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<sup>1</sup> NCPA 2021 Digest, <https://ncpa.org/sites/default/files/2021-10/2021-Digest.pdf>

<sup>2</sup> Id.

As the Committee continues to explore policies to address service and access needs in rural communities, such as the Rural Emergency Hospital requirements and policies being considered at this meeting, the Committee should recognize the importance of pharmacy in assisting in that task. Where pharmacy is not present, [adherence to a prescription regime decreases](#)<sup>3</sup> – leading to additional costly hospitalizations and emergency room visits. Patients in rural areas should have an additional licensed medical professional available to access who shares knowledge about the community and the people who inhabit it. The lack of pharmacies in rural areas due to closure and other economic factors put those communities at risk and place additional burdens on patients to travel distances for their care.

NCPA is partnering on a multi-year effort with the University of Southern California School of Pharmacy to address growing concerns about barriers in pharmacy access, including closures, in rural and underserved areas. The collaborative effort will generate real-time information on issues surrounding pharmacy access to provide better data. NCPA will be happy to share the data from these studies with the Committee when completed.

### Conclusion

NCPA greatly appreciates the opportunity to share information with the Committee related to addressing the needs of rural populations. NCPA looks forward to continuing to work with the Health Resources and Services Administration as well as other interested stakeholders to develop workable solutions which provide patients located in rural areas with a high quality of care. Should you have any questions, please contact me at [ronna.hauser@ncpa.org](mailto:ronna.hauser@ncpa.org) or (703) 838-2691.

Sincerely,



Ronna B. Hauser, PharmD  
Senior Vice President, Policy & Pharmacy Affairs



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<sup>3</sup> Qato DM, Alexander GC, Chakraborty A, Guadamuz JS, Jackson JW. Association Between Pharmacy Closures and Adherence to Cardiovascular Medications Among Older US Adults. *JAMA Netw Open*. 2019;2(4):e192606. doi:10.1001/jamanetworkopen.2019.2606

October 25, 2021

Steve Hirsch, Administrative Coordinator  
National Advisory Committee on Rural Health and Human Services  
c/o Federal Office of Rural Health Policy  
Health Resources and Services Administration  
5600 Fishers Lane  
17W59D  
Rockville, MD 20857  
*Submitted via email*

Dear Administrative Coordinator Hirsch, Committee Chair Colyer, and the Members of the National Advisory Committee on Rural Health and Human Services:

On behalf of Allina Health, this letter is in response to the opportunity to provide public comments during the Committee's three-day virtual meeting. Our letter focuses on the new Rural Emergency Hospital designation, and reiterates the comments we submitted to CMS on the CY 2022 OPPS Proposed Rule, which included a Request for Information on this new classification. Overall, we recommend the committee provide recommendations to the Secretary that achieves Congressional intent and helps maintain access to care for rural communities.

Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families, and communities throughout Minnesota and western Wisconsin. We serve our communities by providing exceptional care as we prevent illness, restore health, and provide comfort to all who entrust us with their care. As a not-for-profit health care system with 29,000 employees, Allina Health cares for patients from beginning to end-of-life through our 90+ clinics, 11 hospitals, 15 pharmacies, specialty care centers and specialty medical services providing home care, senior transitions, hospice care, and emergency medical transportation services. As a community provider, we are focused on eliminating health disparities and unnecessary variations in quality of care and improving the health of our communities.

## Rural Emergency Hospitals Designation

The Consolidated Appropriations Act (CAA) of 2021 established Rural Emergency Hospitals (REHs) as a new provider type beginning January 1, 2023. To qualify for enrollment as an REH, a provider must, on the enactment date of the CAA 2021, either already be designated as a Community Access Hospital or a rural subsection (d) hospital with not more than 50 beds. In addition, the REH must meet certain other requirements, including, but not limited to the following:

- An annual per patient average length of stay of 24 hours or less in the REH;
- Staff training and certification requirements established by the Secretary;

- Emergency services CoPs applicable to CAHs; hospital emergency department CoPs determined applicable by the Secretary;
- The applicable SNF requirements (if the REH includes a distinct part SNF);
- A transfer agreement with a level I or level II trauma center; and
- Any other requirements the Secretary finds necessary in the interest of the health and safety of individuals who are furnished REH services.

As the Committee provides recommendations to the Secretary of Health and Human Services, **we urge flexibility in how REHs determine use of existing space that would have otherwise been for inpatient beds to meet the needs of communities served.**

### Eligibility for 340B

Currently, CAHs have access to the 340B prescription drug program. This program is critical to providing access to prescription drugs and supporting safety net providers. REHs will be paid by Medicare at a rate higher than the otherwise applicable payment under the OPSS, and include additional monthly payment subsidies. The additional monthly facility payment made to a Rural Emergency Hospital (REH) is the difference between what was paid to CAHs and what would have been paid to CAHs under the Prospective Payment System (PPS).

The rate that was paid to the CAHs already includes a reduced payment related to reduced drug costs and the PPS payment does not include the effects of 340B savings. For those reasons, the calculation should have a way to take into account the effect that 340B drug savings has on the rate, or REHs should be able to be eligible for 340B drug savings. **We encourage the development of a reimbursement methodology that:**

**1. Considers the effect of 340B savings on payment and/or 2.**

**Allow REHs to participate in the 340B drug savings program.**

REHs should be eligible for drug savings under the 340B program. An REH will no longer be a CAH automatically eligible for 340B, nor will it have inpatient volume to measure the requisite 11.75% disproportionate share adjustment. **We strongly encourage the agency to allow REHs to participate in the 340B drug savings program had they been previously eligible.**

### Facility Payments and Attestation

The statute requires a facility that is seeking REH enrollment must provide a detailed description of how they intend to use the additional facility payments provided under the REH classification.<sup>4</sup> **We recommend the rules governing REH designation allow hospitals to use the additional facility payments as best suited for their communities, including facility investments and depreciation expense.**

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<sup>4</sup> CMS, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals CY 2022 Proposed Rule", 86 FR 42289 (2021).

**Allina Health supports a reporting process that is simplified and streamlined that allows us to have some flexibility to do what is best for our communities.** We encourage the use of existing reporting mechanisms to include this information, such as hospital cost reports. We oppose significant, stringent requirements that specifically dictate where and how funds are to be used, and the creation of another reporting portal. Flexibility is paramount as we understand how to best use funds to support providers, facilities, programming, depreciation, equipment, and more in communities with an REH.

### Licensed Beds, Average Length of Stay, and CAH Re-enrollment

Given the novel nature of this designation and the future uncertainty that may exist, **Allina Health believes the agency should outline a process for a hospital that is enrolled as an REH, to be able to revert to its original designation.** If the REH designation does not meet needs or expectations for any reason, the REH should be allowed to revert to a prior designation with the ability to recoup the same number of inpatient beds.

The CAA specified that to qualify as REH, facilities must have an average length of stay of less than 24 hours, similar in nature to the “96 hour rule” that exists for currently designated CAHs. Since the onset of COVID-19, our hospitals continue to face significant strain with high patient volumes and staffing shortages. **In developing regulations for the 24-hour average length of stay rule, we ask for flexibility in recognizing bed capacity issues that may require patients to be in an REH for longer than 24 hours.**

In addition, statutes creating an REH allows only existing CAHs or subsection (d) hospitals with not more than 50 beds to be eligible for REH status. States regulate hospital-licensed beds and some use a variety of policies to manage or cap licensed beds across hospitals.

**We encourage the adoption of a policy that directs states to allow participation as an REH while maintaining the number of licensed inpatient beds within an organization.** For instance, if a current CAH moves into the REH designation, the number of beds should be allowed to be transferred within an organization (same Taxpayer Identification Number) indefinitely. This will ensure that if an REH needs to revert to a CAH or other designation, the facility will not need to seek new licensed beds. **Finally, the creation of the REH designation should recognize and honor any existing federal or state-based agreements with existing hospitals, including waivers pertaining to CAH distance policies or other applicable arrangements.**

### Mental Health Access

A needed consideration to make is the impact on rural mental health. Rural residents frequently have to travel longer distances to see providers, with weather and road issues creating further challenges. Telehealth is critical in providing access to care, but there may be challenges with lack of adequate broadband internet and the need for inpatient mental health beds. A 2017 report on mental health in Minnesota found that the ratio of population to mental health providers showed that there was an insufficient mental health workforce in rural parts of the state, with a

ratio of 1,960 people to each mental health provider in rural or isolated areas, as compared to 340 people per provider in metropolitan areas.<sup>5</sup>

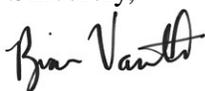
Given these factors and the growing mental health crisis, we request that consideration be given for inpatient excluded mental health beds. **Specifically, we urge that REHs be provided the ability to operate a 10-bed inpatient psychiatric excluded unit.** We note that Critical Access Hospitals may also operate with up to 10 psychiatric beds as a distinct part unit (DPU).<sup>6</sup>

### *Conclusion*

On behalf of Allina, Health, we appreciate the opportunity to provide comments to the National Advisory Committee on Rural Health and Human Services on the future designation of Rural Emergency Hospitals. We urge the committee to provide recommendations to the Secretary of Health and Human Services in developing forthcoming regulations to achieve Congressional goals of the legislation and to protect and invest in rural health care.

Please feel free to contact us with any questions.

Sincerely,



Brian Vamstad, PhD  
Manager, Regulatory Affairs and Payment Policy  
Allina Health  
[Brian.Vamstad@allina.com](mailto:Brian.Vamstad@allina.com)

October 21, 2021

Steven Hirsch  
Administrative Coordinator at the Federal Office of Rural Health Policy  
Health Resources and Services Administration  
5600 Fishers Lane, 17W59D  
Rockville, Maryland 20857

**RE: National Advisory Committee on Rural Health and Human Services:  
Recommendations to the Secretary on Rural Emergency Hospitals**

*Submitted via email: [shirsch@hrsa.gov](mailto:shirsch@hrsa.gov)*

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<sup>5</sup> Hung, Peiyin, Katy Kozhimannul, Carrie Henning-Smith, and Michelle Casey. "Closure of Hospital Obstetric Services Disproportionately Affects Less-Populated Rural Counties." University of Minnesota Rural Health Research Center, April 2017. [http://rhrc.umn.edu/wp-content/files\\_mf/1491501904UMRHRCOBclosuresPolicyBrief.pdf](http://rhrc.umn.edu/wp-content/files_mf/1491501904UMRHRCOBclosuresPolicyBrief.pdf).

To whom it may concern,

The American Association of Nurse Practitioners, representing more than 325,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide input to the National Advisory Committee on Rural Health and Human Services as the committee considers recommendations to the Secretary of Health and Human Services regarding rural emergency hospitals (REHs). As health care providers in rural areas and areas of lower socioeconomic and health status, NPs understand the barriers to care that vulnerable patients face on a daily basis.<sup>7, 8, 9</sup> As NPs play an important role in providing care to rural patient populations, we strongly encourage the committee to recommend that the conditions of participation for rural emergency hospitals permit nurse practitioners to practice to the full extent of their education and clinical training.

NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising, and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform more than one billion patient visits annually.

NPs practice in nearly every health care setting including hospitals, clinics, Veterans Health Administration and Indian Health services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health care settings.

NPs take a whole-person centered approach to health care delivery and decades of evidence demonstrate the high-quality<sup>4</sup>, cost-effective<sup>10</sup> care that NPs provide to their patients. As of 2019, there were more than 163,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare

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designated provider specialty.<sup>11</sup> Approximately 40% of Medicare patients receive billable services from a nurse practitioner<sup>12</sup> and approximately 80% of NPs are seeing Medicare and Medicaid patients.<sup>13</sup> NPs have a particularly large impact on primary care as approximately 70%

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<sup>7</sup> Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *Journal of General Internal Medicine*, 4–6. <https://doi.org/10.1007/s11606-017-4287-4>.

<sup>8</sup> Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. *Journal of the American Medical Association*, 321(1), 102–105.

<sup>9</sup> Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. *Medical Care Research and Review*, Epub ahead. <https://doi.org/10.1177/1077558718793070> <sup>4</sup>  
<https://www.aanp.org/images/documents/publications/qualityofpractice.pdf>.

<sup>10</sup> <https://www.aanp.org/images/documents/publications/costeffectiveness.pdf>.

<sup>11</sup> <https://www.cms.gov/files/document/2019cpsmdcrproviders6.pdf>

<sup>12</sup> <https://www.cms.gov/files/document/2019cpsmdcrphysupp6.pdf>

<sup>13</sup> [NP Fact Sheet \(aanp.org\)](https://www.aanp.org)

of all NP graduates deliver primary care.<sup>14</sup> In fact, NPs comprise approximately one quarter of the primary care workforce, with that percentage growing annually.<sup>15</sup>

In a 2020 AANP member survey, more than 15 percent of NPs reported working in communities with a population of less than 10,000, and 4.2 percent of NPs work in communities with a population of less than 2,500. In these smaller communities, NPs most frequently reported practicing in rural health clinics.<sup>11</sup> Nurse practitioners have long been essential health care providers in underserved communities and play a

critical role as primary care providers for vulnerable populations. As noted in the National Academies of Science, Engineering and Medicine (NASEM) report *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* “nurses work in areas that are underserved by other health care providers and serve the uninsured and underinsured.”<sup>16</sup>

According to the Health Resources and Services Administration (HRSA), there are 4,563 rural health professional shortage areas, with a population of 24,141,163 patients in the United States.<sup>17</sup> Rural communities are disproportionately impacted by health care inequities, which are exacerbated when communities experience rural hospital closures. However, when rural hospitals do close, APRNs, including NPs, continue to provide care in those communities. According to the Government

Accountability Office (GAO), “from 2012 to 2017, the availability of all physicians declined more among counties with closures (16.2 percent) compared to counties without closures (1.3 percent)” whereas “[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent).”<sup>18,19</sup>

Despite the importance of NPs to rural communities, arbitrary and outdated barriers to practice within federal regulation prohibit NPs from providing care to the full extent of their education and clinical training. As precedent has shown, when barriers to NP practice are removed the result is better access to care for underserved patient populations.

An example of NPs expanding critical access to care in rural and underserved communities is through the authorization of NPs to order medication assisted-treatment (MAT) for patients suffering from opioid use disorder (OUD). As of November 2020, the Drug Enforcement Administration (DEA) reported that over 18,000 NPs and PAs obtained a Drug Addiction Treatment Act (DATA) waiver to treat patients with OUD.<sup>15</sup> Studies have found that NPs have greatly increased access to MAT in rural and underserved communities.<sup>20</sup> In rural communities, NPs and PAs were the first waived clinicians in 285 rural counties covering 5.7 million

<sup>14</sup> <https://www.aanp.org/about/all-about-nps/np-fact-sheet>.

<sup>15</sup> [Rural and Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners](#), Hilary Barnes, Michael R. Richards, Matthew D. McHugh, and Grant Martsof, *Health Affairs* 2018 37:6, 908-914. <sup>11</sup> [Research Reports and Resources \(aanp.org\)](#)

<sup>16</sup> NASEM: *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*

<sup>17</sup> [Shortage Areas \(hrsa.gov\)](#)

<sup>18</sup> <https://www.gao.gov/assets/gao-21-93.pdf>.

<sup>19</sup> FR 69153. (Nov. 2, 2020).

<sup>20</sup> <https://jamanetwork.com/journals/jama/fullarticle/2730102?widget=personalizedcontent&previousarticle=2737024>. <sup>17</sup> <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00859>.

residents.<sup>17</sup> The Medicaid and CHIP Payment and Access Commission found that the number of NPs prescribing buprenorphine for the treatment of OUD, and the number of patients with

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OUD treated with buprenorphine by NPs increased substantially in the first year NPs were authorized to obtain their DATA waiver, particularly in rural areas and for Medicaid beneficiaries.<sup>18</sup>

As the advisory committee considers recommendations to the Secretary on rural emergency hospitals, we encourage the members to recommend policies which remove barriers to care for nurse practitioners. The authorizing statute for REHs, *The Consolidated Appropriations Act of 2021* (Public Law No.116-260), grants the Secretary the authority to determine “such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals.”<sup>19</sup> Ensuring maximum flexibility for providers in REHs is in the best interest of the communities they will serve. In the 2022 Hospital Outpatient Prospective Payment System proposed rule, CMS included a request for information (RFI) on specific questions for consideration as they draft conditions of participation (CoPs) for REHs. Below are the policy recommendations that AANP made to CMS which will better enable REHs to serve patients. We appreciate the Committee’s consideration of these comments as it develops its recommendations for the Secretary.

We broadly recommended that as CMS creates CoPs, they reflect the importance of nurse practitioners within REHs and authorize NPs to practice to the full extent of their education and clinical training. Our responses to specific questions posed within the RFI are below.

1. *What are the barriers and challenges to delivering emergency department services customarily provided by hospitals and CAHs in rural and underserved communities that may require different or additional CoPs for REHs (for example, staffing shortages, transportation, and sufficient resources)?*

Rural and underserved communities have historically experienced a greater degree of health care provider shortages than other communities, and the COVID-19 pandemic is exacerbating this disparity. As such, it is important that any COPs developed for REHs authorize all clinicians, including NPs, to practice to the full extent of their education and clinical training. This will maximize the ability of REH staff to provide high-quality, medically necessary treatment to their patients, without unnecessary and burdensome limitations to practice.

2. *An REH must provide emergency and observation services and may elect to provide additional services as determined appropriate by the Secretary. What other outpatient medical and health services, including behavioral health services, should the Secretary consider as additional eligible services? In particular, what other services may otherwise have a lack of access for Medicare beneficiaries if an REH does not provide them?*

The GAO report on rural hospital closures contains a breakdown of the number of closed rural hospitals that offered a specific type of health care service and the impact closures had on the

median distance in miles to the next hospital offering that service.<sup>21</sup> We encourage CMS to review that list for the potential inclusion of services that have been the most greatly impacted by those closures. Behavioral health and substance use treatment services are some of the most heavily impacted according to the GAO, as well as many therapy services.

<sup>18</sup> <https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicare/>

<sup>19</sup> [H.R.133 - 116th Congress \(2019-2020\): Consolidated Appropriations Act, 2021 | Congress.gov | Library of Congress](https://www.congress.gov/bills/116/133/all-actions/2020/09/24)

We also encourage CMS to include cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR) and pulmonary rehabilitation (PR). This is consistent with the goals of the administration's Build Back Better agenda which calls for the expansion of pulmonary rehabilitation in rural communities with high rates of chronic obstructive pulmonary disease.<sup>22</sup> As CMS evaluates the inclusion of these services, we also recommend that nurse practitioners be authorized to order and supervise CR, ICR and PR. NPs are fully qualified to order and supervise these services based on their education and clinical training. This barrier harms patients by causing unnecessary delay in treatment. CMS recognizes that cardiac rehabilitation improves long-term patient outcomes but is underutilized.<sup>23</sup> It is important that NPs be authorized to order and supervise these clinically effective and cost-saving treatments.

As noted in this proposed rule, REHs are also authorized to include distinct part skilled nursing facilities (SNFs). We strongly encourage CMS to adopt CoPs for SNFs in REHs which authorize nurse practitioners to perform the initial patient assessment and all other mandatory assessments, consistent with the language in 42 CFR § 483.30(f) for Medicaid nursing facilities. As advanced practice registered nurses, NPs have a unique understanding of the skilled nursing, and other, needs of SNF residents. Studies have demonstrated that NP participation in SNFs lowers overall costs and improves quality of care.<sup>24</sup> Creating further alignment between Medicare and Medicaid will also improve care for dual eligibles and help address issues of health care disparities.

3. *What, if any, virtual or telehealth services would be appropriate for REHs to provide, and what role could virtual care play in REHs?*

In the 2021 Medicare Physician Fee Schedule proposed rule, CMS requested feedback on including REH's as telehealth originating sites beginning in 2023. We support for the proposal to amend the regulation at § 410.78 (Telehealth Services), to include rural emergency hospitals as telehealth originating sites beginning in CY 2023. Rural emergency hospitals will provide a critical bridge for communities that lack access to care, and for patients who may face challenges in accessing broadband. Ensuring that REHs can serve as originating sites will expand equitable access to care for the communities they serve.

<sup>21</sup> *Ibid.*, see Table 4.

<sup>22</sup> <https://www.whitehouse.gov/briefing-room/statements-releases/2021/08/13/fact-sheet-biden-administration-takes-steps-to-address-covid-19-in-rural-america-and-build-rural-health-back-better/>.

<sup>23</sup> 82 FR 50784, 50800.

<sup>24</sup> <https://www.managedhealthcareconnect.com/articles/comparison-nurse-practitioner-and-physician-practice-models-nursing-facilities>.

4. *Should REHs include Opioid Treatment Programs (OTP), clinics for buprenorphine induction, or clinics for treating stimulant addiction in their scope of services? Please discuss the barriers that could prevent inclusion of each of these types of services.*

REHs should be authorized to include OTPs or clinics for treating substance use disorder. Many rural communities continue to lack access to treatment for substance use disorder. REHs can be vital in increasing access to these services. If an REH has the capability to meet the requirements to establish an OTP, clinic for buprenorphine induction, or clinic for treating stimulant addiction, they should be authorized to do so. Staffing and ensuring appropriate follow up care will be two of the bigger barriers that REHs face in providing these services. It is important that REHs establish relationships with clinicians in the community, such as NPs, who can provide the necessary outpatient follow-up care to patients suffering from substance use disorder to ensure that they remain on an appropriate treatment plan and receive the services necessary to support their recovery. As mentioned above, since NPs were granted

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the authority to provide MAT for the treatment of OUD, they have been vital to increasing access to this medically necessary treatment, particularly in rural and underserved communities.

5. *The REH must meet staff training and certification requirements established by the Secretary. Should these be the same as, or similar to, critical access hospital (CAH) requirements (Personnel qualifications, § 485.604 and Staffing and staff responsibilities, § 485.631)? Are there additional or different staff training and certification requirements that should be considered for REHs and why? Are there any staffing concerns that the existing CAH requirements would not address?*

For the certification requirements for nurse practitioners within REHs we recommend that CMS adopt the language currently used in 42 CFR § 410.75 which states that an NP must:

“(i) Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.”<sup>24</sup>

This language is reflective of current NP certification requirements, and would align the REH regulations with other Medicare program regulations to create consistency and reduce confusion.

We also encourage CMS to adopt REH regulations consistent with the waiver that is currently in effect under the COVID-19 Public Health Emergency of the CAH requirement at § 485.631(b)(2). This waives the requirement that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH. This will provide additional flexibility for REHs to meet the needs of their patients and enable nurse practitioners to practice to the full extent of their education and clinical training within the facilities.

6. *How can the CoPs ensure that a REH’s executive leadership (that is, its governance, or persons legally responsible for the REH) is fully invested in and held accountable for*

*implementing policies that will reduce health disparities within the facility and the community that it serves?*

We encourage CMS to adopt COPs that require the inclusion of nurse practitioners in the development, implementation and review of the REH policies as well as participation as full members on medical staffs. This is similar to the requirements for other rural facilities such as rural health clinics and critical access hospitals. This better enables NPs providing health care within the facility to provide feedback regarding the facility operation and management, so that REH leadership is well informed on all aspects of patient care. In addition, we recommend that creating leadership roles such as patient liaisons is important for creating bridges to the community, thus ensuring that the patient voice is heard.

These recommendations are consistent with The National Academies of Sciences, Engineering and Medicine (NASEM) report “*The Future of Nursing 2020-2030, Charting a Path to Health Equity*” which highlights the importance of removing barriers on APRNs. NASEM recommends “all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality, and value.”<sup>25</sup> This was also stated by the World Health Organization’s *State of the World’s Nursing 2020* report which recommended modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training,

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noting the positive impact it would have on addressing health care disparities and improving health care access within vulnerable communities.<sup>26</sup>

We appreciate the Committee’s consideration of these comments, and its important focus on the health of rural Americans. Ensuring that rural emergency hospitals are able to best serve their communities by utilizing NPs to the full extent of their education and clinical training will be of critical importance moving forward. Should you have comments or questions, please contact MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,



Jon Fanning, MS, CAE, CNED  
Chief Executive Officer  
American Association of Nurse Practitioner

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