October 26, 2021

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

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

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the National Council for Mental Wellbeing (National Council), the unifying voice for nearly 3,500 mental health and substance use treatment organizations serving more than 10 million adults, children, and families, we write to express our sincere thanks for your recent invitation to the Behavioral Health Care community and other interested parties to contribute to a bipartisan Committee effort addressing deleterious barriers to mental health care access. Your unwavering commitment to demonstrating the many ways in which the COVID-19 pandemic has worsened the mental health and substance use challenges faced by Americans, as well as your tremendous efforts thus far in responding to the pandemic through the provision of unprecedented investments in mental health, substance use treatment, and suicide prevention has shone a critical spotlight on the continued need to ensure invaluable access to care for people in need across our nation.

COVID-19 Exacerbated Overlapping Mental Health/Substance Use Crises

The May 12th and June 15th Subcommittee and Full Committee hearings dedicated to the state of the mental health and substance use crisis impacting the nation, for which we are particularly grateful, highlighted not only the pre-existing difficulties in accessing mental health and substance use services, but the alarming increases in rates of anxiety and/or depression in adults, the profound impact of psychological distress on Hispanic and low-income Americans, and the tragic 30 percent increase in overdose deaths last year, equating to 93,000 lives lost across our great nation. Thank you for your commitment to bipartisan policy solutions that will improve access to care for millions of American experiencing mental health and substance use challenges.

Certified Community Behavioral Health Clinics

Expanding the Certified Community Behavioral Health Clinic (CCBHC) model, which provides critical care for people with mental health and substance use challenges, remains a crucial priority for the National Council. In the 117th Congress, Senators Stabenow and Blunt, together with Representatives Matsui and Mullin, introduced the Excellence in Mental Health and Addiction Treatment Act (S. 2069/H.R. 4323) with the goal of expanding access to community-based mental health care and substance use treatment services. Originally created in the Protecting Access to Medicare Act (PAMA) of 2014, this invaluable demonstration program, which has now expanded to ten (10) states, seeks to provide comprehensive, coordinated mental health and substance use

services through a nationwide network of Certified Community Behavioral Health Clinics. This program is crucial to redesigning the nation's mental health and substance use treatment system as it increases access to high quality care for people living with mental health and substance use challenges, including those with schizophrenia, bipolar disorder, major clinical depression, and opioid use disorder (OUD). Additionally, through meaningful partnerships with Federally Qualified Health Centers (FQHCs) and front-line primary care providers, CCBHCs successfully help manage the high incidence of comorbid chronic diseases in this patient population, including diabetes, heart diseases, cirrhosis, emphysema, Hepatitis C, and HIV.

In a detailed and comprehensive report released recently, the findings of the Government Accountability Office (GAO) were overwhelmingly positive, leading to one conclusion: CCBHCs have the potential to transform the delivery of community-based mental health and substance use treatment across the nation. For example, GAO found that among the eight (8) originally participating demonstration states, half "assessed potential cost savings from the demonstration resulting from reductions in the use of more expensive care, such as emergency department visits."

Moreover, GAO found evidence that CCBHCs were achieving larger behavioral health policy goals. For example, in Oregon, access to care was significantly improved. "Officials in Oregon told [GAO investigators] that, whereas they anticipated their CCBHCs providing services to between 30,000 and 35,000 individuals in each of the first two years of the demonstration, they found that over 50,000 individuals received CCBHC services in each of these 2 years." In Missouri, state officials "identified a decrease in emergency room visits and hospitalizations of over 70 percent after 6 months for clients engaged in the Emergency Room Enhancement initiative." In New York, "for CCBHC clients in demonstration year one, monthly inpatient costs and monthly emergency room costs each decreased by over 25 percent…."

It's clear that CCBHCs are achieving their primary objective: to increase access to high quality care for Americans living with mental health and substance use challenges, thereby ensuring the first line of mental health and substance use treatment is ***not*** correctional facilities, homeless shelters, or emergency rooms.

Senate Finance Committee Behavioral Health Areas of Interest:

a.) Strengthening Workforce/Reducing Burnout Among Behavioral Health Practitioners

Community Behavioral Health Staff Retention Initiative

Print and electronic media have reported that stress, social distancing, and the uncertainties flowing from the COVID-19 pandemic have triggered widespread depression and anxiety. At the same time, the National Council for Wellbeing, through a series of surveys conducted in 2020, found that many front-line services, such as assertive community treatment services (mobile outreach to meet people where they are in the community) and harm reduction were curtailed, while mental health and substance use health programs were closed, and community mental health and substance use clinics experienced reimbursement reductions averaging 25 percent nationwide, with staff turnover reaching crisis levels.

Specifically, community-based mental health and substance use care clinics have struggled to retain front-line clinical staff during a period of extraordinary crisis when the demand for community-based mental health and substance use treatment services has skyrocketed as a result of the social isolation and economic dislocation caused by the COVID-19 pandemic.

Across the nation, National Council member organizations are confronting extraordinary challenges in retaining necessary staff levels. Additional federal funding, dedicated to community-based mental health and substance use organizations to support their workforce, for the purposes of providing retention bonuses as it relates to hazard pay, overtime pay, and shift deferential pay for a specific set of clinical staff that are necessary to continue the provision of high-quality mental health and substance use services is a crucial need across our nation to retain and promote our workforce and allow them the ability to help mentor future clinical staff.

It is imperative that we find a way to retain and reward a burnt-out mental health and substance use workforce to ensure we can meet the steady increase in demand for services seen in the past two years. This could be achieved through a time limited demonstration program targeting retention of community mental health and substance use service providers through the provision of retention incentives for services provided to the community. Facilities could be limited to those located in mental health professional shortage areas, as defined by the Secretary in consultation with Administrator of the Health Resources and Services Administration, and later broadened if needed to address the immediate mental health and substance use crisis.

b.) Increasing Access To Care/Policies that Improve Access To & Quality Of Care

Medicare Mental Health Access Improvement Act

Bipartisan legislation introduced by Senators Barrasso and Stabenow, and Representatives Thompson and Katko, the Medicare Mental Health Access Improvement Act (S. 828/H.R. 432) would allow Marriage and Family Therapists (MFTs) and Licensed Mental Health Counselors (LMHCs) to receive reimbursement from Medicare for their services, adding an estimated 225,000 providers to the Medicare mental health and substance use workforce.

The current exclusion of MFTs and LMHCs from receiving reimbursement for treating Medicare beneficiaries often results in denial of vital mental health services to individuals in need. Medicare provider eligibility for MFTs and LMHCs is long overdue. MFTs and LMHCs represent nearly 40 percent of licensed mental health practitioners and are an integral part of the mental health and substance use care delivery system – providing critically important services to clients experiencing anxiety, depression, and substance use challenges. Unfortunately, Medicare is the only major insurance provider that does not recognize MFTs and LMHCs.

Since the Department of Health and Human Services (HHS) Secretary declared a Public Health Emergency (PHE) due to COVID-19 on January 31, 2020, older Americans' emotional, mental, and physical wellbeing has been significantly impacted. The Kaiser Family Foundation found that, as of April 2020, almost half of Americans reported negative impacts to their mental health related to the

COVID-19 pandemic.[1] In March 2020 alone, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Disaster Distress Hotline saw an 891 percent increase in calls.[2] Statistics like this demonstrate that, along with the COVID-19 pandemic, the nation is facing a mental health epidemic.

As of 2019, over 77 million people in the United States live in Mental Health Professional Shortage Areas, as defined by the Health Resources and Services Administration (HRSA),[3] and 50 percent of rural counties in America have no practicing psychiatrists, psychologists, or social workers.[4] However, over 225,000 graduate-level mental health professionals are in place across the nation to help address these treatment gaps. These MFTs and LMHCs are recognized by Medicaid, TRICARE, the VA, and most private insurers, leaving only Medicare beneficiaries without access to this crucial resource for needed mental health and substance use care. MFTs and LMHCs are critically necessary members of the behavioral health care workforce who are prepared to ensure Medicare beneficiaries gain access to the care they need.

Notably, Medicare has not updated its covered provider list since 1989 with the passage of the Omnibus Budget Reconciliation Act, effectively creating a mental health and substance use coverage gap for Medicare beneficiaries which S. 828/H.R. 432 is designed fill. According to a recent New York Times article, Virginia Tech professor of Counseling Education, Dr. Matthew Fullen surveyed 3,500 practicing licensed counselors and found that over 50 percent had turned away patients because of the Medicare coverage gap, with almost 40 percent having been forced to refer existing patients elsewhere once they become Medicare eligible. The Medicare Mental Health Access Improvement Act should be a central component of any bipartisan action taken by the Senate Finance Committee to address the mental health and substance use treatment workforce shortage.

Adding Regional Call Centers/Crisis Stabilization To CAHOOTS

In the American Rescue Plan (PL 117-2), Congress took an important step in preparing for the implementation of the new 9-8-8 National Suicide Prevention Lifeline by providing Medicaid financing for a key element of the continuum of crisis care: mobile crisis teams. These teams, composed of clinical social workers and peer support specialists, respond to individuals experiencing a psychiatric episode and/or substance use crisis in tandem with, or in place of, local law enforcement.

However, as the federal government prepares for the implementation deadline of 9-8-8 in July 2022, we must ensure that a crisis service continuum is solidified in all states. The crisis service continuum consists of three (3) core elements: call centers, mobile crisis units, and short-term acute care crisis stabilization programs. The value of this continuum is demonstrated when individuals in

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[1] Kaiser Family Foundation. (2020). The implications of COVID-19 for mental health and substance use.
[2] A crisis mental-health hotline has seen an 891% spike in calls. CNN, April 10, 2020. See here.
[3] *Designated Health Professional Shortage Areas Statistics*, *Third Quarter of Fiscal Year 2019*, *Designated HPSA Quarterly Summary*, Bureau of Health Workforce, HRSA, U.S. Department of Health & Human Services, June 30, 2019.
[4] *Workforce Issues: Integrating Substance Use Services into Primary Care*, SAMHSA-HRSA Center for Integrated Health Solutions, Office of National Drug Control Policy, August 2011.

mental health or substance use crisis are diverted away from hospital emergency departments and county jails where their needs are unlikely to be met. Community residential programs, as well as community-based mental health and substance use health clinics, provide effective, cost-efficient crisis stabilization services. It should be noted that 79 percent of CCBHCs coordinate with local hospitals and emergency departments to prevent avoidable admissions when individuals are in crisis. Similarly, many community mental health clinics, including Didi Hirsch Community Mental Health Services in Los Angeles, host crisis help lines.

At present, every state has at least one element of a crisis care model, and in many states that element is a 24/7 crisis help line. It seems clear that any action taken by the Senate Finance Committee provides a unique opportunity to assist states and local jurisdiction in standing up a full crisis care continuum to address what is likely to be an enormous expression of need across the United States. Specifically, Vibrant Emotional Health estimates that utilization of the National Suicide Prevention Lifeline will increase from 2 million to 9 million in the first year – an astonishing 300 percent increase that could significantly impact the capacity of community hospital emergency departments nationwide. In a crisis care context, low-income persons eligible for Medicaid accessing services often have no prior connection to the mental health and/or substance use care system and typically do not have existing mental health and/or substance use diagnoses.

Given these pressing circumstances, the National Council strongly urges the Committee to consider legislation that enhances the existing CAHOOTS Act program by adding clear Medicaid reimbursement pathways for both crisis stabilization beds, as well as staffing and operations costs for local and regional crisis suicide prevention hotlines, therefore ensuring that states have the financing necessary to develop infrastructure for the entire crisis care continuum in time for 9-8-8.

c.) *Expanding Telehealth*

Telehealth has served as a lifeline for many during the COVID-19 pandemic, allowing individuals to continue to connect to providers/organizations from the safety of their homes rather than delay or forgo care entirely. Additionally, access to telehealth benefitted individuals with pre-existing transportation difficulties and/or those in rural or underserved areas. When the PHE concludes, one area of significant concern is ensuring continued access to needed mental health services.

Unfortunately, the Consolidated Appropriations Act, 2021 (P.L. 116-260) contained a provision that arbitrarily limits access specifically to tele-mental health services by requiring an in-person visit within six-months to continue care through telehealth. This requirement would go into effect the day after the PHE concludes, immediately hindering access to only those receiving mental healthcare through telehealth. Notably, this requirement does not exist for telehealth access to substance use or opioid use disorder services, which was permanently made available in the SUPPORT for Patients and Communities Act (P.L. 115-271).

Authored by Senators Cassidy and Smith and Representatives Matsui and Johnson, the Telemental Health Care Access Act (S. 2061/H.R. 4058) would remove the in-person requirement imposed solely on tele-mental health services, thereby not further arbitrarily impeding access during a time of expanded need. We urge the Committee to include the Telemental Health Care Access Act of 2021 as a priority in any forthcoming action taken to address barriers to mental health care access.

Please accept our gratitude for your outstanding leadership and dedication to bolstering our nation's mental health and substance use treatment systems and for your acute awareness of the access gaps that continue to perpetuate existing barriers to mental health and substance use services. We stand prepared to be a resource to you and the Committee as you evaluate policy recommendations.

Sincerely,

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