



November 15, 2021

The Honorable Ron Wyden  
Chairman  
Committee on Finance  
221 Dirksen Senate Office Building  
United States Senate  
Washington, DC 20510

The Honorable Mike Crapo  
Ranking Member  
Committee on Finance  
239 Dirksen Senate Office Building  
United States Senate  
Washington, DC 20510

Re: Request for Information on Behavioral Health Care

Dear Chairman Wyden and Ranking Member Crapo:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the Senate Finance Committee's bipartisan effort to examine behavioral health care needs and assess the factors contributing to gaps in care. As noted by the Committee, the COVID-19 pandemic has exacerbated unmet behavioral health needs and highlighted the ongoing struggle that individuals face in accessing timely, quality mental health care and substance use disorder services.

Mental health is a fundamental component of overall health. Mental illness affects people of all ages and incomes and can be as debilitating as any other major medical illness. In general, mental health services should have parity with (i.e., be covered at levels equivalent to) other health services regardless of payer or coverage type. We also recommend greater coordination between federal agencies and departments, as there are many agencies engaged in behavioral health services and workforce development – ACL, HRSA, SAMHSA, VA, to name a few. As you consider evidence-based solutions for improving access to behavioral health care services, we urge you to take into account the needs and perspective of older Americans seeking care.

According to a University of Michigan [poll](#) sponsored by AARP, nearly one in five older adults (age 50 to 80) say their mental health has gotten worse since the pandemic began in March 2020, and more than one in four say they are more anxious or worried than before the COVID-19 era. Similarly, more than one in three older adults reported feeling a lack of companionship and nearly half reported feeling isolated from others in the past year. Other AARP [research](#) shows that socially isolated older adults are at greater risk for poor health and death than their well-connected counterparts, and social isolation leads to much higher spending in Medicare.

### **Strengthening Workforce**

Medicare covers outpatient mental health services provided by physicians (especially psychiatrists), clinical psychologists, clinical social workers, clinical nurse specialists, nurse

practitioners, and physician assistants. Medicare does not cover treatment by licensed professional counselors. Medicare should expand the list of mental health professionals who can be reimbursed under Medicare to cover all providers who are fully licensed by their state for independent practice. For example, AARP has supported legislation such as the *Mental Health Access Improvement Act*, which would let licensed professional counselors and marriage and family therapist bill Medicare directly.

Similarly, the use of nurse practitioners (NPs) and clinical nurse specialists (CNSs) to provide some services to patients may increase access to mental health services and also prove cost-effective. Examples of Medicare and Medicaid barriers that restrict the ability of NPs and CNSs to practice to the full extent of their education and clinical training include physician supervision requirements in rural health clinics, federally-qualified health centers, Medicaid clinics, critical access hospitals, and acute hospitals. These barriers limit consumer access to quality behavioral and physical health care. Removing these barriers to care is also aligned with the National Academy of Medicine's *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* report which recommended that "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."

Further, long-standing efforts to deinstitutionalize mentally ill patients have not led to corresponding and necessary changes in community-based mental health care delivery. In combination with substantial reductions in mental health funding, this shift has made it difficult for many patients to obtain the mental health services they need. These difficulties are made worse by the current shortage of geriatric mental health and substance use professionals.

A 2012 [report](#) by the Institute of Medicine—*The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?*—found that very few providers enter, work in, and remain in the fields of primary care, geriatrics, mental health, substance use, and geriatric mental health and substance use. To help address the need for providers, the federal government should increase funding for community-based mental health and substance use services through the mental health block grant, with a larger portion of funds targeted toward nontraditional providers of services for the older population. Services should include adult day service centers and other community-based long-term services and supports providers. Moreover, it is important for service providers to conduct culturally appropriate outreach to older adults because older adults typically will not self-refer.

### **Increasing Access to Care**

Mental health disorders are frequently undiagnosed or misdiagnosed in older patients. Older adults are more likely than younger adults to receive inappropriate or inadequate mental health services, and perceived social stigma and denial can also impede accurate diagnosis and

treatment. While Medicare's coverage of mental health and substance use services has improved over the years, coverage restrictions that do not apply to other health services remain.

Medicare covers some mental health-related preventive services with no cost-sharing, including annual screenings for depression and alcohol misuse screening. Yet coverage for subsequent services can be limited. For example, for those who screen positive for alcohol misuse, Medicare will cover only four brief, face-to-face behavioral counseling interventions per year. Similarly, Medicare will cover medical nutrition therapy for certain medical conditions, but not for mental health conditions such as eating disorders.

Moreover, despite growing evidence supporting the effectiveness of multi-disciplinary, community-based geriatric mental health treatment teams (e.g., physicians, social workers, nurses, psychologists, and pharmacists), Medicare limits access to this type of care. Instead, Medicare should expand its coverage of outpatient services that have been shown to help individuals with mental illnesses remain in the community. At the same time, Medicare should eliminate the 190-day lifetime limit on inpatient psychiatric care in freestanding psychiatric hospitals under Part A. Individuals should be able to get care in the site and setting that best meets their needs.

### **Expanding Telehealth**

Though telehealth utilization has decreased from its peak in April 2020, one recent [study](#) estimated that telehealth use is still 38 times higher than prior to the beginning of the pandemic, and that telehealth makes up roughly 40% of psychiatric outpatient claims and 30% of substance use disorder treatment claims. While the risks of COVID-19 may have been the catalyst for telehealth's rapid expansion, it is not responsible for its sustained significance. Telehealth can play a long-term role in health care delivery and can help fill important gaps whenever barriers restrict access to in-person care. Federal law and policy should facilitate access to mental telehealth services to the greatest feasible extent.

Although certain flexibilities are currently in place in the Medicare program to provide mental health and other services by a hospital to a patient in the home remotely through the use of telehealth, those flexibilities will expire at the end of the public health emergency (PHE). In instances where a beneficiary may be receiving mental health services from hospital clinical staff who cannot bill Medicare independently for their professional service, the beneficiary would then need to physically travel to the hospital to continue receiving the services post-PHE. AARP is concerned that this could have a negative impact on access to care in areas where beneficiaries may only be able to access mental health services provided by hospital staff and, during the PHE, have become accustomed to receiving these services in their homes. AARP strongly supports allowing the home to be an originating site for mental health services provided remotely. Furthermore, we believe an in-person encounter is not necessary to establish a relationship for coverage of mental health telehealth services, nor does there need to be an in-person visit within 6 months prior to a telehealth visit.

AARP also supports including audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders when the originating site is the patient's home. Many individuals, particularly Medicare beneficiaries, rely on audio-only communication to receive mental health services. Mental health services provided through telehealth should be available to new and established patients since many individuals in need of mental health care may have limited mobility or transportation creating a barrier to in-person visits. AARP urges that individuals should be able to establish a relationship with a mental health professional via interactive telecommunications systems, including audio-only communications.

### **Conclusion**

Thank you for the opportunity to provide AARP's perspective on improving access to behavioral health services. If you have any questions about our comments or need more information, please feel free to contact me or Andrew Scholnick of our Government Affairs staff at 202-434-3770 or [ascholnick@aarp.org](mailto:ascholnick@aarp.org).

Sincerely,



Bill Sweeney  
Senior Vice President  
Government Affairs