The Jewish Federations OF NORTH AMERICA | Strategic Health Resource Center

November 11, 2021

The Honorable Ron Wyden
Chairman
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member,
Senate Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The Jewish Federations of North America (Jewish Federations) joined by the Network of Jewish Human Service Agencies (NJHSA) write today in response to your September 21, 2021, letter seeking recommendations from behavioral health stakeholders on ways to reduce barriers to accessing evidence-based mental health and substance use disorder treatment for Americans who rely on Medicaid, Medicare, the Children's Health Insurance Program (CHIP) and the Affordable Care Act marketplaces. We thank you for your leadership and sustained efforts to improve access to coverage and care for millions of Americans, both adults and children, who are experiencing mental conditions and substance use disorders. As revealed by the Committee's May 12th Subcommittee on Health hearing entitled, *"The COVID-19 Pandemic and Beyond: Improving Mental Health and Addiction Services in Our Communities,"* and the full Committee hearing on June 15th, entitled "*Mental Health Care in American: Addressing Root Causes and Identifying Policy Solutions,"* the need to address systemic barriers to care has never been more urgent.

We look forward to working with you on this vital endeavor and focus our recommendations set forth in greater detail below on four policy areas that our behavioral health provider agencies and the people they serve have identified as crucial to sustaining and growing their work, increasing their capacity to treat more people in their communities, and ensuring that they are able to offer the most effective approaches to care possible: (1) expanding the Medicaid Certified Behavioral Health Clinic program nationwide; (2) sustaining and improving telehealth for mental health and

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substance use disorder care; (3) realizing the full potential of telehealth, addressing workforce shortages in the behavioral health field, and improving the country's ability to respond to emergencies by relaxing current restrictions on professional state licensure to allow for more licensure reciprocity, particularly for behavioral health providers; and (4) growing the behavioral workforce in other ways.

About Us

Jewish Federations is one of the largest philanthropic networks in the United States. Together, we raise and distribute more than $3 billion annually for social welfare, social services, and educational needs. Our local 146 federations support one of the largest networks of nonprofit social service providers in the country, including 97 nursing home and aging providers, 125 Jewish family services agencies that provide mental health and substance use treatment services, and more than a dozen group homes. Our partner agencies serve people of all denominations, backgrounds, and socioeconomic levels. Our network of federations and partner agencies are committed to ensuring that everyone in our communities can live with dignity and achieve a decent quality of life.

NJHSA represents 150 non-profit human service organizations in the United States, Canada, and Israel. Our members provide a full range of human services for the Jewish community and beyond, regardless of faith, background, ethnicity, and ability to pay. Services include supplemental food assistance, health care, career, and employment and mental health services, as well as programs for youth, family and seniors, Holocaust survivors, immigrants and refugees, people with disabilities, and caregivers.

Bold Action is Needed to Address Access Barriers to Mental Health and Addiction Care

As our provider agencies know first-hand, the nation's mental health system is seeing surging demand, which was already on a disturbing rise even before the COVID-19 pandemic. As has been widely reported, from August 2020 to February of this year, more than 4 in 10 adults reported experiencing anxiety

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or depression.[1] Further, the Centers for Disease Control (CDC) and the National Center for Health Statistics found in late 2020 that the nation had experienced the largest number of drug overdoses ever recorded in a single year,[2] meanwhile the Well Being Trust reported that the deaths of despair of suicides, drug and alcohol abuse have been increasing for years.[3] And last year, the number of children and youth going to emergency rooms for mental health crises and suicide attempts rose dramatically,[4] leading three major children's health organizations to recently declare a state of emergency for children's mental health. As a nation, there are many steps we can take to improve access to effective behavioral health care. Below are the steps we recommend in particular.

Expanding the Certified Behavioral Health Clinic Program Through Excellence

To better promote the integration and coordination of behavioral health and primary care and improve access to care -- a key innovation we have long supported -- we recommend nationwide expansion of the Certified Community Behavioral Health Clinic (CCBHC) Medicaid pilot demonstration program through the bipartisan, bicameral *Excellence in Mental Health and Addiction Treatment Expansion Act of 2021 (S. 2069/H.R. 4323)*. Thanks to earlier federal investment from Congress, hundreds of CCBHCs

[1] Vahratian, A.; Blumberg,, S.; Terlizzi, E.; Schiller, J., Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic, MMWR Morb Mortal Wkly Rep 2021; 490-494.
[2] Centers for Disease Control and Prevention (CDC), "Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic, CDC Health Alert Network (December 17, 2020).
[3] Petterson, Steve et al., "Projected Deaths of Despair During the Coronavirus Recession," Well Being Trust (May 8, 2020).
[4] Leeb, R.T., Bitsko, R.H., Radhakrishnan, L., Martinez, P., Njai, R., and Holland, K.M. (2020). Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic—United States, January 1-October 17, 2020. Oct. 2020. MMWR Morb Mortal Wkly Rep 2020;79:1675-1680. Yard, E., Radhakrishnan, L., Ballesteros, M.F., et al. (2021). Emergency Department Visits for Suspected Suicide Attempts Among Persons 12-25 Before and During the Pandemic—United States, January 2019-May 2021. MMWR Morb Mortal Wkly Rep 2021;70L888-894.

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are now operating in our communities throughout the country, offering more robust services that provide more timely access to care, stabilize people in crisis, and ensure essential treatment for low-income Americans with serious, complex mental illnesses and substance use disorders. CCBHCs integrate additional services to offer a community-based, holistic, and innovative approach to behavioral health care. This approach emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. CCBHCs also make strong efforts to coordinate with other entities in their communities, such as hospitals, emergency departments, and law enforcement to divert people in crisis to more appropriate treatment. The CCBHC Medicaid pilot program is currently only open to 10 states. This legislation would allow the program's expansion to any state interested in participating.

In fact, two Jewish family service agencies in New York – the Westchester Jewish Community Services and the Jewish Board of Families & Children's Services -- are now participating as CCBHCs and both enthusiastically support this model of care as it is allowing them to expand their array of services and address the needs of more people in underserved parts of their catchment areas. After learning about the work of these two agencies, more of our providers have expressed interest in adopting this approach, particularly if it is sustained through Medicaid. Accordingly, we strongly recommend the Committee include this vital legislation in the behavioral package you are developing.

Reducing Barriers to Care Through Telehealth, Including Audio-Only

Jewish Federations and NJHSA greatly appreciated Congress' permanent authorization of Medicare-coverage for telemental health services after the expiration of the Public Health Emergency.[5] We also applaud the Centers for Medicare and Medicaid Services (CMS) for promulgating the Calendar Year 2022 Physician Fee Schedule Final Rule (Final Rule) released on November 5, 2021, that allows Medicare-coverage of telehealth from patients' homes and sustains the ability of patients to receive mental health and substance use

[5] Consolidated Appropriations Act of 2021, Pub. L. 116-260 §123 (Dec. 27, 2020).

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treatment services utilizing the audio-only modality effective January 1, 2022. These are tremendous steps forward in ensuring the continuation of telehealth for both mental health and addiction treatment services on a permanent basis for millions of patients in need. As CMS itself acknowledged, the ability to provide services through audio-only telehealth has allowed providers to reach more patients and improve beneficiary access in areas experiencing behavioral health provider shortages or that lack sufficient broadband coverage (including in urban underserved areas), and has been a digital equalizer for individuals who cannot use or do not have access to smartphones due to low-income, disability, and for people of color.[6] The experiences of our extensive network of agencies across the country confirm these findings.

We, nevertheless, recommend that Congress act to remove the current statutory requirement of in-person service as a check on the provision of telemental health services after the end of the Public Health Emergency. This in-person service prerequisite will serve as an unnecessary barrier to care, undermining a key benefit of telehealth, and is particularly unwarranted for telemental health services. We recognize that CMS relaxed the six-month in-person requirement to 12 months in the Final Rule but note that there is no comparable in-person restriction on access to telehealth for substance use treatment services. Even with this expansion to 12 months, we nevertheless believe that such a restriction is unnecessary. A recent report from U.S. Department of Health and Human Services' Office of the Inspector General found that 78 percent of Medicare beneficiaries who received psychotherapy through telehealth throughout the pandemic already had an established relationship with their treating provider.[7] We believe that this in-person requirement for telemental health actually will compromise access to care for older adults, individuals with disabilities and others with transportation and mobility challenges, as well as for those who live a longer distance from their treating providers. **Accordingly, we urge Congress to pass the bipartisan *Telemental Health Care Access Act (S. 2061/H.R. 4058),* which would**

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[6] 86 Fed. Reg. 39104, 39148 (July 23, 2012).
[7] Office of Inspector General, HHS, *Data Snapshots* (Oct. 2021).

remove the statutory requirement that Medicare beneficiaries be seen in person within six months of being treated for a telemental health service.

In revising and updating current telehealth policy, we also recommend that Congress include a provision to ensure that telehealth for mental and behavioral health services -- including audio-only telehealth services -- be reimbursed at the same rate as in-person services, the non-facility rate. For mental and behavioral health providers like our agencies, whose patients rely heavily on telehealth services, returning payment for telehealth services to pre-pandemic reimbursement levels would be problematic and could have the effect of reducing access to telehealth. Given the significant investments providers must make to purchase and maintain telehealth technology and platforms, lowering the telehealth reimbursement rate could discourage many providers from continuing to offer telehealth as an option, thereby jeopardizing the recent improved access to mental and behavioral health services for many beneficiaries.

Finally, we recommend passage of the bipartisan *Telehealth Improvement for Kids' Essential Services (TIKES) Act (S. 1798),* which would promote access to telehealth services for children through Medicaid and CHIP while also evaluating children's telehealth utilization for barriers, opportunities, and outcomes. Telehealth has proved to be an essential tool in providing children access to behavioral health care, including children with disabilities and those from low-income families or who live in rural and underserved communities.

Eliminating Mental Health Professional Licensure Barriers to Care

Temporary suspension of professional licensing laws in emergency situations is a common approach states take to help manage short-term crises, such as in response to natural disasters and their aftermath.[8] In fact, almost every state modified its licensure requirements/renewal policies for healthcare providers, particularly for telehealth, during the height of the

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[8] National Conference of State Legislatures, "Occupational Licensing During Public Health Emergencies", retrieved on November 5, 2021.

pandemic.[9] These changes allowed behavioral health professionals to provide services to patients wherever they were located, greatly expanding access to care throughout the country. However, as of September 2021, about half of states have retracted these licensure flexibilities.[10]

The COVID-19 pandemic clearly challenged the traditional presumption that disaster response is by its very nature short-term or isolated to a specific location, highlighting the need for the nation to prepare itself for longer lasting national public health emergencies. For this reason and because our nation remains under the COVID-19 Public Health Emergency**, we recommend that Congress pass the bipartisan, bicameral *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S. 168/H.R. 708)*, which would provide temporary state licensing reciprocity for all licensed and certified practitioners or professionals (those who treat physical and mental health conditions) in all states for all types of services (in-person and telehealth) for the duration of this unprecedented emergency and for a limited normalization period after the emergency declaration is lifted.**

We further recommend that the Committee examine authorizing health professional licensure reciprocity for future national public health emergencies and consider more permanent flexibilities as well. Although progress has been made among physicians to allow for a pathway to licensure reciprocity (and to a more limited extent for psychologists), there currently is no similar pathway for social workers. The nonprofit, behavioral health provider agencies in our network employ mostly social workers to provide services. The absence of state licensure reciprocity outside of the current pandemic for our agencies' employees serves as a barrier to care in emergencies, as well as for patients who have reason to temporarily move out of state. It also significantly limits telehealth's potential to address behavioral health professional workforce shortages and surging mental health and addiction treatment needs.

[9] U.S. Dept. of Health and Human Services, "Telehealth Licensing Requirements and Interstate Compacts," retrieved on November 5, 2021.
[10] Alliance for Connected Care, State Telehealth and Licensure Expansion COVID-19 Dashboard, retrieved on November 5, 2021.

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Two of our agencies' recent experiences -- in Surfside, FL, and New Orleans, LA -- illustrate how licensure barriers constrain the ability of our network of agencies across the country to support their partner agencies and the people they serve in other parts of the country when needed. Hundreds of survivors of the recent building collapse in Surfside required emergency services, as well as counseling, to address the longer lasting traumatic impact from losing their loved ones, friends, and homes. Jewish Community Services South Florida provided extensive aid to the survivors, but its partner agency, the Jewish Family Service Houston (JFS Houston) in Texas, also sought to help due to its specialized expertise in disaster response mental health, case management, and counseling for clients suffering the traumatic effects of disasters. Florida's state licensing law for social workers, however, limits out-of-state emergency services to 15 days. As a result, JFS Houston was forced to limit the assistance it could provide to the Surfside community to staff training and case management, but could not provide counseling services, even though clinicians from JFS Houston were available and prepared to help. Even more recently, following Hurricane Ida in September, the Jewish Family Service of Greater New Orleans was forced to cease providing needed mental health care to patients who evacuated to safety in other states, disrupting these patients' treatment with trusted mental health providers during a time of crisis. If there was licensure reciprocity, vulnerable evacuees could have continued receiving care through telehealth from their longstanding providers.

Beyond the context of natural disasters and public health emergencies, we now live in a world where people are far more mobile than in the past, traveling out-of-state for lengthy periods of time for many reasons, including students who attend colleges and universities outside their state of residence. State licensure requirements serve as a barrier to care for these individuals as well, forcing them to transfer to different mental health providers every time they move. With the widespread adoption of telemental health, these disruptions in care could be avoided. **For the reasons above, we urge Congress to pass the TREAT Act and explore expanding health professional licensure reciprocity on a more permanent basis.**

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Growing the Behavioral Healthcare Workforce

Even prior to the pandemic, all states were experiencing serious shortages among mental health and substance use disorder treatment professionals.[11] Pre-pandemic projections showed that by 2025 the shortages would be even worse.[12] With today's surging demand these shortages have only been exacerbated, but at the same time we are hearing from a number of our agencies that they have experienced substantial workforce losses during the pandemic. We, therefore, recommend several measures Congress can take to alleviate these shortages.

Specifically, we recommend increasing the federal reimbursement rate for mental health and substance use disorder care under Medicaid through passage of the *Medicaid Bump Act (S. 1727/H.R. 3450)*. As the Committee knows, Medicaid is the nation's largest insurer of mental health and substance use treatment for both adults and children. However, many beneficiaries remain on long waitlists for mental and behavioral health services or languish for long periods of time in emergency rooms awaiting treatment. The Medicaid Bump Act would incentivize states to expand their Medicaid coverage of mental health and substance use treatment services by providing a corresponding raise in the Federal Assistance Percentage (FMAP) matching rate to 90 percent for behavioral health services. Significantly, increasing Medicaid reimbursement rates also would flow to the mental health and substance use treatment workforce, greatly enhancing the behavioral health system's ability to recruit and retain needed providers.

We also recommend expanding Medicare beneficiaries' access to a broader range of mental health providers through: (i) **the bipartisan *Mental Health Access Improvement Act of 2021 (S. 828/H.R. 432)*** (which would require Medicare to cover medically necessary behavioral health services provided by licensed mental health counselors and marriage and family therapists, who comprise 40 percent of the mental health workforce); and (ii) **the bipartisan *Improving Access to Mental Health Act (S. 870/H.R. 2035)***

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[11] Behavioral Health + Economics Network, Behavioral Health Workforce Factsheet (2018).
[12] *Id.*

(which would increase Medicare beneficiaries' access to mental health services in Skilled Nursing Facilities, improve Medicare beneficiaries' access to Health and Behavior Assessment and Intervention Services, and align Medicare reimbursement rates for Clinical Social Workers with other non-physician providers).

In conclusion, we are extremely grateful for the opportunity to share our experiences and recommendations with the Committee. We thank you for your leadership in exploring ways to improve access to mental and behavioral health care for people in need throughout the country and for our nonprofit agencies that serve more than 1 million people every year. Please do not hesitate to contact Elizabeth A. Cullen, Counsel for Health Policy, The Jewish Federations of North America, at Elizabeth.Cullen@jewishfederations.org, if you wish to follow up or have any questions.

Sincerely,

Elizabeth A. Cullen, Counsel for Health Policy
The Jewish Federations of North America

Reuben D. Rotman, President & CEO
Network of Jewish Human Service Agencies

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Washington, DC 20001

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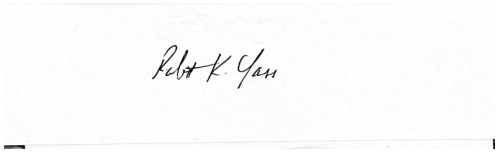
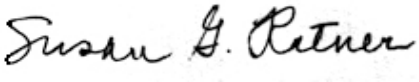


Robert K. Yass, Co-Chair
Health & Long-Term Care Committee
The Jewish Federations of North America



Susan G. Ratner, Co-Chair
Health & Long-Term Care Committee
The Jewish Federations of North America

Sincerely,

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Washington, DC 20001

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