



# Medicare Mental Health Workforce Coalition

The Honorable Ron Wyden  
Chairman  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510-6200

The Honorable Mike Crapo  
Ranking Member  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510-6200

**Re: Response to the Senate Finance Committee’s Request for Policy Proposals to Improve Access to Mental Health and Substance Use Disorder Services - The Mental Health Access Improvement Act of 2021 (S. 828)**

October 28, 2021

Dear Chairman Wyden and Ranking Member Crapo:

The Medicare Mental Health Workforce Coalition appreciates the Senate Finance Committee’s bipartisan commitment to address the urgent behavioral health care and substance use disorder needs of Americans, including older and disabled Americans, through an evidence-based approach. We are a coalition of national and state organizations collectively representing hundreds of thousands of mental health and addiction disorder providers, patients, families of patients, payers, and other stakeholders committed to strengthening Medicare beneficiaries’ access to mental health and addiction care, building the workforce we need now and in the future, and modernizing coordination of delivery and payment systems for behavioral health and addiction care.

## Introduction

Even before the COVID-19 pandemic began disproportionately impacting older and disabled Americans,<sup>1</sup> approximately one in four Medicare beneficiaries suffered from a mental illness.<sup>2</sup>

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<sup>1</sup> Koma, W., et al., “[One in Four Older Adults Report Anxiety or Depression Amid the COVID-19 Pandemic](#),” Kaiser Family Foundation (October 9, 2020) (Kaiser, Older Adults, 2020).

<sup>2</sup> J. Figueroa, J. Phelan, J. Orav, et al., “[Association of Mental Health Disorders With Health Care Spending in the Medicare Population](#),” JAMA (March 19, 2020) (pre-pandemic data analysis finding that 22.7% of individuals in the Medicare fee-for-service cohort analyzed were diagnosed with a serious mental illness (defined as bipolar disease, schizophrenia or related psychotic disorders, and excluding depression and neurological disorders such as dementia) and 7.5% had another common mental health disorder (defined as anxiety disorders, personality disorders, and posttraumatic stress disorder) (Medicare Spending on Mental Health Disorders, 2020). *See also* B. McGinty, “[Medicare’s Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement](#),” The Commonwealth Fund, Issue Brief (July 9, 2020) (Commonwealth Fund, Medicare Gaps, 2020); and Fullen, M., Lawson, G., Sharma, J., “[Analyzing the Impact of the Medicare Coverage Gap on Counseling Professionals: Results of a National Study](#),” Journal of Counseling & Development, Vol. 98 (April 2020) (noting, based on pre-pandemic

The COVID-19 pandemic has exacerbated the mental health crisis in the United States, with older and disabled individuals disparately impacted by social isolation, loneliness, anxiety, and bereavement. In July 2020, close to half of older adults (ages 65 and older) reported that worry and stress related to coronavirus had a negative impact on their mental health, up from 31% in May, according to a Kaiser Family Foundation tracking poll.<sup>3</sup> Yet, according to the National Academy of Medicine, older adults are consistently underserved when it comes to behavioral health care.<sup>4</sup>

As the Committee recognizes in its Request for Information (RFI), mental and physical health comorbidities often compound and worsen physical health outcomes. The presence of a mental illness can profoundly affect patients' ability, and the ability of health care systems, to manage other chronic medical conditions. It is well documented that, for older and disabled adults on Medicare, poor mental health can lead to worse health outcomes and greater use of health care services, as well as more expensive interventions for non-mental health conditions.<sup>5</sup>

The resulting cost to the Medicare program is substantial. Experts have estimated that at least 4.2% of Medicare fee-for-service spending went to mental health services in 2015 and an additional 8.5% went to additional medical spending associated with mental illness -- a total of 12.7% going either directly or indirectly to mental health conditions, not including the additional cost of treatment related to substance use disorders (SUDs).<sup>6</sup>

Despite the growing toll taken by mental illness and SUDs among the Medicare population, Medicare beneficiaries have less access to mental health and addiction disorder providers than enrollees in virtually all other health plans, including Tricare, the Veterans Administration, Medicaid, and most Medicare Advantage, commercial, and employer plans, because licensed professional mental health counselors (LPCs) and licensed professional marriage and family therapists (LMFTs) are not eligible to participate in the Medicare program. In addition to participating in almost all other federal healthcare programs, these counseling professionals are eligible for placement through the National Health Service Corps under the Public Health Service Act.<sup>7</sup> Although the Medicare program recognizes the importance of behavioral health counseling for beneficiaries, these services remain only available from psychiatrists, psychologists, psychiatric nurse specialists, and licensed clinical social workers (LCSWs),

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research, that, "Approximately 10% of men and 15% of women over age 65 experience depressive symptoms, and these symptoms are often correlated with greater functional disability, higher rates of physical illness, and increased risk of dementia." (Fullen, Analyzing the Coverage Gap, 2020).

<sup>3</sup> Kaiser, Older Adults, 2020. According to a study from the National Academies of Sciences, Engineering, and Medicine, 43% of adults over 60 reported feeling lonely in February 2020, just before the scope of the pandemic became clear. National Academy of Sciences, "[\*Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System\*](#)," National Academies Press (February 27, 2020).

<sup>4</sup> Institute of Medicine, "[\*The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?\*](#)," The National Academies Press (2012).

<sup>5</sup> See Medicare Spending on Mental Health Disorders, 2020.

<sup>6</sup> Medicare Spending on Mental Health Disorders, 2020, [eTable4](#).

<sup>7</sup> 42 U.S.C. § 254d(a)(3)(E).

despite the fact that LPCs and LMFTs have master's or doctoral level training comparable to LCSWs and psychiatric nurse specialists.<sup>8</sup>

Unfortunately, the coverage gap for individuals relying on Medicare for their health care coverage means:

- Limited access to less costly treatment options;
- Lack of continuity of therapy when individuals age into Medicare or become Medicare-eligible due to permanent disability;
- 40% of the master's level behavioral health professionals is unavailable to beneficiaries;
- Beneficiaries face barriers to better integration of physical and mental health care;
- For dual eligibles and veterans with Medicare, lack of access to coordinated benefits because LPCs and LMFTs are not recognized as Medicare providers; and
- For those living in rural areas of the country with few or no available Medicare providers, beneficiaries foregoing or discontinuing therapy altogether.

The Mental Health Access Improvement Act of 2021 (S. 828), led by Committee members Senators Barrasso and Stabenow, would close the gap in federal law that prevents LPCs and LMFTs from being Medicare providers. The legislation would give Medicare beneficiaries immediate access to over 225,000 additional licensed mental health professionals and help close the widening treatment gap.

As outlined below in response to the related questions posed by the Committee in its RFI, the measure meets many of the important policy goals the Committee has identified.

### **Related RFI Questions**

- **What policies would encourage greater behavioral health care provider participation in federal healthcare programs?**
- **Should federal licensing and scope of practice requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?**

Since 1989, despite worsening shortages of behavioral health providers, particularly in rural areas of the country, the only master's level clinicians eligible to participate in the Medicare program are LCSWs and psychiatric nurse specialists.<sup>9</sup> During the 30-year period since the provider list was last updated, the mental health landscape has changed substantially. LPCs and LMFTs are licensed in every state, and there is a well-established accreditation and training

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<sup>8</sup> American Association for Marriage and Family Therapy, "[About Marriage and Family Therapists](#)," 2019; American Counseling Association, "[Choosing a Career in Counseling](#)," updated July 15, 2021.

<sup>9</sup> Congress added licensed clinical social workers as independent mental health providers and lifted restrictions on services provided by psychologists in the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6113, 103 Stat. 2106 (1989).

process for each profession.<sup>10</sup> The Mental Health Access Improvement Act requires LPCs and LMFTs to meet the minimum criteria required for being a Medicare-eligible LCSW; i.e., the requirements for board certification.<sup>11</sup> The table below illustrates the comparability of education, training, supervision, and licensure for each of the three professions:

	Licensed Clinical Social Worker <sup>12</sup>	Licensed Mental Health Counselor	Licensed Marriage and Family Therapist
Current Medicare Provider:	Yes	No	No
Education:	Master's or Doctoral Degree in social work	Master's or Doctoral Degree in mental health counseling or a related field	Master's or Doctoral Degree in marriage and family therapy or a related field
Experience:	Two years of post-graduate supervised clinical social work experience	Two years of post-graduate supervised mental health counselor practice	Two years of post-graduate clinical supervised experience in marriage and family therapy
Licensure requirement:	Licensed or certified to practice as a clinical social worker by the State in which the services are performed	Licensed or certified as a mental health counselor within the State of practice	Licensed or certified as a marriage and family therapist within the State of practice

LPCs and LMFTs are also an integral part of the current mental health system nationwide -- *except in the Medicare program*. As Medicare enrollment has increased over the past three decades, the proportion of counselors to other mental health provider professionals has

<sup>10</sup> For example, in order to be board certified, LPCs typically must complete a master's degree or higher in counseling with a major study in counseling, as well as 3,000 hours of counseling experience and 100 hours of supervision over a two-year post-master's time period. See [Understanding Board Certification and Licensure](#), National Board for Certified Counselors. In order to qualify as a Medicare provider, LCSWs must meet similar requirements and be licensed or certified in the state in which they practice or, in the case of individuals in a state that does not provide for licensure or certification, the LCSW must have completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary of Health and Human Services), and meet such other criteria as the Secretary establishes. See Section 1861(hh)(1) of the Social Security Act, 42 U.S.C. § 1395x(hh)(1) (2021). See also Fullen, M., Wiley, J., Morgan, A., "[The Medicare Mental Health Coverage Gap: How Licensed Professional Counselors Navigate Medicare-Ineligible Provider Status](#)," *The Professional Counselor*, Vol. 9, Issue 4, pp. 310-323 (2019).

<sup>11</sup> See "The Mental Health Access Improvement Act of 2021," S. 828, Section 2(a)(2).

<sup>12</sup> 42 U.S.C. § 1395x(hh)(1) (2021).

substantially increased. These mental health counseling professionals now comprise over 40% of the master's level behavioral health workforce in the United States.<sup>13</sup>

The Mental Health Access Improvement Act of 2021 would not change the mental health benefit or modify LPCs' or LMFTs' scope of practice. Rather, it would help correct the workforce shortage for Medicare beneficiaries who need mental health services. Moreover, passage of the legislation would incentivize counseling certification programs to focus on the unique mental health and SUD needs of the growing geriatric population.

It is crucially important that we strengthen the capabilities and effectiveness of the overall health care workforce to better meet the needs of older and disabled individuals with medically complex conditions; especially those coping with mental illness and/or SUD along with conditions such as diabetes, lung disease, cardiovascular disease, and other comorbidities associated with early mortality, disability, and impairments in psychosocial functioning.<sup>14</sup> LPCs and LMFTs, who frequently practice in multi-disciplinary settings, are well-positioned to play a key role in collaborative care models designed to improve medical and mental health outcomes and functioning.<sup>15</sup>

With respect to SUD, as the Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized, those who currently work most frequently with older individuals (e.g., primary care physicians, assisted living and nursing home staff, emergency department staff, inpatient hospital staff, and caregiver/family members) are not routinely trained to recognize or effectively address serious mental illnesses (SMIs).<sup>16</sup> LPCs and LMFTs, who are trained in treatment and prevention of mental health and routinely coordinate care with medical providers and other health care professionals, can bring much needed skills and integrative care experience to the delivery of coordinated, person-centered care. These integrated approaches are vital to improving health outcomes for older and disabled individuals and reducing the overall burden of mental and physical disease.

It is important to note that older adults can be particularly vulnerable to the negative effects of substances such as alcohol and prescription drugs. Individuals with cognitive impairments such as dementia may have more difficulty using alcohol or prescription drugs safely, and are at greater risk of falls and accidents, as well as adverse effects from drug interactions. As SAMHSA has noted, most providers and professionals lack specialized training in geriatric substance misuse, and most family members and caregivers do not know how to recognize and

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<sup>14</sup> For example, the American Mental Health Counselors Association (AMHCA), a Coalition member, offers training and certification in geriatric counseling. See AMHCA, [Clinical Mental Health Counseling Specialist in Geriatric Counseling](#). Ensuring that LPCs and LMFTs can be reimbursed as Medicare providers would encourage more counseling professionals to seek out such additional expertise.

<sup>15</sup> See Unützer, J., et al., ["The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes."](#) Center for Health Care Strategies and Mathematica Policy Research, Health Home Information Resource Center (May 2013).

<sup>16</sup> Substance Abuse and Mental Health Services Administration, ["Older Adults Living with Serious Mental Illness: The State of the Behavioral Health Workforce"](#) (2019).

respond to these issues in older family members.<sup>17</sup> When providers are able to adapt interventions to the physical, cognitive, and psychosocial needs prevalent for their older clients, these interventions are more likely to be effective.<sup>18</sup>

One of the entry-level specialty areas for counselors seeking licensure is addiction counseling, involving course work that focuses on the neurological, behavioral, psychological, physical, and social effects of psychoactive substances and addictive disorders on the user and significant others, screening and diagnosis, cultural factors relevant to addiction and addictive behavior, and development of individualized intervention strategies.<sup>19</sup> Ensuring that LPCs and LMFTs participate in the Medicare program will improve the program's ability to identify and address addiction disorders and reduce the growing toll taken by SUD on beneficiaries.

- **What federal policies would best incentivize behavioral health care providers to train and practice in rural and other underserved areas?**
- **Are there structural barriers, such as the size of the provider network, travel time to a provider and time to an appointment, that impede access to the behavioral health care system?**

As of June 30, 2021, over 125 million people in the United States live in Mental Health Professional Shortage Areas, as defined by the Health Resources and Services Administration (HRSA).<sup>20</sup> Approximately one-fifth of those living in rural areas have a mental illness.<sup>21</sup> Older rural adults, especially men, are also among those at highest risk for suicide.<sup>22</sup> There are more veterans in rural areas, with more than 25% of all veterans living in rural places, and older veterans who die by suicide are more likely to live in rural areas compared to their younger counterparts.<sup>23</sup>

The country faces not just a shortage of behavioral workforce professionals, but a maldistribution of those who provide mental health and SUD services. Despite higher rates of SUD and suicide in rural communities, approximately 50% of rural counties in America have no practicing psychiatrists, psychologists, or social workers.<sup>24</sup>

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<sup>17</sup> SAMHSA, "[Treating Substance Use Disorder in Older Adults: Updated 2020](#)."

<sup>18</sup> *Id.*

<sup>19</sup> See, e.g., Council for Accreditation of Counseling and Related Educational Programs, [Accreditation Standards](#), 2016, pp. 20-22.

<sup>20</sup> *Designated Health Professional Shortage Areas Statistics, Third Quarter of Fiscal Year 2021, Designated HPSA Quarterly Summary*, Table 5, Bureau of Health Workforce, Health Resources and Services Administration, U.S. Department of Health & Human Services, June 30, 2021.

<sup>21</sup> Morales, D., et al., "[A Call to Action to Address Rural Mental Health Disparities](#)," *J. Clin. Transl. Sci.* (October 2020).

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> *Workforce Issues: Integrating Substance Use Services into Primary Care*, SAMHSA-HRSA Center for Integrated Health Solutions, Office of National Drug Control Policy, August 2011; Bailie, M., et al., "[Confronting Rural America's Health Care Crisis](#)," Bipartisan Policy Center (April 21, 2020) (recommending that LMFTs and LPCs be added to the list of Medicare providers as a method of increasing access to care, emphasizing that ensuring an adequate rural health workforce will help stabilize and reform the rural health infrastructure) (BPC, Rural Mental Health, 2020).



Among those mental health providers who *do* work in rural communities, 60.7% are counselors (including LPCs, LMFTs, and others),<sup>25</sup> which suggests that counselors play a key role in providing rural mental health services outside of Medicare.<sup>26</sup> Unfortunately, since LPCs and LMFTs are not Medicare providers, rural Medicare beneficiaries must seek out licensed clinical social workers, psychiatric nurse practitioners, psychologists or psychiatrists, who can be much harder to find and farther away.<sup>27</sup> Recognizing LPCs and LMFTs as Medicare providers would significantly improve access to behavioral and addiction care for older and disabled Americans living in rural areas, and incentivize these professionals to train, practice, and remain in rural areas of the country.

- **What barriers, particularly with respect to the physician and non-physician workforce, prevent patients from accessing needed behavioral health care services?**

The Medicare coverage gap is one of the most significant barriers preventing older and disabled Americans from accessing needed behavioral health care. Dr. Matthew Fullen and colleagues at Virginia Tech surveyed 3,392 practicing licensed counselors in 2019 and found that over 50% had turned away patients because of the Medicare coverage gap, with almost 40% having been forced to refer existing patients elsewhere once they became Medicare eligible.<sup>28</sup> This suggests that, contrary to assumptions that Medicare beneficiaries tend not to be interested in seeking mental health services, many beneficiaries do seek out such care, only to encounter barriers to getting the help they need.<sup>29</sup>

There can be serious consequences to forgoing treatment or undertreating mental health conditions, particularly for people in the Medicare program who may suffer from the comorbidity of mental illness and chronic disease.<sup>30</sup> The coverage gap also disrupts the continuity of mental health treatment for individuals who become Medicare eligible because of

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<sup>25</sup> Larson, E., et al., “[Supply and Distribution of the Behavioral Health Workforce in Rural America](#),” Data Brief #160 (September 2016) (Larson, 2016).

<sup>26</sup> Fullen, M., Brassoie, N., et al., “[The Impact of the Medicare Mental Health Coverage Gap on Rural Mental Health Care Access](#),” *Journal of Rural Mental Health*, 44(4), pp. 243-251 (2020); *see also* Larson, 2016.

<sup>27</sup> *Id.*

<sup>28</sup> Fullen, M., Lawson, G., Sharma, J., “[Analyzing the Impact of the Medicare Coverage Gap on Counseling Professionals: Results of a National Study](#),” *Journal of Counseling and Development*, Vol. 98 (March 8, 2020) (38.8% of the counselors surveyed referred existing clients to Medicare-covered when they became eligible for the program, and 39.9% agreed to see a Medicare-enrolled client pro bono or on a sliding scale (e.g., because of ethical concerns about transitioning a vulnerable client to alternative care or no care). (Fullen, Medicare Coverage Gap, 2020).

<sup>29</sup> A recent PAN Foundation poll of 1,000 Medicare-covered older adults found that 67% said they would be comfortable seeking and receiving mental health care, despite one in five responding that their family members, friends, and acquaintances attached stigma to seeking treatment for mental health. In addition, 71% said they had never been screened by their providers for a mental health condition. PAN Foundation, “[Addressing the Gaps in Mental Health Coverage for Medicare Beneficiaries](#),” June 3, 2021.

<sup>30</sup> Fullen, Medicare Coverage Gap; *see also* Unützer, J., et al., “[Healthcare Costs Associated with Depression in Medically Ill Fee-for-Service Medicare Participants](#),” *J. Am. Geriatr. Soc.*, March 2009” (finding that depression is associated with significantly higher healthcare costs in fee-for-service Medicare recipients with diabetes mellitus and congestive heart failure).

age or disabilities while in counseling. And when LPCs and LMFTs have to turn away clients because of the gap, individuals in need of counseling may experience long wait-lists before they can see a Medicare provider.<sup>31</sup>

The gap poses a particularly sad irony for individuals qualifying for Medicare who are under age 65 because of a permanent disability, six out of 10 of whom were diagnosed with mental disorders in 2019.<sup>32</sup> The disruption in care for dual eligibles battling serious mental illness, particularly those who more frequently have negative encounters with the criminal justice system,<sup>33</sup> is especially concerning.

The exclusion of LPCs and MFTs from Medicare also creates a lack of “program compatibility” between Medicare and Medicaid.<sup>34</sup> Since Medicare does not recognize LPCs or LMFTs as eligible providers, the beneficiary cannot produce a claim denial for counseling under Medicare so as to trigger Medicaid coverage, even when the Medicaid program might otherwise cover the service. This exacerbation of coverage gaps can also extend to veterans covered by Medicare, interfering with the veteran’s choice of provider.

### Conclusion

Policy experts consistently recommend including LPCs and LMFTs in the Medicare program. For example, in 2017, the Interdepartmental Serious Mental Illness Coordinating Committee urged the Congress “remove exclusions that disallow payment to certain qualified mental health professionals, such as marriage and family therapists and licensed professional counselors, within Medicare.”<sup>35</sup> Likewise, in 2020, the Commonwealth Fund recommended that policymakers close the remaining gap in Medicare by allowing reimbursement for mental health services by the more than 140,000 LPCs in the United States.<sup>36</sup> Similarly, in 2021, a Bipartisan Policy Center Task Force recommended that Congress expand the mental health provider categories covered under Medicare, in order to address shortages in rural areas while lowering federal reimbursement barriers to integrating primary and mental health care.<sup>37</sup>

Based on the foregoing, the undersigned respectfully urge the Finance Committee to include the Mental Health Access Improvement Act (S. 828), in the Committee’s behavioral health package. We believe passage of the legislation is crucial to strengthening the behavioral health and addiction workforce, ensuring Medicare beneficiary access to mental health counseling and therapy, fostering better integration and coordination, and better coordinating benefits for Medicare beneficiaries, dual eligibles, and veterans.

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<sup>31</sup> Fullen, Medicare Coverage Gap, 2020.

<sup>32</sup> Social Security Administration, SSI annual statistical report, 2019.

<sup>33</sup> BPC, Rural Mental Health, 2020.

<sup>34</sup> Coverage Gap Impact on Rural Mental Health, p. 247.

<sup>35</sup> Report to Congress, “[\*The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers\*](#),” SAMHSA, Interdepartmental Serious Mental Illness Coordinating Committee (2017), Recommendation 2.8(d), p. 83.

<sup>36</sup> Commonwealth Fund, Medicare Gaps, 2020, p. 5.

<sup>37</sup> BPC, Rural Mental Health, 2020, p. 15.



If our Coalition or any of its members can be of any assistance, or if you have any questions, please contact David Connolly of the Connolly Group at [davidaconnollyjr@gmail.com](mailto:davidaconnollyjr@gmail.com) or 202-557-1728 or the American Counseling Association's (ACA) Chief Government Affairs and Public Policy Officer, Brian D. Banks, at [bbanks@counseling.org](mailto:bbanks@counseling.org) or at 703-543-9471.

Thank you very much for your consideration. We look forward to working with you.

Sincerely,

American Association for Marriage and Family Therapy  
American Counseling Association  
American Mental Health Counselors Association  
Association for Behavioral Health and Wellness  
California Association of Marriage and Family Therapists  
Centerstone  
Center for Medicare Advocacy  
Michael J. Fox Foundation for Parkinson's Research  
National Association for Rural Mental Health  
National Association of County Behavioral Health and Developmental Disability Directors  
National Board for Certified Counselors  
National Council for Mental Wellbeing  
National Council on Aging  
National Association for Rural Mental Health

cc: Senator John Barrasso  
Senator Debbie Stabenow