New Jersey Association of
Mental Health and Addiction Agencies, Inc.

November 15, 2021

The Honorable Ron Wyden
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

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

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the New Jersey Association of Mental Health and Addiction Agencies, Inc. and its approximately 160 members that provide mental health and substance use treatment services and supports, I thank you for this opportunity to respond to your request for information on legislative proposals that will improve access to health care services for Americans with mental health and substance use disorders.

Expand the Certified Community Behavioral Health Clinic Demonstration Program

Advancing integration, coordination, and overall access to behavioral health care requires recognition of the social and physical determinants of health like trauma, poverty, employment, and housing have a profound effect on outcomes. One model to expand access to care that has been successful in this coordination role is the Certified Community Behavioral Health Clinics (CCBHCs). The CCBHCs provide a comprehensive set of services including 24-hour crisis care, a full continuum of mental health and substance use treatment, case management, and peer support.

Currently there are 340 CCBHCs in 40 states serving an estimated 1.5 million people. However, only those CCBHCs serving in the Medicaid demonstration program are eligible for the prospective payment rate that offers a sustainable financing mechanism to support their operations long-term. It provides sufficient funding to enable recruitment and retention of qualified professionals, unlike most funding streams that keep providers from offering competitive wages. Currently only 10 states participate in the demonstration program while new CCBHCs in those states and all CCBHCs in other states are only eligible for time-limited grant monies. We strongly encourage the Committee to support the Excellence in Mental Health and Addiction Treatment Act of 2021 (S. 2069) that would expand the Medicaid demonstration program nationwide and authorize substantial grant funds.

Address the Workforce Shortage to Improve Access to Care

First and foremost, the many discrepancies exposed during the COVID-19 pandemic between behavioral health and intellectual and developmental disability (I/DD) workers and the broader health care workforce should be addressed. Throughout the pandemic, many states did not

recognize behavioral health and I/DD workers as "essential health workers". As a result, many of these critical care providers were not eligible for special programs and recognition given to other medical personnel including distribution of personal protective equipment (PPE). It is vital that any workforce proposals the Committee pursues treat behavioral health and I/DD workers as full members of the health care workforce.

Provide Funding that is Dedicated to Recruitment and Retention

Fundamentally, the workforce crisis is tied to the insufficient rate of reimbursement for treatment services which severely constrains the resources that treatment programs are able to dedicate to recruiting and keeping qualified clinicians. Because the problem is persistent and systemic, and because a majority of resources geared toward workforce are available as one-time only money, it does not allow the field to build out a sustainable workforce infrastructure. Without a reliable and sufficient base, we simply cannot compete with other organizations for staff necessary to serve patients in need. This is creating new barriers to treatment. For some members, the workforce shortage has resulted in reduced treatment capacity as providers have capped enrollment at programs for lack of staffing. While staffing problem existed pre-COVID-19, the pandemic has exacerbated the situation to crisis levels with no end in sight.

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, providers 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 our workforce.

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.

Expand Programs that Support Recruitment, Training and Loan Forgiveness

There are several federal programs that support recruitment, training, and placement of behavioral health providers. These include the Health Resources and Services Administration's (HRSA) National Health Service Corps, Graduate Psychology Education and Behavioral Health Workforce Training and Education programs, the Substance Use Disorder Treatment and Recovery Loan Repayment Program, as well as the Substance Use and Mental Health Services Administration's (SAMHSA) Minority Fellowship Program. While these programs differ in scope, all of these programs should be increased in size to help build a diverse, inclusive workforce. The expansion of loan repayment and forgiveness programs for people who enter and remain in the behavioral health field would provide incentives for people to enter this rewarding but challenging field.

The Medicaid BUMP Act (S1727)

At the same time, providing an increase in the reimbursement rates for mental health and substance use disorder (SUD) treatment services, especially in Medicaid, would help programs offer higher wages or greater capacity to retain their workforce. The Medicaid BUMP Act (S. 1727) would address this problem by changing the federal/state cost share so that Medicaid would reimburse states for 90 percent of the cost of providing new mental and behavioral health services, and require States to use the additional federal funds as a supplement rather than a replacement of State funding levels.

Mental Health Access Improvement Act (S. 828) and Promoting Effective and Empowering Recovery Services in Medicare (PEERS) Act (S. 2144)

The Mental Health Access Improvement Act (S. 828) would allow marriage and family therapists (MFTs) and mental health counselors to receive reimbursement from Medicare for their services, adding an estimated 225,000 providers to the Medicare behavioral health workforce. The Promoting Effective and Empowering Recovery Services (PEERS) in Medicare Act (S. 2144) allows for the participation of peer support specialists in the provision of integrated behavioral health services to Medicare beneficiaries. Additionally, the legislation provides a comprehensive definition of peer support specialists in the Medicare program.

MFTs, mental health counselors and peer support specialists play a vital role in the behavioral health field. The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes peer support as an effective and evidence-based practice, making peer support specialists a vital part of the care team. Allowing Medicare beneficiaries access to MFTs, counselors and certified peer support specialists will expand community-based mental health and substance use treatment services and reduce costly hospitalizations for Medicare beneficiaries.

These two legislative proposals would bring parity to the Medicare program. Each professional type is recognized and eligible for reimbursement by other federal programs including Medicaid, TRICARE and the Veterans Administration. Excluding reimbursement from Medicare for these services limits access and treatment options for millions of Americans. Simultaneous passage of these bills would ensure Medicare beneficiaries have access to the entire behavioral health care team continuum.

Mainstreaming Addiction Treatment Act (S445)

Currently, the Drug Enforcement Agency (DEA) requires an additional waiver to prescribe buprenorphine for treatment of opioid use disorder (OUD). No such requirements exist for providers licensed to prescribe opioids to treat pain or for other substance use and mental health medications that are also DEA controlled substances. The additional waiver to prescribe buprenorphine for OUD stigmatizes the medication and deters prescribers from engaging in care. The Mainstreaming Addiction Treatment (MAT) Act (S. 445) removes the requirement that a health care practitioner apply for a separate waiver through the DEA to dispense buprenorphine for maintenance or detoxification treatment and would substantially increase access to critical, life-saving substance use treatment. The bill also directs the Substance Abuse and Mental Health

Services Administration to conduct a national campaign to educate health care practitioners and encourage them to integrate substance use disorder treatment into their practices.

Improve Access to Care for Incarcerated Individuals upon their Release

Medicaid Reentry Act (S.285)

The Medicaid Reentry Act (S.285) requires states to make Medicaid available for incarcerated individuals no less than 30 days prior to release, ensuring more coordinated behavioral and other health care for people reentering communities, a measure made more critical than ever right now during the pandemic. According to the Bureau of Justice Statistics, nearly half of people in the criminal justice system have a diagnosable mental health condition. Of those with serious mental illness (e.g., schizophrenia), approximately 75% also have a co-occurring SUD. The first two weeks after release from incarceration, a person is at the highest risk for an overdose. In fact, recently released individuals are roughly 129 times more likely to die of a drug overdose during this time compared to the general population. By allowing for Medicaid coverage for eligible incarcerated individuals up to 30 days before their release from jail or prison, upon release, individuals would have timely access to substance use, mental health and other health-related services. This access to care is necessary to break the cycle of recidivism and prevent death and other harms.

Improve Access to Residential Treatment: Eliminate the Medicaid IMD Exclusion

The Medicaid Institutions of Mental Diseases (IMD) Exclusion is one of the foremost barriers to clients accessing both mental health and SUD treatment. We urge the Committee to end the arbitrary IMD Exclusion in any legislative package it advances to address gaps in behavioral health. In doing so, Congress would expand access to treatment for Medicaid beneficiaries in every state – capacity that is urgently needed as the opioid and suicide pandemics are claiming lives at a historic and alarming rate.

The IMD Exclusion is a Federal financing rule from 1965 that bars federal Medicaid matching dollars for treatment in facilities with more than 16 beds. While intended to prevent incentives for the warehousing of psychiatric patients, the 16 or fewer bed limit makes it extremely difficult to operate a residential, community-based treatment program while complying with staff/patient ratios, counseling and coverage hours, and other regulations. There is no known clinical justification for limiting Medicaid reimbursement to services provided at a facility of 16 beds or less. The IMD Exclusion itself is incompatible with any conception of parity, because it causes serious gaps in the availability of non-hospital residential treatment services.

While no clinical benefit is attributed to the IMD Exclusion, the potential cost of its elimination is often cited as a reason for taking no action. However, this fails to account for the ongoing current costs that are incurred by failing to provide access to residential treatment. In recent years, hundreds of organizations, associations and individuals across the country have identified the elimination of the IMD as a priority. According to the U.S. Government Accountability Office in their April 2020 publication *"Medicaid State Views on Program Administration*

Challenges", Medicaid officials from 47 states identified the IMD Exclusion as a barrier to provision of proper addiction and mental health treatment.

Expand and Enforce Parity

Health insurance – public and private - should provide comprehensive mental health and substance use disorder coverage without arbitrary limits on treatment. Establishing and enforcing laws and policies that ensure parity between behavioral health and physical health services in all forms of insurance coverage must be a priority. Parity is the basic idea that addiction and mental health treatment should be covered at the same level as care for other health conditions. There have been significant efforts on the federal level to achieve this which have helped create a more level playing field to treat mental and physical health conditions alike. However, significant disparities in coverage for behavioral health treatment remain and many people are still being denied the care that they need. Some forms of insurance are allowed to place limitations on mental health coverage (importantly, the 2008 Mental Health Parity and Addiction Equity Act does not apply to Medicare, certain state Medicaid programs, Veterans Administration or short-term limited duration health plans). Federal laws do not require parity in reimbursement rates and, consequently, result in barriers to access as people cannot find in-network mental health care providers. Enforcing parity is complex partly because a patchwork of federal and state entities are responsible for enforcement and the onus is largely on consumers to file individual claims of discrimination. Federal law should require parity between reimbursement rates for mental health and SUD treatment and those for other health conditions, and work to achieve parity in all forms of health coverage.

Telehealth

The Telemental Health Care Access Act (S. 2061)

Telehealth has served as a lifeline for many during the COVID-19 pandemic, allowing individuals to continue to connect to providers 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 Public Health Emergency (PHE) concludes, one area of significant concern is ensuring continued access to needed mental health services. As we continue to adapt to the new challenges presented to us by the COVID-19 pandemic, we are grateful for the leadership within the Federal government to improve and expand telehealth services during the PHE. We are particularly grateful that, beginning January 1, 2022, Medicare is eliminating many barriers to tele-behavioral health care including elimination of geographic limitations and support for audio-only behavioral 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).

The Telemental Health Care Access Act (S. 2061) 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 accessing mental health care.

Provide Full Support to Implementation of Crisis Response Systems in All States

Behavioral Health Crisis Services Expansion Act. (S.1902)

In the American Rescue Plan (P.L. 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 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 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.

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, we strongly urge 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.

This bill empowers communities to establish a continuum of care for individuals experiencing a mental or behavioral health crisis and requires the establishment of standards. It identifies the minimum components of a system as: crisis call center, mobile crisis response teams, crisis receiving and stabilization facilities and behavioral health urgent care facilities. It also makes changes to Medicare, Medicaid, group health plans and other coverage to mandate coverage for crisis response services.

Thank you again for this opportunity to provide input and for your outstanding leadership and dedication to improving our nation's mental health and substance use treatment systems and efforts to overcome barriers to accessing care that face our nation's most vulnerable populations.

Sincerely,

Debra L. Wentz, Ph.D.
President and CEO