



November 15, 2021

The Honorable Ron Wyden
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
U.S. Senate
239 Dirksen Senate Office Building
Washington, DC 20510

Re: Request for Information on Behavioral Health

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the National Association of Counties (NACo) and the 3,069 counties we represent, thank you for the opportunity to respond to your September 21, 2021 [open letter](#) that requested recommendations on policy options to improve access to health care services for Americans with mental health and substance use disorders. We applaud your leadership on this issue and share your goal of alleviating access barriers to care that exacerbate the rates of untreated mental and behavioral health conditions in the United States, particularly in the aftermath of the ongoing pandemic.

NACo assists county governments in pursuing excellence in public service to produce healthy, vibrant, safe and resilient communities. Counties are integral to the nation's behavioral health system. We act as financial investors and coordinate the provision of behavioral health services within county owned and operated community health facilities. In nearly every state and the District of Columbia, there is at least one mental health facility operated by a county, local or municipal government. Additionally, counties help finance and administer Medicaid services, the largest source of funding for behavioral health services in the United State.

The COVID-19 pandemic greatly exacerbated the rates of unmet behavioral and mental health illness, thereby impacting counties and our residents. Counties have been on the front lines of the pandemic, protecting the health our communities, while also working to mitigate the effects of the pandemic on county resources, services and resident mental health. **Counties are committed to strong intergovernmental partnership to advance policies that provide the resources needed to address the long term behavioral and mental health needs of our residents.**

As we work towards our shared goal of protecting our nation's residents, America's counties offer the following policy recommendations that would enhance behavioral health care:

Strengthen the Behavioral Health Workforce

- ***Incentivize local behavioral workforce development and recruitment, particularly in rural areas.*** According to data from the Robert Wood Johnson Foundation, 30 percent of the nation's population lives in a county designated as a mental health professional shortage area. The U.S. Department of Health and Human Services (HHS) expects this number to grow over the next

decade as the number of providers nationwide is projected to decrease by 20 percent, while demand is anticipated to increase exponentially. The shortage of mental health professionals is especially challenging in rural counties where health care resources, personnel and access barriers are persistent. For example, in Oregon, the ratio of residents to mental health providers can be as large as 640 to 1 in some counties, while in Idaho that number is as large as 5,370 to 1 in certain counties.

NACo supports federal funding for programs and initiatives that both assist with and incentivize the recruitment, training and placement of behavioral health providers that will work within local communities. Specifically, programs like 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

Increase Integration, Coordination and Access to Care

- ***Remove exclusion policies that create barriers to treatment services.*** A federal statute known as the Medicaid Institutions for Mental Diseases (IMD) exclusion currently prohibits Medicaid reimbursement for psychiatric care provided in treatment facilities with more than 16 beds, a policy that has created significant barriers in the provision of county operated inpatient mental health services. As a result of this statute, low-income individuals on Medicaid are often unable to access inpatient mental health services, leading to inequities in access to treatment and care that negatively impacts the health of local communities.

Easing the Medicaid IMD exclusion has been a longstanding behavioral health priority for counties, as it can expand the treatment capacity of county-operated hospitals and behavioral health authorities. The SUPPORT Act ([P.L. 115-271](#)) and new regulatory flexibilities permitted through the use of Section 1115 behavioral health waivers have authorized partial lifts of the IMD exclusion to allow for the treatment of substance use disorders. However, further legislative action is needed to repeal this decades old rule and restore equitable access to mental health treatment and services in local communities.

- ***Provide resources that remove barriers and increase the use of substance use disorder (SUD) drug therapies across a variety of provider settings.*** Medicaid is a vital source of health coverage for individuals suffering with a substance use disorder, paying for approximately one quarter of mental health and substance use disorders in the United States. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), nearly 12 percent of Medicaid beneficiaries over 18 have a substance use disorder.

Medicaid has allowed many states to increase access to medication-assisted treatment (MAT), the most effective treatment for an opioid use disorder (OUD). All state Medicaid programs cover at least one of the three medications—methadone, buprenorphine and naltrexone — used for MAT, and most cover all three. However, despite these advancements, there are still gaps that remain in Medicaid coverage for medications to treat OUD, with 14 states lacking any facility that offers MAT or accept Medicaid coverage for treatment. Additionally, there are persistent use management policies under Medicaid that create barriers to authorization and restrictions on treatment duration and doses.

SUD is heavily concentrated in county jails, with a staggering 63 percent of jail inmates suffering with a substance abuse condition, including OUD. However, [data](#) from the National Academy of Sciences reports that only 5 percent of people with an OUD in jail and prison settings receive medication treatment. Medicaid expansion under the Affordable Care Act has created an opportunity for justice-involved individuals – who are disproportionately low-income – to access health care coverage under the program. However, a federal statute known as the Medicaid Inmate Exclusion Policy (MIEP) prohibits the use of federal funds and services, such as Medicaid, for medical care provided to “inmates of a public institution.” This policy has created significant barriers to the use of MAT in jail facilities, which disproportionately houses both convicted and non-convicted individuals suffering from OUD.

NACo supports the removal of legislative barriers, such as the MIEP, that restricts the ability of local providers to treat SUD through MAT and other means, in various settings.

Improve Reimbursement Mechanisms and Finance Behavioral Health Care Enhancements

- ***Sustained funding for outpatient mental health services, specifically related to the development of local crisis response infrastructures.*** The American Rescue Plan Act provided a 3-year enhanced federal matching rate under Medicaid for states to expand access to mobile crisis intervention services. These services are led by behavioral health professionals and help de-escalate behavioral health crises, while also connecting them to community-based services for treatment. Crisis response services also reduce the fiscal burden of behavioral health crises faced by counties by minimizing emergency department visits and hospitalizations and contributing to lower rates of arrest and incarceration of people with behavioral health conditions, who are disproportionately represented in local jails. For this reason, NACo supports sustained federal funding to support local crisis response infrastructures through Medicaid.

America’s counties appreciate the opportunity to respond to the open letter and urge that the above policy recommendations be included in any future legislation. As intergovernmental partners, we stand ready to work with you to advance policy that will improve and increase equitable access to mental and behavioral health services for all residents. If you have any questions, please feel free to contact Blaire Bryant, NACo Associate Legislative Director, at bbryant@naco.org or at 202.942.4246.

Sincerely,



Matthew D. Chase
Executive Director
National Association of Counties



November 12, 2021

Chairman Ron Wyden
Senate Committee on Finance
221 Dirksen Senate Office Bldg.
Washington, DC 20510

Ranking Member Mike Crapo
Senate Committee on Finance
239 Dirksen Senate Office Bldg.
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is pleased to offer comments in response to the Senate Committee on Finance's request for information on behavioral health care. As the country's single largest payer for behavioral health services, Medicaid is uniquely positioned to address gaps in our systems of care for mental health and substance use. NAMD encourages the Committee to give state Medicaid programs additional tools to improve the accessibility, affordability, and quality of behavioral health care.

Specifically, we recommend that Congress:

- **Repeal the IMD exclusion**, an outdated provision that unduly limits access to medically necessary intensive inpatient care
- **Allow states to provide Medicaid coverage for incarcerated individuals within 90 days of release**, lowering the risk of behavioral health crises during re-entry
- **Lift the prohibition on Medicaid paying directly for room and board costs** associated with evidence-based behavioral health services
- **Address urgent workforce shortages** by allowing states to claim federal match on training programs and by providing federal resources to support sustainable rate increases
- **Ensure that telehealth services are high-quality and accessible** while preserving access to in-person care where appropriate
- **Build robust crisis continuums** by creating clear Medicaid reimbursement structures for 988 hotlines and providing ongoing funding for mobile crisis teams and crisis stabilization centers
- **Better integrate primary care and behavioral health care** by removing regulatory barriers and promoting coordination
- **Meet the unique needs of children and young adults** by addressing workforce gaps and funding new models of care

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Medicaid's Role in the Behavioral Health Care System

Today, Medicaid covers approximately one in four Americans.¹ Medicaid members have a diverse range of experiences, but do, as a whole, have significant behavioral health needs: 28 percent of adults covered by Medicaid have a mental illness, as compared to 19 percent of adults with private insurance.² As the nation's primary source of coverage for low-income people and people with disabilities, Medicaid also often serves individuals with complex behavioral health, physical health, and social needs. Effectively meeting these needs requires holistic interventions that cut across our country's siloed systems of care.

As the single largest payer for behavioral health services in the United States,³ Medicaid is uniquely positioned to address gaps in our systems of care for mental health and substance use. NAMD encourages the Committee to give state Medicaid programs additional tools to improve the accessibility, affordability, and quality of behavioral health care.

Strengthening Medicaid's Ability to Address Behavioral Health

In addition to the Committee's specific areas of interest, which are discussed in detail below, NAMD has identified overarching opportunities for Congressional action.

Specifically, we recommend that Congress:

- **Repeal the IMD exclusion.** The institutions for mental diseases (IMD) exclusion prohibits Medicaid from paying for care provided in residential treatment centers with more than 16 beds, representing a major barrier to treatment access. Since the IMD exclusion's enactment in 1965, the nation's understanding of mental health and addiction has evolved significantly and states have shifted away from institutional models of care, instead developing robust community-based options. However, residential care is sometimes clinically necessary, and the IMD exclusion prevents states from effectively providing this care. The negative impacts of the exclusion span the behavioral health system: it has hindered states' efforts to use Qualified Residential Treatment Programs (QRTPs) to improve their child welfare systems, limits the ability of Medicaid to fund residential care for substance use, and disproportionately impacts treatment access in rural communities that lack wide provider networks. Repealing the exclusion would significantly expand access to services for Medicaid members and ensure the full continuum of service needs are met.

¹ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

² <https://www.macpac.gov/wp-content/uploads/2020/09/Behavioral-Health-in-Medicaid-Work-Plan-and-Initial-Analyses.pdf>

³ <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf>

- NAMD recognizes that the history of institutionalization creates concerns about a potential return to the conditions that led to the creation of the IMD exclusion. To mitigate these concerns and firmly situate IMDs within a full care continuum, Congress could consider establishing quality of care and programmatic standards that ensure members are placed in the least restrictive settings that meet their clinical needs and that stays in institutions are short-term; require states to maintain full continuums of care with robust community-based options; and institute mechanisms to ensure providers deliver care that meets national standards. Such requirements align with those established within current 1115 demonstration waivers allowing IMD coverage in certain circumstances for individuals with substance use disorders or serious mental illnesses.
- **Allow states to provide Medicaid coverage for incarcerated individuals within 90 days of release.** People who are re-entering from incarceration are at significantly higher risk of drug overdoses and other behavioral health crises in the weeks following their release. The option of pre-release coverage allows states to coordinate care, create pathways to services in the community, and prevent gaps in medication access. Together, these efforts can lower the risk of overdose, recidivism, and other negative outcomes.
- **Lift the prohibition on Medicaid paying directly for room and board costs associated with evidence-based behavioral health services.** A lack of stable housing is a major barrier to recovery for many people with behavioral health conditions. Currently, Medicaid is only able to pay for room and board in institutional care settings like nursing homes. This severely limits states' abilities to provide evidence-based interventions like permanent supportive housing that holistically address members' behavioral health needs, along with residential treatment modalities.
- **Create new authorities or modify existing authorities to allow fee-for-service Medicaid delivery systems to provide wrap-around services for behavioral health.** Wrap-around services, such as housing, employment, and family supports, can be crucial elements of behavioral health treatment plans. Currently, states with managed care delivery systems can use mechanisms like directed payments and in lieu-of services to provide these supports to their Medicaid members. Fee-for-service delivery systems should be granted these same flexibilities to ensure equitable access to services across states.

Building a Strong Workforce

States identify workforce shortages as one of the biggest – if not the biggest – challenges facing their behavioral health care systems. Although these issues span the continuum of care, states identified acute shortages among specific provider types (including psychiatrists, social workers, and psychiatric nurse practitioners), multi-lingual providers, and Black/Latino providers. These shortages are compounded by financial

and regulatory barriers that discourage provider participation in Medicaid and CHIP, threatening the ability of Medicaid members to access behavioral health care.

Increasing Medicaid reimbursement rates to be more competitive with commercial rates is an important first step in addressing these challenges. However, we encourage Congress to craft a broader strategy to recruit, train, and retain behavioral health care providers, with a specific focus on diversifying the workforce and ensuring access in rural and underserved communities. We also encourage Congress to address the barriers (including lower reimbursement rates, higher administrative burdens, and higher rates of no-shows) that reduce provider participation in Medicaid and CHIP.

Specifically, Congress could:

- **Allow states to generate federal match on workforce training programs,** including programs focused on developing career paths for peers and community health workers. This would give states the financial resources they need to create strong pipelines to careers in behavioral health. Alternatively, Congress could establish other funding models like grants to support the development of training programs.
- **Diversify the types of providers in the behavioral health workforce by creating incentives for the use of peer support professionals, community health workers, and health navigators and create pathways for these workers to become licensed providers.** These direct support professionals can fill existing gaps in care and create a more stable and resilient workforce. Congress should also create pathways for these types of workers to become licensed providers.
- **Expand scholarship and loan forgiveness programs and create incentives for practicing in rural or underserved communities.** Scholarship and loan forgiveness programs should explicitly aim to increase the number of multilingual and Black/Latino providers. Congress should also consider providing financial incentives like loan forgiveness programs, increased reimbursement rates, and tax credits to providers who agree to practice in rural or underserved communities.
- **Reduce administrative burdens associated with Medicaid and CHIP participation.** This could include loosening documentation requirements like treatment planning, simplifying processes for enrolling as a Medicaid provider, and providing greater flexibility in reimbursement structures to allow for case rates or bundled payments for multiple services.

Developing Robust Continuums of Crisis Services

Adults with mental illness who are covered by Medicaid are significantly more likely to be involved in the justice system than those who are privately insured,⁴ highlighting the need for robust crisis intervention services. Recent Congressional actions, including the American Rescue Plan's state option for mobile crisis response teams and the designation of 988 as the nation's crisis hotline, have created new opportunities to build out these services. However, states report ongoing regulatory, financial, and operational barriers to developing full continuums of crisis care.

Specifically, we encourage Congress to:

- **Create clear Medicaid reimbursement structures for 988 hotlines.** Although Medicaid members will undoubtedly utilize 988 hotlines, it is unrealistic to expect hotline workers to gather a person's insurance information while they are experiencing a behavioral health crisis. In order to effectively plan for 988 implementation, states need additional information on Medicaid's approach to reimbursement. Congress should also develop ways to ensure that commercial payers cover their fair share of 988 operating costs, as telecommunications fees and Medicaid reimbursements are unlikely to cover the full costs of operating these hotlines.
- **Create ongoing federal investments in mobile crisis teams.** The American Rescue Plan created new opportunities for states to fund mobile crisis teams through their Medicaid programs. Congress and federal agencies should work with commercial payers and other stakeholders to develop sustainable funding models beyond Medicaid, along with ensuring long-term fiscal support for Medicaid's role in providing these services.
- **Exempt crisis stabilization centers from the IMD exclusion.** Crisis stabilization centers provide short-term residential care to people experiencing behavioral health emergencies, preventing clinically inappropriate and costly stays in emergency rooms and jails. These stays last no longer than 72 hours. As states look to develop their crisis stabilization continuums by creating these settings, there is a risk that the IMD exclusion's 16-bed cap will inhibit the scalability of these services. This challenge is particularly acute in rural communities with limited provider networks. Even if Congress does not repeal the IMD exclusion, NAMD believes that crisis stabilization centers – which, by definition, provide short-term stays – are not the types of institutions that Congress intended to exclude from Medicaid coverage.

Notably, building out a strong continuum of behavioral health services is crucial to ensuring the success of crisis response interventions. Without accessible treatment options, hotlines and crisis teams have nowhere to divert patients. NAMD strongly

⁴ <https://www.macpac.gov/wp-content/uploads/2020/09/Behavioral-Health-in-Medicaid-Work-Plan-and-Initial-Analyses.pdf>

encourages Congress to consider investments in treatment system capacity as a crucial aspect of developing crisis response systems.

Integrating Behavioral Health and Primary Care

Our country's health care system is fragmented, which can make accessing behavioral health services complex and confusing. To address this, we must "meet people where they are" by providing behavioral health assessments, treatment, and care coordination in the places people already go for help. As the nation's largest platform for health care delivery, primary care settings are a key site for this type of integration.

To promote behavioral health and primary care integration, Congress could:

- **Provide comprehensive education on integrated models of care for health care professionals**, including physicians, registered nurses, physician assistants, psychiatric nurse practitioners, social workers, and other providers.
- **Remove regulatory barriers that restrict access to medications for opioid use disorder in primary care settings.** Strict regulations on the provision of methadone restrict the ability of primary care providers to treat opioid use disorder. Congress should also lift the X waiver requirement for buprenorphine prescribing. Together, these actions would facilitate the integration of addiction treatment services into primary care, greatly expanding access to treatments for opioid use.
- **Promote the adoption of electronic health records/electronic medical records by behavioral health providers.** Behavioral health providers were initially excluded from HITECH funds, which slowed the adoption of electronic health records and electronic medical records. This has made coordination between provider types more difficult. Congress should provide additional funding targeted at the behavioral health provider- or clinic-level to support the adoption of interoperable and integrated systems. This could potentially include re-appropriation of HITECH funds with the inclusion of behavioral health providers to correct their initial exclusion from these funds.
- **Evaluate data sharing restrictions and other regulatory barriers that restrict integration.** The Coronavirus Aid, Relief, and Economic Security (CARES) Act included data sharing provisions that better align 42 CFR Part 2 with HIPAA. However, HHS is still developing the final rules,⁵ so it is unclear how these changes will impact data sharing, and states report that many providers lack a strong understanding of what data sharing is allowable even under current law. The federal government should evaluate these questions and provide clear guidance to providers. Additionally, Congress should evaluate if there are regulatory barriers in Medicaid reimbursement policy that may restrict integration.
- **Launch Center for Medicare & Medicaid Innovation (CMMI) models** aimed at integrating behavioral health care and primary care for Medicaid members.

⁵ <https://www.samhsa.gov/newsroom/statements/2021/42-cfr-part-2-amendments-process>

As we build capacity in the primary care system to address behavioral health, it is also important to increase the accessibility of specialty care for people with severe and persistent mental illnesses or substance use disorders. Certified Community Behavioral Health Clinics (CCBHCs), which provide timely access to care and robust coordination with social services and the justice system, may be a particularly valuable model for these patients, although many models of specialty care exist.

It is also important to note that the US territories face unique challenges providing behavioral health services, including critical shortages of providers and lack of telehealth access. Congress should consider dedicated funding to build out behavioral health care systems in the US territories, along with addressing the longstanding fiscal challenges⁶ faced by the territories' Medicaid programs.

Ensuring that Telehealth Services are High-quality and Accessible

The COVID-19 pandemic dramatically accelerated the uptake of telehealth for behavioral health services. The quality and cost-effectiveness of telehealth relative to in-person care is not yet clear, and we support ongoing research to explore these questions. However, most states report that telehealth appears to increase access to care and retention in services and is generally acceptable to patients.

It is crucial to ensure that the widespread adoption of telehealth does not create new disparities in behavioral health care access. States emphasize the need to close the “digital divide” and ensure that both providers and Medicaid members have access to the technology needed for telehealth services. Telehealth is also not an appropriate or preferred model of care for all patients (for example, people who are experiencing intimate partner violence, participants in group therapy, or patients who are not comfortable using computers or smartphones), so it is essential that in-person options also remain accessible.

To accomplish these aims, Congress could:

- **Allow Medicaid to fund broadband connectivity, along with room and board.** It is very challenging for Medicaid members who lack internet connectivity and stable housing to access telehealth. Funding broadband connectivity and lifting the prohibition on Medicaid paying for room and board costs associated with evidence-based behavioral health services can help prevent new disparities in access to behavioral health care.
- **Provide long-term federal funding for technology and broadband connectivity.** Additional federal funding (such as long-term Federal Communications Commission funding) for broadband connectivity and technological devices is crucial to ensuring patient access. Funds should also

⁶ <https://medicaiddirectors.org/wp-content/uploads/2019/11/50-copies-NAMD-Territory-Survey.pdf>

support providers who are seeking to adopt telehealth modalities, with an emphasis on smaller providers who may lack the funds to pay for these systems.

- **Fund ongoing research into the effectiveness of telehealth for various behavioral health interventions.** The relative effectiveness of telehealth for different models of behavioral health care and different patient populations remains unclear. Congress should fund ongoing research into best practices.
- **Develop reimbursement models that incentivize providers to offer both in-person and telehealth options.** States emphasize that providing in-person care can be associated with additional long-term costs to providers, including overhead costs. Increased reimbursement rates or other financial incentives may encourage behavioral health providers to continue providing multiple modalities of care.

Meeting the Unique needs of Children and Young People

Children and young people face different behavioral health challenges than adults, and Congress should consider distinct approaches to improve the accessibility and quality of care for this population. States report a critical shortage of providers specializing in children's behavioral health, which is compounded by a lack of treatment availability after school or work hours. As in the adult system, enhancing reimbursement rates, creating additional loan forgiveness programs and scholarships, and offering career development opportunities is essential to addressing these shortages. In addition, Congress should specifically consider the needs of young people with co-occurring intellectual and developmental disabilities (IDD) and mental health conditions.

States also emphasize the unique care coordination needs of children and young people. Caregiver or family involvement is critical, and young people are more likely to be involved in multiple systems (including education, child welfare, and the juvenile justice system). In these cases, providing effective treatment often requires a care coordination team or providers who are well-versed in working across systems. Congress should develop reimbursement structures that incentivize this type of care coordination, and clear guidelines for braiding funding across these different systems.

Specifically, Congress should:

- **Develop treatment options for young people with co-occurring IDD and mental health conditions.** States emphasize the lack of treatment options for these young people, who are generally served through Medicaid waiver programs. Congress should convene experts to develop new models of care for this patient population.
- **Address ongoing challenges implementing QRTPs.** QRTPs, which were created by the Family First Act, are a type of setting that provides behavioral health services to young people in foster care. States face challenges implementing this care model due to the IMD exclusion, which prohibits states

from using federal Medicaid funds for mental health facilities with more than 16 beds.

- **Incentivize states to enhance Medicaid reimbursement rates for providers who specialize in children’s behavioral health**, and fund scholarships, loan forgiveness programs, and training programs to build a stronger workforce. Congress should also consider specific career development opportunities for peer support specialists, peer family specialists, community health workers, and non-clinical professionals.
- **Develop CMMI models or provide other dedicated funding to help states build cross-system relationships.** Care coordination across health care, juvenile justice, child welfare, and education systems is essential to providing holistic care to young people. Federal agencies should also provide clear guidelines for braiding federal funding sources across these systems.
- **Fund ongoing research specifically into the safety and efficacy of telehealth for children’s behavioral health issues.** There are additional considerations associated with providing telehealth to children, including issues of consent and challenges recognizing child abuse. As part of a broader research effort, Congress should create dedicated funding for studying the use telehealth in children’s behavioral health services.

Addressing the behavioral health needs of our country will require sustained efforts and creative solutions that cut across providers, payers, and systems. Medicaid is uniquely positioned to help drive these improvements. NAMD appreciates the opportunity to provide these comments to the Committee and looks forward to working together to improve our country’s behavioral health care system.

Sincerely,



Jami Snyder
NAMD President
Director
Arizona Health Care
Cost Containment System



Allison Taylor
NAMD President-Elect
Director of Medicaid
Indiana Family and
Social Services Administration



October 25, 2021

The Honorable Ron Wyden, Chairman
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D. C. 20510

The Honorable Mike Crapo, Ranking Member
U. S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Chairman Wyden and Senator Crapo:

The National Association of Mental Health Program Directors (NASMHPD)—the organization representing the state executives responsible for the \$41 billion public mental health service delivery systems serving 7.5 million people annually in 50 states, 5 territories, and the District of Columbia—is writing in response to the request for information on legislative, evidence-based solutions to enhance behavioral health care. NASMHPD is very thankful for the opportunity to provide solutions in the areas of increasing integration, coordination, and access to care, as well as strengthening the workforce.

Increasing Integration, Coordination, and Access to Care

State Mental Health Authority priorities at this time focus on improving and building the crisis continuum. NASMHPD is concerned that building the crisis continuum may not be done in time for the implementation of the 988 national crisis lifeline in July 2022 if funding is not increased for states to be adequately prepared. This increased funding would provide sustainable funding for the call centers, mobile crisis units, and the crisis receiving/stabilization programs in the community. Crisis services are essential to providing individuals the best care and support while diverting away from unnecessary higher levels of care and jail.

NASMHPD is urging support for the passage of the Behavioral Health Crisis Services Act (S.1902), as well as a companion bill in the Senate to the House bill (H.R. 4035), the Crisis Enhancement Act. The Behavioral Health Crisis Act helps to expand funding for the entire crisis continuum, while the Crisis Enhancement Act increases the Mental Health Block Grant (MHBG) crisis care set-aside to 10%. Both of these legislative measures greatly help states build their funding for these very needed services that will expand access and care for all who are in behavioral health crisis. Currently, Senate Appropriations has recommended a continued 5% set-aside in the MHBG. States must have more sustainable funding to build the nationwide crisis services continuum.

Additionally, because many individuals, perhaps the vast majority, who utilize the suicide prevention lifeline have neither a prior mental illness diagnosis, nor any previous contact with the public mental health system, NASMHPD urges the continuation of the waivers provided in the Labor/HHS Appropriations provisions. These provisions entail the financing of the crisis care set-aside waive the statutory requirements limiting MHBG programming to persons with serious mental illnesses and children with serious mental and emotional disturbance.

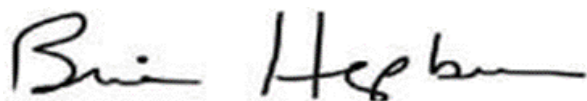
Strengthening the Workforce

NASMHPD recognizes and supports peer support specialists as key contributors to behavioral health integrated teams of care. Peer support specialists are providers with lived experience of a mental health or substance use disorder who have specialized training and certification to deliver support services under appropriate state or national certification standards. And, with the increasing workforce shortages, it's even more vital now to utilize these specialized providers as much as possible. NASMHPD urges the support and passage of the Promoting Effective and Empowering Recovery Services (PEERS) Act, S.2144, to create the ability to reimburse peer support under

collaborative care and other behavioral health integration codes in Medicare. Older persons are needing more support in this challenging time with the public health emergency and increasing loneliness and isolation as a result. The states need this help to continue to combat the behavioral health crisis as well as the critical shortage in the behavioral health workforce.

Again, thank you for the opportunity to provide solutions to the growing need for behavioral health services nationwide and we look forward to working with you on these endeavors.

Sincerely,



Brian M. Hepburn, M.D.

Executive Director

National Association of State Mental Health Program Directors (NASMHPD)



National Association of County Behavioral Health and Developmental Disability Directors



National Association for
Rural Mental Health

November 8, 2021

The Honorable Ron Wyden
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
U.S. Senate
239 Dirksen Senate Office Building
Washington, DC 20510

Re: Request for Information on Behavioral Health

Dear Chairman Wyden and Ranking Member Crapo,

The National Association of County Behavioral Health and Developmental Disability Directors represents more than 750 county mental health, substance use, and developmental disability directors and their programs throughout the US. These programs serve as the behavioral health safety net for more than 45% of the US population.

We write in response 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.

Workforce

Over 130 million Americans live in areas with a shortage of mental health providers.¹ This shortage is expected to grow over the next decade with the number of providers projected to decrease by 20% while demand increases.²

The COVID-19 pandemic exposed many discrepancies between behavioral health and intellectual and developmental disability (I/DD) workers and the broader health care workforce. For example, 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.

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.

¹ *Shortage Areas*, Health Resource and Services Administration 2021

² *Health Workforce Projections*, Department of Health and Human Services, Health Resources and Services Administration.
<https://bhwr.hrsa.gov/data-research/review-health-workforce-research>

Congress should also fund initiatives aimed at better supporting people with lived experience building careers in the mental health and substance use treatment workforce. Funding for peer certification, education, and training should be prioritized as a part of a broader health workforce development agenda.

Increasing Integration, Coordination, and Access to Care

Advancing integration, coordination, and overall access to behavioral health care requires coordination between several sectors including public safety, education, social services, and behavioral health. It also requires the recognition 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 are non-profit organizations or units of a local behavioral health authority that provide a comprehensive set of services including 24-hour crisis care, case management, and peer support. Currently there are 340 CCBHCs in 40 states serving an estimated 1.5 million people.³

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. Currently only 10 states participate in this program while those in other states are eligible for grant monies. We strongly encourage the Committee to support the Excellence in Mental Health and Addiction Treatment Act of 2021 that would expand the Medicaid demonstration program nationwide.

Telehealth

Telehealth is an effective tool to help Americans, especially ones living in rural areas, to access behavioral health care. According to a recent Inspector General report states who have done evaluations of telehealth have found that it has increased access and reduced costs including reduced savings of \$484,000 in transportation costs.⁴

As demand for telehealth services increase it is essential that Congress continue to invest in the infrastructure that supports these services including expanding high-speed broadband and providing technical support and assistance to providers to adopt telehealth. Congress should also permanently authorize the expanded use of telehealth to induct new patents onto needed medications and provide on-going counseling. They should also allow Medicare reimbursement for audio-only service delivery to ensure all people have access to care given the challenges some face in accessing audio-visual technologies.

Thank you again for the opportunity to share our views with the Committee. We applaud your leadership on this issue and offer ourselves as a resource going forward.

Sincerely,



Jonah C. Cunningham
President and CEO
NACBHDD and NARMH

³CCBHC 2021 Impact Report, the National Council for Mental Wellbeing, 2021

⁴ Opportunities Exist to Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid, Office of Inspector General. 2021.