

November 10, 2022

RE: Enhancing the Mental Health Workforce Discussion Draft

Dear Chair Wyden, Ranking Member Crapo, Senator Stabenow, and Senator Daines,

The undersigned 61 organizations want to begin by thanking you and the rest of the Senate Finance Committee for your ongoing efforts to address the mental health (MH) and substance use disorder (SUD) workforce crisis. We are leading organizations working to advance MH and SUD care and applaud the release of the [Enhancing the Mental Health Workforce discussion draft](#). **We write today to recommend that you (1) clarify the bill’s language to ensure that Medicare beneficiaries with a primary diagnosis of SUD or no co-occurring MH condition can access the critical services they need and (2) resolve other barriers that prevent the MH and SUD workforce from meeting its full potential.** We also have some additional recommendations that we hope you will include in future legislation.

Amidst the ongoing opioid public health emergency and at a time when over 100,000 individuals have died from overdoses in the past year,¹ only 11% of Medicare beneficiaries with SUD are able to access the SUD treatment they need.² During 2021, fewer than 1 in 5 of the 1.1 million Medicare beneficiaries with an opioid use disorder (OUD) received medications for OUD, and approximately 50,400 Medicare Part D beneficiaries experienced an overdose.³ Of Medicare beneficiaries with a SUD who receive behavioral health services, only 20% of those behavioral health services are actually delivered by behavioral health specialists.⁴ We applaud your work thus far, and appreciate any additional ways you can strengthen access to MH and SUD care.

I. Recommendations on the Workforce Discussion Draft

A. Section 11: Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services Under Part B of the Medicare Program

1. Explicitly Authorize Otherwise Qualified SUD Counselors in the Medicare Program

MH workforce legislation must recognize that the workforce that treats SUD overlaps with, but is also distinct from, MH professionals. For example, while Medicare defines mental illness to include SUD, some States separately license or certify SUD counselors, and thus they must be explicitly included in legislation to meet the needs of the millions of Medicare beneficiaries with a primary diagnosis of SUD or no co-occurring MH condition. We view such important

¹ National Center for Health Statistics, “Provisional Drug Overdose Death Counts,” Centers for Disease Control and Prevention (accessed Sept. 30, 2022), <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

² William J. Parish, et al., “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers,” *American Journal of Preventative Medicine* 225-232 (Aug. 2022), <https://www.sciencedirect.com/science/article/abs/pii/S0749379722001040>.

³ U.S. Dep’t of Health & Human Services Office of Inspector General, “Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue to be Concerns for Medicare Beneficiaries” (Sept. 2022), <https://oig.hhs.gov/oei/reports/OEI-02-22-00390.pdf>.

⁴ U.S. Government Accountability Office, “Medicare: CMS Should Provide Beneficiaries More Information about Substance Use Disorder Coverage” 15 (May 2020), <https://www.gao.gov/assets/gao-20-408.pdf>.

clarifications as consistent with what we understand to be the intent of the Committee – that is, to increase access to community-based counseling by non-physician practitioners and to help ameliorate the MH workforce crisis. While we support the Committee’s proposal to authorize coverage of Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) under Part B of the Medicare program, **we respectfully ask the Committee to amend the definition of “mental health counselor” in the proposed 42 U.S.C. 1395x(III)(4) to authorize coverage of practitioners who are licensed or certified as substance use disorder counselors and otherwise meet the proposed criteria.** In its report on Mental Health Care in the United States: A Case for Federal Action, the Committee already recognized that the behavioral health workforce includes these types of providers.⁵

Suggested language (amendments in bold):

(4) MENTAL HEALTH COUNSELOR.—The term ‘mental health counselor’ means an individual who—

*(A) possesses a master’s or doctor’s degree in mental health **or substance use disorder** counseling or a related field;*

*(B) after obtaining such a degree has performed at least 2 years of supervised mental health **or substance use disorder** counselor practice; and*

*(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor, ~~or~~ professional counselor, **substance use disorder counselor, alcohol and drug counselor, or addiction counselor** in such State.*

We also note that, in Section 13, the bill separately defines “specified health services” to include persons with a SUD diagnosis as well as those with a MH diagnosis, further suggesting the intent of this legislation is to ensure sufficient access to both MH and SUD treatment services for Medicare beneficiaries. Within Section 13, we recommend the Committee use consistent language in the proposed 42 U.S.C. 1395l(m)(5)(A) and (5)(B) to ensure that specified health services include those furnished for purposes of diagnosis, evaluation, and treatment of a mental health or substance use disorder. The proposed language could be construed to include only treatment for individuals with a diagnosed SUD and not the necessary diagnosis and evaluation services that are covered for other MH conditions.

2. Set Non-Discriminatory Reimbursement Rates

We also recommend that the Committee revise the proposed reimbursement rate standard (80% of the lesser of the actual charge for the services or 75% of the amount determined for payment of a psychologist) to be, at the very minimum, comparable to those for non-physician practitioners on the medical side. Non-physician medical practitioners are reimbursed at 80% of the lesser of the actual charge or 85% of the physician fee schedule. As the Committee tries to

⁵ United States Senate Committee on Finance, “Mental Health Care in the United States: The Case for Federal Action” 8 (Mar. 2022), <https://www.finance.senate.gov/imo/media/doc/SFC%20Mental%20Health%20Report%20March%202022.pdf>.

remedy issues in the Social Security Act that perpetuate discrimination against individuals with MH and SUD – and to fight the ongoing workforce shortage, MH crisis, and opioid public health emergency – **we urge the Committee to set adequate rates for MH and SUD practitioners that are on par with those for medical practitioners.**

Furthermore, although the proposed Section 12 will increase access to clinical social worker (CSW) services, **we encourage the Committee to resolve this discriminatory reimbursement rate percentage decrease for CSWs as well to promote the greatest possible access to MH and SUD care for Medicare beneficiaries.** According to CMS, behavioral health providers make up the largest share of providers that opt-out of Medicare (43%).⁶ It is necessary to establish adequate reimbursement rates to incentivize CSWs and other MH and SUD providers to join and remain active in the Medicare program so beneficiaries can access the treatment they need without the undue burden of going out-of-network and paying out-of-pocket.

B. Section 17: Distribution of Additional Residency Positions in Psychiatry and Psychiatry Subspecialties

There are roughly 41.1 million people who need treatment for SUD in the United States.⁷ While there are shortfalls at all levels, one of the most serious is among addiction medicine fellowships accredited by the Accreditation Council for Graduate Medication Education (ACGME). Currently, there are only 92 ACGME-accredited addiction medicine fellowship programs in the nation⁸ – far below the recommended goal of 125 fellowships by 2022 set by the President’s Commission on Combating Drug Abuse and the Opioid Epidemic five years ago.⁹ Addiction medicine and addiction psychiatry fellowships are critical to ensuring that adults and adolescents have access to specialty SUD treatment.

The Committee’s legislation currently proposes adding new physician residency positions funded by Medicare to teaching hospitals for training new physicians in psychiatry and psychiatry subspecialties. **To ensure inclusion of critical psychiatry subspecialties, including multispecialty addiction medicine¹⁰ and addiction psychiatry, we respectfully request amending the proposed 42 U.S.C. 1395ww(h)(10)(F)(ii) to read as follows:**

⁶ Chris Larson, “43% of Medicare Opt-Outs are Behavioral Health Providers,” Behavioral Health Business (Apr. 26, 2022), <https://bhbusiness.com/2022/04/26/43-of-medicare-opt-outs-are-behavioral-health-providers/>.

⁷ SAMHSA, “Highlights for the 2020 National Survey on Drug Use and Health,” (Oct. 2021), https://www.samhsa.gov/data/sites/default/files/2021-10/2020_NSDUH_Highlights.pdf.

⁸ “Accredited Addiction Medicine Fellowships,” American College of Academic Addiction Medicine (ACAAM) (accessed Oct. 3, 2022), <https://www.acaam.org/fellowship-training>.

⁹ “Final Report,” The President’s Commission on Combating Drug Addiction and the Opioid Crisis (Nov. 1, 2017), https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf.

¹⁰ On ACGME’s website, “addiction medicine” is listed under “psychiatry subspecialties”. “Psychiatry,” Accreditation Council for Graduate Medical Education (accessed Oct. 3, 2022), <https://www.acgme.org/specialties/psychiatry/overview/>. While some psychiatrists may further train in *multispecialty* addiction medicine, board certification in the medical subspecialty of addiction medicine is through the American Board of Preventive Medicine, not the American Board of Psychiatry and Neurology. Thus, to ensure inclusion of addiction medicine in the proposed legislation, it should explicitly mention “addiction medicine.” In a recent final rule, CMS explicitly stated that “the subspecialties of Psychiatry include . . . *multispecialty addiction medicine*” for the avoidance of doubt. “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals,” 86 Fed. Reg. 73416, 73439 (Dec. 27, 2021).

(ii) – *PSYCHIATRY OR PSYCHIATRY SUBSPECIALITY RESIDENCY* - The term ‘psychiatry or psychiatry subspecialty residency’ means a residency in psychiatry, addiction medicine, addiction psychiatry, child and adolescent psychiatry, consultation-liaison, or geriatric psychiatry as accredited by the Accreditation Council for Graduate Medical Education for the purpose of preventing, diagnosing, and treating mental health or substance use disorders.¹¹

C. Medicaid and CHIP Provisions (Sections 21 and 22)

We support the Committee’s proposals to increase MH and SUD provider capacity under the Medicaid program as well as provider education, training, recruitment, and retention, especially with the focus on reimbursement and networks. Recognizing that reimbursement rate setting and network design are non-quantitative treatment limitations (NQTLs) under the Parity Act, **we urge the Committee to include a requirement under the proposed Section 21 that States participating in the demonstration project conduct the appropriate Parity Act analysis and document their compliance for the Medicaid and CHIP plans using standard templates and data collection processes, developed by CMS to ensure comprehensive analysis.** State analyses should be included in the annual report requirements under subsection (6).

Additionally, we recommend that Section 22 require the Secretary of Health and Human Services (HHS) to issue updated guidance biennially to States on how to conduct and demonstrate Parity Act compliance for these key NQTLs and describe common NQTLs that CMS has identified in State programs, which limit access to MH and SUD care in violation of the Parity Act. CMS has not issued public guidance on Parity Act compliance in Medicaid and CHIP since its [2017 toolkit](#) and has never issued a report on State compliance. Such guidance by the Departments of Labor, HHS, and Treasury for private health plan compliance has proven invaluable to improve health plan coverage and for enforcement purposes. Improving Parity Act enforcement in Medicaid is a critical step to improve recruitment and retention of MH and SUD providers.

D. GAO Report on Workforce Barriers to Care for Beneficiaries with SUD

Another cost-efficient way to improve the workforce is to request a report from the Government Accountability Office that would identify and ameliorate barriers to MH and SUD treatment for Medicare beneficiaries with SUD. We recommend that such a report include, at a minimum, an analysis of:

- The policies and practices in Medicare for MH and SUD services that are more restrictive than, and not comparable to, those used for medical and surgical services – including those imposed by Medicare Administrative Contractors and Medicare Advantage and Part D Plans – and the steps necessary to achieve true parity in Medicare;

¹¹ According to ACGME’s website, the following areas of medicine are also listed as “psychiatry subspecialties”: brain injury medicine, forensic psychiatry, hospice and palliative medicine, and sleep medicine. The undersigned defer to lawmakers as to whether any of these should also be included in this legislation. “Psychiatry,” Accreditation Council for Graduate Medical Education (accessed Oct. 3, 2022), <https://www.acgme.org/specialties/psychiatry/overview/>. The undersigned also support the Opioid Workforce Act (S. 1438).

- The providers and overall workforce that currently provides prevention, diagnosis, and treatment for individuals with SUD, the settings in which those providers practice, whether those providers and facilities are covered by Medicare, and what would be a fair and appropriate reimbursement rate for them to meet the needs of Medicare beneficiaries;
- The standards and conditions of participation that would be necessary to authorize community-based substance use disorder treatment facilities in Medicare; and
- The levels of care in the American Society of Addiction Medicine (ASAM) Criteria¹² for the treatment of SUD for which there is currently not a specific benefit (intensive outpatient and residential treatment) and what policy changes would be needed to make these services available to Medicare beneficiaries, or how existing codes (such as the bundled codes for SUD coordination and counseling and the OTP benefit) can meet those service levels. There should be further analysis on the current state of the partial hospitalization (PHP) benefit and whether the covered services being provided to Medicare beneficiaries with SUD are consistent with the ASAM Criteria and what changes may be necessary to ensure that this evidence-based treatment is available and accessible to beneficiaries.

II. Recommendations for Future Legislation to Resolve Other Barriers to MH/SUD Treatment in Medicare

We thank the Committee for its discussion drafts on youth mental health, telehealth, and the workforce, and we appreciate the ongoing efforts to increase integration, coordination, and access to care and ensure parity between behavioral and physical health care. To truly address the workforce issues, the Committee must resolve other barriers to MH and SUD treatment in Medicare that prevent the workforce from meeting its full potential. Further, in order to truly integrate MH and SUD treatment with physical healthcare, it is necessary to get baseline and non-discriminatory coverage of MH and SUD services, settings, and providers. We recognize that the Committee may need to work on these issues in a future Congress, and we would be happy to work with Members and staff to help make MH and SUD treatment truly available and accessible to Medicare beneficiaries.

A. Authorize Medicare Coverage of Freestanding Community-Based SUD Treatment Facilities

Due to the long history of segregating SUD treatment from medical care, and even MH care, many SUD services are still delivered in freestanding community-based SUD treatment facilities. These settings are often licensed and certified by the States in which they are located to deliver SUD treatment and staffed by SUD professionals and paraprofessionals. These locations are where many individuals with SUD currently seek treatment, and we need to meet those patients – and their providers – where they are, especially in Black, Indigenous, people of color (BIPOC) communities to address long-standing health disparities. Currently, only 42% of facilities that offer SUD treatment accept Medicare because of this authorization gap, which is starkly different than other health care financing systems: 74% accept private health insurance, 71% accept

¹² American Society of Addiction Medicine (ASAM) Criteria, <https://www.asam.org/asam-criteria>.

Medicaid, and 49% accept other state-financed health insurance.¹³ **We urge the Committee to authorize Medicare coverage of freestanding community-based SUD treatment facilities as a permissible setting for the full continuum of SUD and co-occurring MH services, including early intervention, outpatient, intensive outpatient, partial hospitalization, and residential services.** It is vital to ensure that these facilities – where individuals can step up and step down in service intensity as needed – are available to support continuity of care and allowing beneficiaries to get the best possible care in the least restrictive setting.

B. Ensure Medicare Beneficiaries Can Access PHP and IOP Services for SUD under any Legislation Expanding Access to IOP Services for MH

Medicare covers the least intensive and most intensive types of treatment but fails to cover intermediate levels of care for beneficiaries with MH and SUD (other than partial hospitalization (PHP) services for beneficiaries with a MH diagnosis). The House Ways & Means Committee has recently released a Committee Print to amend the definition of PHP services to establish coverage of intensive outpatient (IOP) services under Medicare. While the proposed language is a good start for expanding access to IOP services for individuals with MH conditions, it falls short of making IOP and PHP truly available to Medicare beneficiaries with SUD since freestanding community based SUD facilities are not included. **We urge the Committee to take up the IOP bill and, at a minimum, include a directive to the Centers for Medicare and Medicaid Services (CMS) to revise its regulations to ensure that both IOP and PHP are covered for individuals with a primary diagnosis of a SUD or no co-occurring MH condition, consistent with the ASAM Criteria’s PHP and IOP levels of care.**¹⁴

C. Authorize the Full Range of Non-Physician MH and SUD Practitioners in the Medicare Program

The SUD workforce also includes non-physician practitioners who have licensure or certification as SUD or addiction counselors but who do not have masters-level degrees. Congress has previously recognized these practitioners in the SUPPORT Act,¹⁵ and **we encourage the**

¹³ SAMHSA, National Survey of Substance Abuse Treatment Services (N-SSATS): 2020: Data on Substance Abuse Treatment Facilities 31-32 (June 2021),

https://www.samhsa.gov/data/sites/default/files/reports/rpt35313/2020_NSSATS_FINAL.pdf.

¹⁴ Recent research by RTI International estimated that the cost of adding a *full* IOP benefit for SUD to the Medicare program would cost approximately \$928 million annually (for an estimated 116,029 Medicare beneficiaries who would access this benefit), although such costs would be largely offset by reduced hospitalizations and emergency department visits as well as reduced incidence of comorbid conditions caused by untreated SUD. See William J. Parish & Tami L. Mark, “The Cost of Adding Substance Use Disorder Services and Professionals to Medicare,” RTI International (Aug. 2022), https://www.lac.org/assets/files/LAC_Medicare_Budget_Impact_Report_08_08_2022-submitted.pdf.

¹⁵ As a result of the SUPPORT Act of 2018, Congress has already authorized Medicare to reimburse for substance use counseling when it is delivered “by a professional to the extent authorized under State law to furnish such services” in Opioid Treatment Programs (OTPs). 42 U.S.C. 1395x(jjj)(1)(C). Opioid use disorder care teams under the Opioid Use Disorder Treatment Demonstration Program may include “other practitioners licensed under State law to furnish psychiatric, psychological, counseling, and social services to applicable beneficiaries.” 42 U.S.C. 1395cc-6(c)(2)(A)(ii). For the loan repayment program for SUD treatment workforce, employment is defined as including a range of professionals, including counselors, “who are licensed or certified in accordance with applicable State and Federal laws” and “where the primary intent and function of the position is in the direct

Committee to give future consideration to authorizing the full range of SUD counselors that are already serving patients in Medicaid and private insurance to ensure continuity of care and the strongest possible workforce. Recent research by RTI International estimated that the cost of adding all SUD counselors to the Medicare program would cost approximately \$66 million annually (for an estimated 58,890 Medicare beneficiaries who would access this benefit), although such costs would be largely offset by reduced hospitalizations and emergency department visits as well as reduced incidence of comorbid conditions caused by untreated SUD.¹⁶

Coverage of peer support specialists would further ensure access to the full range of services and supports Medicare beneficiaries with MH and SUD need. **We applaud the Committee for including the PEERS Act of 2021 (S.2144) in its Improving Integration, Coordination, and Access to Care Discussion Draft to enhance the MH and SUD workforce.** Peer support can be an effective, evidence-based practice that reduces hospital admission rates and inpatient services, increases treatment engagement and social functioning, and decreases substance use and depression as well as costs to the mental health system.¹⁷ Peers can complement existing providers – including therapists, case managers, and physicians – and round out the coordinated team to help individuals better engage in services, manage physical, MH and SUD conditions, build support systems, and live self-directed lives in their communities. Furthermore, most state Medicaid programs have begun to cover peer support services for behavioral health conditions, and 38 states cover some type of peer support for persons with SUD.¹⁸

D. Apply the Mental Health Parity and Addiction Equity Act to Medicare

As the President’s 2023 Budget and Senate Finance Committee’s bipartisan report have highlighted, Medicare is not subject to the Mental Health Parity and Addiction Equity Act (Parity Act). As a result, Medicare beneficiaries do not have coverage of or access to the full range of MH and SUD benefits they need, and often lose access to treatment they were receiving prior to becoming eligible for Medicare because most private insurance and Medicaid plans are subject to this non-discrimination law. Although Congress has eliminated disparate financial requirements for Medicare beneficiaries, Medicare still imposes both quantitative and non-quantitative treatment limitations that would violate the Parity Act.¹⁹ **We encourage the Committee to apply the Parity Act to Medicare Parts A, B, C, and D as the critical next step to make MH and SUD services available and accessible to the millions of Medicare beneficiaries in need of treatment.**

treatment or recovery support of patients with or in recovery from a substance use disorder.” 42 U.S.C. 295h(i)(3)(A).

¹⁶ See William J. Parish & Tami L. Mark, *supra* note 14.

¹⁷ SAMHSA, “Peers Supporting Recovery from Mental Health Conditions” (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/peers-supporting-recovery-mental-health-conditions-2017.pdf.

¹⁸ MACPAC, “Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder” 6-9 (July 2019), <https://www.macpac.gov/wp-content/uploads/2019/07/Recovery-Support-Services-for-Medicaid-Beneficiaries-with-a-Substance-Use-Disorder.pdf>.

¹⁹ Medicare Addiction Parity Project, “The Path to Parity: Applying the Parity Act to Medicare to Improve Access to Substance Use Disorder and Mental Health Care,” Legal Action Center (June 2022), <https://www.lac.org/assets/files/Path-to-Parity-MAPP-2022.06.14.pdf>.

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Thank you again for your tremendous work and for the opportunity to provide comments on the draft legislation and future opportunities for the Committee. Please contact Deb Steinberg at the Legal Action Center (dsteinberg@lac.org) and Kelly Corredor at the American Society of Addiction Medicine (kcorredor@asam.org) with any questions.

Sincerely,

2020 Mom
Active Minds
Addiction Policy Forum
Addiction Professionals of North Carolina*
American Academy of Social Work and Social Welfare
American Association for the Treatment of Opioid Dependence (AATOD)
American Association of Nurse Anesthetists
American Association of Psychiatric Pharmacists (AAPP)
American College of Academic Addiction Medicine (ACAAM)
American Counseling Association
American Group Psychotherapy Association
American Mental Health Counselors Association
American Osteopathic Academy of Addiction Medicine
American Society of Addiction Medicine
Anxiety and Depression Association of America
Behavioral Health Association of Providers*
California Consortium of Addiction Programs and Professionals*
Colorado Society of Addiction Medicine
Colorado Treatment Services
Community Bridges Inc.
Community Catalyst
Community Oriented Correctional Health Services
Edwin C Chapman MD PC
Faces & Voices of Recovery
Families USA
Illinois Society of Addiction Medicine
Inseparable
International Certification & Reciprocity Consortium*
International OCD Foundation
Legal Action Center*
Medicare Rights Center
Mental Health America
Michigan Society of Addiction Medicine
NAADAC, the Association for Addiction Professionals
National Alliance for Medication Assisted Recovery
National Association for Behavioral Healthcare

National Association for Rural Mental Health
National Association of Addiction Treatment Providers
National Association of County Behavioral Health and Developmental Disability Directors
National Association of Social Workers
National Center for Advocacy and Recovery, Inc.
National Eating Disorders Association
National Health Care for the Homeless Council
National Health Law Program
National Safety Council
New Jersey Society of Addiction Medicine
Northern New England Society of Addiction Medicine
Oregon Society of Addiction Medicine
Partnership to End Addiction
Police, Treatment, and Community Collaborative (PTACC)
RI International
Shatterproof
Talbot Legacy Centers
TASC
Teri's Health Services
The College for Behavioral Health Leadership
The Kennedy Forum
The National Alliance to Advance Adolescent Health
Treatment Communities of America
University of Southern CA
Wisconsin Society of Addiction Medicine

* Organizations with an asterisk request that the Committee use the term "Professional Counselor" instead of "Mental Health Counselor" in Section 11 (proposed 42 U.S.C. 1395x(III)). This is the more commonly used term by the Centers for Medicare & Medicaid Services, states, and counselors, and it is inclusive of Mental Health Counselors.