



**The Honorable Richard Neal**  
**Chairman**  
**Committee on Ways and Means**  
**U.S. House of Representatives**  
**1102 Longworth House Office Bldg.**  
**Washington, DC 20515**

**The Honorable Kevin Brady**  
**Ranking Member**  
**Committee on Ways and Means**  
**U.S. House of Representatives**  
**1102 Longworth House Office Building**  
**Washington, DC 20515**

**ATTACHMENT 3**

**RE: National Coalition on Mental Health and Aging Comments in Addressing “America’s Mental Health Crisis” to Improve Access to Behavioral Health Services for Older Adults**

Dear Chairman Neal and Ranking Member Brady:

The National Coalition on Mental Health and Aging (NCMHA) appreciates the Ways and Means Committee’s bipartisan commitment to address the urgent behavioral health care needs of all Americans, including aging Americans.

NCMHA is composed of 70 national and state organizations, professional associations, and federal agencies that represent the behavioral health interests of older adults with mental health conditions. We play a leading role in policy analysis and development, and provide a forum for sharing, learning and technical assistance for professionals in behavioral health, the aging network, consumer advocates, and government. The NCMHA provides opportunities for members to work together toward improving the availability and quality of mental health and preventive and treatment strategies for aging Americans and their families through education, research, and public awareness.

**I. Background: Why Older Adult Mental Health Matters**

The NCMHA is concerned that as we age mental health issues are neglected in many discussions on how to improve access to behavioral health care services.

The population of aging Americans in the U.S. will nearly double between 2010 and 2029. More importantly, adults 65 and older will increase from 13% to 20% of the population, roughly equal to the population of children under age 18. During this same time period, the older population will become more diverse; older adult Hispanic/Latinos will increase by 200% and African Americans by 115%.<sup>1</sup>

The aging of baby boomers means that within just a couple decades, aging Americans are projected to outnumber children for the first time in U.S. history. By 2034, 77 million people will be 65 years and older compared to 76.5 million under the age of 18.<sup>2</sup>

---

<sup>1</sup> <https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf>

<sup>2</sup> <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>

---

If the prevalence of mental health disorders among aging Americans remains unchanged, the number of aging Americans with mental health and/or substance disorders could reach 15 million people (and these numbers are conservative, according to an Institute of Medicine report<sup>5</sup>). That is staggering growth, and our public and private sector service systems are not prepared to handle this impending issue.<sup>3,3</sup>

Currently, up to 8 million aging Americans – nearly one in five – have one or more mental health or substance use conditions which present unique challenges for their care.<sup>4</sup> Unfortunately, only 4% to 28% of aging Americans with mental health and/or substance use disorders get treatment. Minority older adults are less likely to use or receive mental health services. Of those who receive treatment, most go initially to primary care physicians, who provide minimally adequate care less than 15% of the time.<sup>5</sup>

Aging Americans with mental illness have the highest Medicare costs – 2 to 3 times the cost of other beneficiaries. Untreated mental and substance use disorders among aging Americans exacerbate health conditions, decrease life expectancy, and increase overall healthcare costs.<sup>6,7,8</sup>

Mental health disorders, particularly depression and anxiety, are major contributors to—and are exacerbated by—social isolation, which results in diminished quality of life, further barriers to intervention, and premature institutionalization.<sup>9</sup>

The opioid epidemic has had a profound impact on Medicare beneficiaries and has led to significant increases in deaths due to overdoses or suicide. Moreover, the lack of access to behavioral health services for aging Americans with mental health conditions in rural and frontier areas worsens by the day.

Aging Americans have one of the highest suicide rates in the nation, completing suicide nearly 30% more than the general population. In particular, white males 85 and over complete suicide at nearly four times the rate of the general population. As life expectancy increases, it is reasonable to anticipate that increasing numbers of older adults will probably die by suicide.<sup>10</sup>

---

<sup>3</sup> U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

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

<sup>5</sup> Wang PS, Lane M, Olfson M, Pincus H, Wells KB, Kessler RC (2005). Twelve-Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 62: 629-640.

<sup>6</sup> U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

<sup>7</sup> Husaini, B.A., et. Al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. *Psychiatric Services*, 51, 1245-1247.

<sup>8</sup> Katon, W., Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research*, 53, 859-863.

<sup>9</sup> Warner, J. P. (1998) Quality of life and social issues in older depressed patients. *International Clinical Psychopharmacology*, 13, Supplement 5, S19–24.

<sup>10</sup> Mortality Reports. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention. <http://www.cdc.gov/ncipc/wisqars/>

---

<sup>3</sup> Grayson, V., and Velkoff, V., (2010), *THE NEXT FOUR DECADES, The Older Population in the United States: 2010 to 2050, Current Population Reports, P25-1138*, U.S. Census Bureau, Washington, DC. Retrieved from: <http://www.census.gov/prod/2010pubs/p25-1138.pdf>.

Untreated mental health conditions among both aging Americans with physical disabilities and family caregivers are a major cause of avoidable placements in institutional settings.<sup>11-12-13</sup> *But we know that treatment works.* Effective, evidence-based interventions have been developed that can improve the quality of life of older adults with mental health and substance use disorders, including dementia.

## II. RECOMMENDATIONS

In response to the Ways and Means Committee’s invitation to provide comments, we have focused on four areas for action:

- Strengthening the Workforce
- Increasing Integration, Coordination, and Access to Care
- Ensuring Parity Between Behavioral and Physical Health Care, and
- Telemedicine.

Our comments are from the perspective of addressing the needs of aging Americans with mental health conditions and substance use disorders (SUDs).

***DISCLAIMER: The recommendations embodied in the letter do not purport or necessarily reflect the views of all members of the National Coalition on Mental Health and Aging. The Coalition focuses on issues which general consensus can be reached. Government agencies that are members of the Coalition always abstain from all policy recommendations.***

### A. Strengthening the Workforce

#### ***Continued Funding for Workforce Training***

We appreciate that the “Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748)” included language from the proposed “Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness (EMPOWER) for Health Act of 2019 (H.R. 2781)” and “Title VII Health Care Workforce Reauthorization Act of 2019 (S. 2997)” to reauthorize workforce training programs under Title VII of the Public Health Service Act. Among these initiatives are the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Awards (GACAs). The GWEP is currently the only federal program designed to increase the number of providers in a variety of disciplines—including behavioral health and geriatric

---

<sup>11</sup> Grabowski, D.C., Aschbrenner, K.A., Feng, Z., & Mor, V. (2009). Mental illness in nursing homes: Variations across states. *Health Affairs*, 28 (3), 689-700.

<sup>12</sup> Dorenlot P, Harboun M, Bige V, Henrard JC, Ankri J. (2005). Major depression as a risk factor for early institutionalization of dementia patients living in the community. *Int J Geriatric Psychiatry*, 5, 471-8.

<sup>13</sup> Buhr, G., Kuchighatla, M., & Clipp, E. (2006). Caregivers' reasons for nursing home placement: Clues for improving discussions with families prior to the transition. *The Gerontologist*, 46, 52-61.

psychiatry—with the skills and training to care for older adults, educate and engage the broader frontline workforce, and focus on opportunities to improve the quality of care delivered to older adults, particularly in underserved and rural areas. An essential complement to the GWEP, the GACA is designed to increase the number of faculty with geriatrics expertise in a variety of disciplines. NCMHA recommends that Congress prioritize increased funding to expand these

critical programs and move toward closing the current geographic and demographic gaps in geriatrics workforce training.

***Implement Systematic Workforce Recruitment and Retention Strategies at the Federal, State, and Local Levels.***

Critical strategies to address the current and future shortfall in providers who are trained in geriatrics and mental health include:

1. Exploring incentive programs, including loan repayment programs and increased authorization of graduate medical education payments;
2. Expanding required training in geriatrics to long-term care nurses and other allied professionals in addressing psychiatric disorders and behavioral symptoms of dementia; and,
3. Developing approaches to increasing the number of providers with geriatric mental health training, including early educational awareness of geriatrics as a potential health care career path; development of multidisciplinary training in aging and mental health; increasing provider competencies through information-technology mechanisms; and increasing the proportion of educational programs with training in late-life mental disorders.

Of particular importance are strategies designed to provide financial incentives and support to professionals interested in pursuing a career related to geriatrics. For example, a bill in Congress, the Geriatricians Loan Forgiveness Act (H.R. 3046), would extend the National Health Service Corps Loan Repayment Program (NHSC LRP) to the fields of geriatric medicine and geriatric psychiatry.

It is critically important that Congress address workforce shortages in rural and other underserved areas by incentivizing behavioral health providers to practice in these areas. In addition, consideration should be given to expanding Medicare's provider network to include mental health counselors, marriage and family therapists, peer recovery support specialists, and other licensed behavioral health specialists. Access to current Medicare providers should also be strengthened by (a) removing the psychiatrist supervision requirement of clinical psychologists in some settings, (b) enabling beneficiaries to access Health and Behavior Assessment and Intervention (services provided by clinical social workers, and (c) enabling beneficiaries who receive skilled nursing facility (SNF) services under Part A to receive concurrent mental health services by independent (non-SNF) clinical social workers under Part B.

**B. Increasing Integration, Coordination, and Access to Care**

***Medicare and Medicaid Financing Mechanisms Should be Restructured to Support the Integration of Aging Americans Behavioral Health and Primary Care and to Support Interdisciplinary Care Coordination and Treatment Teams.***

The 2012 Institute of Medicine Report “*The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?*” concluded that Medicare and Medicaid coverage policies were a significant financial barrier for aging Americans in obtaining care for mental illness and substance use disorders.<sup>14</sup> Although almost 10 years old, the challenges of older adult mental health described in this report regrettably still ring true today. Due to the current and projected future shortage of behavioral health specialists, much of the care will need to be provided through behavioral health and primary care integration and by interdisciplinary care coordination and treatment teams, which include multiple health care professionals.

### ***CMS Behavioral Health Integration Billing Codes***

A strong body of evidence shows that integrated care models like Collaborative Care, which integrates depression care into general medical settings, can improve behavioral health treatment delivery and outcomes. Historically, however, the care management processes central to integrated care have not been reimbursed by Medicare or most other health plans and health insurers. CMS should assess why there is a low uptake of the integration codes, and how it can work with primary care physicians to address barriers and increase integrated care, and the use of the codes.

### ***Primary Care Medical Homes***

The Primary Care Medical Home (PCMH) is a health care delivery model designed to improve treatment of several chronic conditions, including, but not limited to, mental health conditions. Research suggests it has the potential to improve both mental and physical health care for people with mental illness. The NCMHA recommends that primary care doctors and specialist receive financial incentives for participation in the PCMH.

### ***Medicare Accountable Care Organizations***

The 2010 Affordable Care Act encouraged formation of Medicare accountable care organizations (ACOs). As of January 2020, 558 Medicare ACOs served more than 12.3 million Medicare beneficiaries.<sup>15</sup> However, recent evidence suggests Medicare ACOs have had little to no effect on behavioral health care delivery. Possible reasons are the lack of alignment between payment and mental health performance metrics and the limited number of mental health specialty providers included in ACO networks.

The NCMHA recommends statutory changes to Medicare related to eliminating the limits on inpatient psychiatric hospital care. Specifically, removing policies that (a) limit Medicare beneficiaries to 190 days of care at inpatient psychiatric facilities, (b) exclude mental health counselors from Medicare reimbursement, (c) require psychiatrist supervision of clinical psychologists in some settings, and (d) prevent beneficiaries who receive skilled nursing facility (SNF) services under Part A to receive concurrent mental health services by independent (nonSNF) clinical social workers under Part B will likely increase access to evidence-based services and improve consumer outcomes.

---

<sup>14</sup> *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Jill Eden, Katie Maslow, Mai Le, and Dan Blazer, Editors; Institute of Medicine, The National Academies Press, 2012.

<sup>15</sup> National Association of ACOs, “Welcome,” n.d.

## **Coverage of Tele-Mental Health Services**

Medicare covers behavioral health services delivered via teleconference technology for only a small subset of rural beneficiaries — and those Medicare beneficiaries must receive their telemedicine services at select health care facilities, not at home. For this population subgroup,

tele-mental health coverage has increased mental health service use. Given that research showing tele-mental health services can improve consumer outcomes, expanding Medicare coverage of such services could address some provider shortages, as well.

However, these recommended changes will likely be insufficient to address the overall shortage of mental health providers, since many of these providers already operate at full capacity.

Medicare tele-mental health coverage has been substantially expanded in response to COVID19, with the majority of services, including group counseling, covered by Medicare and reimbursed at the same rate as in-person services. Medicare policy changes also have enhanced accessibility of tele-mental health services by:

- Waiving originating-site requirements and thus allowing beneficiaries to receive telemedicine services from home.
- Waiving HIPAA requirements that tele-mental health services be delivered over secure, audiovisual software platforms and instead permitting delivery by telephone/other means.
- Allowing providers to conduct tele-mental health visits with new patients.
- Allowing providers licensed in one state to deliver telemedicine services to consumers in a different state.

As of February 2022, it is unclear whether these policies will be continued after the COVID-19 pandemic abates. The NCMHA recommends that these policies remain in effect permanently. *Affordable Care Act Medicare Annual Wellness Visit*

While reimbursement mechanisms for the Medicare Annual Wellness Visit now exist through the annual wellness visit and behavioral health integration billing codes, uptake has been low. Only 18 percent of Medicare fee-for-service beneficiaries and 25 percent of Medicare Advantage enrollees have received an AWV.<sup>16</sup>

### **Financial incentives and technical assistance are needed to help primary care practices and clinics to increase uptake of the Annual Wellness Visit, including depression screening and behavioral health integration services.**

Additionally, studies suggest that reimbursement mechanisms have alone not been sufficient to prompt the practice transformation needed to support integration of systematic depression screening and mental health case management services into general medical settings. For example, a team-based approach using nurses, medical assistants, and pharmacists has been effective in increasing access to the AWV. In addition, a broader array of non-professionals

---

<sup>16</sup> [www.aarp.org/content/dam/aarp/ppi/2019/05/annual-wellness-visits-among-medicare-advantage-enrollees.pdf](http://www.aarp.org/content/dam/aarp/ppi/2019/05/annual-wellness-visits-among-medicare-advantage-enrollees.pdf) <sup>18</sup> Kubota, Iyo, "Increasing Access to Medicare Annual Wellness Visits in Primary Care; Utilizing Registered Nurses as part of an Interdisciplinary Team Based Approach" (2020). Doctor of Nursing Practice (DNP) Projects. 201. Galvin SL, Grandy R, Woodall T, Parlier AB, Thach S, Landis S. Improved utilization of preventive services among patients following team based annual wellness visits. *N C Med J.* Sep-Oct 2017;78(5):287-295

should be allowed to conduct the health risk Assessment and make referrals to needed services.

### ***Increased Funding and Reauthorization of the Older Americans Act (OAA)***

The Older Americans Act (OAA) funds critical services that keep our nation's older adults healthy and independent—services like meals, job training, senior centers, health promotion and disease prevention programs, benefits enrollment, caregiver support, transportation, and more. These services and programs address social determinants of health that are critical to the health and quality of life for older persons with behavioral health concerns. OAA services focus on meeting the needs of low income and underserved older adults, who are also most at risk for mental health conditions. The OAA Title III-D Health Promotion and Disease Prevention supports evidence-based programs, like those listed below that address common mental health conditions and substance use disorders among older adults. Compared to other areas for evidence-based health promotion and disease prevention programs, few programs focus on aging Americans mental health and substance use disorders. More support for the development and dissemination of new programs is needed. Title III-E of the OAA provides funding for the National Family Caregiver Support Program, a vital part of our nation's strategy to provide relief to caregivers of persons with Alzheimer's disease and related dementias, mental health and chronic health conditions. Increased funding for the OAA is necessary to address the aging of the population and will be particularly needed as the pandemic evolves and potentially more older adults and caregivers seek services. The OAA is scheduled for reauthorization in 2024. Another challenge is lack of integration between the aging and behavioral health communities to better coordinate services that address needs of older persons with mental health conditions and SUD. The Administration for Community Living/Administration on Aging who administers the OAA, in conjunction with SAMHSA, could be tasked with disseminating and funding models and funding strategies that better integrated the aging network and behavioral health communities.

### **C. Ensuring Parity between Behavioral and Physical Health Care**

#### ***Mental Health Parity and Addiction Equity Act (MHPAEA) Enhancement***

The NCMHA recommends that MHPAEA apply to all current and future public and private payers including Medicare, Medicaid fee-for-service, TRICARE, and Indian Health Services.

#### **Improvements are Needed in Mental Health Provider Networks in Medicare Advantage**

Medicare Advantage (MA) beneficiaries often lack access to in-network behavioral health providers and instead turn to higher-cost out-of-network care.

Medicare Advantage criteria for network adequacy should be revisited with the goal of improving access to in-network specialty mental health providers. To aid consumers in identifying plans with adequate networks, CMS could incentivize plans to make comprehensive, up-to-date provider directories available by incorporating measures of directory adequacy in their star rating system. In addition, few Medicare Advantage plans are offered for people with serious mental illness.

## **Prescription Medication Coverage**

The so-called Medicare doughnut hole, or gap in Part D prescription drug coverage, was closed in January 2020. While this change does not apply specifically to mental health, evidence suggests that it will increase access to needed psychotropic medications. Prior to the policy change, beneficiaries typically reduced their use of antidepressants when they entered the coverage gap. The NCMHA also recommends capping the out-of-pocket costs and other efforts to reduce costs for aging Americans.

## **New Strategies to Address the Mental Health Needs of Rural & Culturally Diverse Older Adults**

All behavioral health services for aging Americans provided should be linguistically, culturally, ethnically, and age appropriate. Racially and ethnically diverse older adults are more likely to live in poverty and to be underinsured. In addition, the problems of health disparities are present even when income and access are plentiful. There are many social factors at the root of disparities, including racism, ageism, and unconscious stereotyping. Aging in place is not a practical option for many rural older adults because of limited access to physical and behavioral health care, and home health services. In Indian County, if an aging American requires longterm care, there are only 17 nursing homes for 567 Federally recognized tribes.<sup>17</sup>

Increased support is needed for the behavioral health services that are aligned with the preferences of aging Americans. For example, approximately 50% of aging Americans state a preference for counseling services over medication management; with older African Americans particularly inclined toward counseling services.<sup>18</sup>

Key Recommendations include:

- Increased funding for the Elder Justice Act, long-term care ombudsman programs, and Adult Protective Services to address elder abuse.
- Enact legislation that supports increased rural broadband access.
- Fund initiatives to eliminate disparities in mental health status and mental health care of older adults through the application of psychological and behavioral research, i.e., putting research into practice, and services that are culturally and linguistically competent.

## **D. Expanding Telehealth**

### ***Codify Expansion of Services***

Pertaining to our comments earlier under “Increasing Integration” section of NCMHA’s comments, it is critically important that Medicare, Medicaid and other payers expand access to digital and tele-health services. These services can extend access to behavioral health care

---

<sup>17</sup> <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/the-tribalnursinghome-collaborative>

<sup>18</sup> Jacqueline Gray, Ph.D. Presentation at the NCMHA Congressional Briefing on Addressing the Crisis in Older Adult Mental Health. *New Strategies and Technology to Address the Mental Health Needs of Rural and Culturally Diverse Older Adults*, May 17, 2018.

throughout the U.S., particularly in rural communities that face shortages of mental health professionals. Telehealth supports the delivery of behavioral health treatments, with outcomes for several conditions and circumstances comparable to receiving in-person care. Stimulated by the COVID-19 pandemic, federal policymakers should codify expansion of these services by ensuring that insurers cover them, that clinicians are adequately reimbursed, and that aging Americans know how to use the technologies. We also need to change regulations to authorize use of and reimbursement for mobile apps and technology tools to engage individuals in therapy.

---

### **III. Conclusion: Opportunities for Improvement in the Post COVID-19 Era**

With the approaching demographic change, we will witness an unprecedented increase in the number of aging Americans with mental health and substance use disorders over the coming decades. The stressors brought on by the COVID-19 pandemic have increased mental health service needs. This makes recent Medicare policies that reduce out-of-pocket costs for outpatient mental health services and medications more important than ever. Depression screening in the annual wellness visit also takes on heightened importance, given the need to identify and treat people with depression related to the COVID-19 pandemic. Opportunities to coordinate mental and physical health care through behavioral integration billing codes and PCMHs could help support COVID-19 testing and treatment for people with mental illness.

Further investigation is needed to identify telehealth policies most likely to increase access to mental health services and improve consumer outcomes. This line of research should explore consumer preferences for tele-mental health services versus in-person treatment.

Congress should provide funding to support research and development of prevention programs to address older adult suicide and bolster the workforce of mental health treatment providers.

Finally, Medicare needs to take advantage of an unrecognized provider groups that provide mental health services in its program to address workforce shortage issues.

Thank you for your consideration of these comments. Please contact me if you have any questions. I can be reached at [joel.miller44@yahoo.com](mailto:joel.miller44@yahoo.com).

Sincerely,

*Joel E. Miller*JEM

Joel E. Miller  
Chair  
National Coalition on Mental Health and Aging

