



Leadership Council
of Aging Organizations

Katie Smith Sloan, Chair

May 19, 2022

The Honorable Ron Wyden
Chair, Senate Finance Committee

The Honorable Mike Crapo
Ranking Member, Senate Finance
Committee

The Honorable Patty Murray
Chair, Senate HELP Committee

The Honorable Richard Burr
Ranking Member, Senate HELP Committee

The Honorable Frank Pallone
Chair, House Energy and Commerce Committee

The Honorable Cathy McMorris Rodgers
Ranking Member, House Energy and
Commerce Committee

The Honorable Richard Neal
Chair, House Ways and Means Committee

The Honorable Kevin Brady
Ranking Member, House Ways and Means
Committee

The Honorable Bobby Scott
Chair, House Education and Labor Committee

The Honorable Virginia Foxx
Ranking Member, House Education and
Labor Committee

Dear Member of Congress,

Leadership Council of Aging Organizations (LCAO), a coalition of 68 national nonprofit organizations concerned with the well-being of America's older populations, wish to highlight pathways to more affordable and accessible behavioral health services and programs for older adults. We recommend 1) facilitating the growth of the behavioral health **workforce**; 2) ensuring mental health **parity in Medicare**; 3) increasing funding for **proven federal programs** to achieve improvements; 4) ensuring better **integration of** behavioral and physical health care; 5) robustly funding **crisis support**; and 6) removing remaining barriers to accessing **telemental health care**. The body of our letter identifies major barriers to care and includes general policy recommendations, and the appendix cites specific bipartisan legislation that aims to address some,

or all of the issues raised. In some cases, where there is not yet proposed legislation that would accomplish our recommendations, we urge Congress to create new bills.

Enactment of LCAO's suggested strategies for decreasing barriers to services for mental health and substance use—including those barriers spotlighted during and exacerbated by the pandemic—not only would enhance the health and well-being of older adults', but also would decrease Medicare costs for beneficiaries and the government in the long term. Congress can provide the public investments private investors cannot or will not. Today's federal investments are necessary to create tomorrow's high-quality, accessible behavioral health services; improved health outcomes; and robust economic growth.

May is not only Older Americans Month, but also Mental Health Awareness Month. As such, there is no better time to elevate the mental health and substance use needs of older adults. Policy action to address these needs will also enhance the health and well-being of family caregivers (some of whom are older adults), who are affected by the mental health and substance use concerns of the people they support and may live with such concerns themselves.

Strengthening the Workforce

A 2012 Institute of Medicine report,¹ found that the national mental and behavioral healthcare workforce is ill equipped—in numbers, knowledge, and skills—to care for a rapidly aging, diverse population. The situation has not improved over the past ten years. The Health Resources and Services Administration projected the supply of workers in select behavioral health professions will fall approximately 250,000 workers short of the projected demand by 2025. The problem is most acute in rural and underserved areas. The United States is also not making the most of its existing behavioral health workforce.

Loan repayment programs, which incentivize workforce development, are prevalent in other healthcare professions, but are not available to some behavioral health care workers; we believe loan forgiveness should be available to all behavioral health professions. We also believe that loan forgiveness should be based on public service, such as provision of crisis response and counseling services for people dealing with mental health or substance use concerns, not on employer eligibility. LCAO further recommends that tuition reimbursement should be available to all behavioral health professions, including social workers.

Medicare also excludes some mental health and substance use disorder (SUD) counselors and all peer support specialists from billing, significantly reducing access to services. LCAO recommends Medicare's definition of approved providers include these essential categories of providers

¹ Institute of Medicine. 2012. *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Washington, DC: The National Academies Press. <https://doi.org/10.17226/13400>.

Parity

The Mental Health Parity and Addiction Equity Act (Parity Act) applies to some Medicaid and private insurance plans, requiring equitable coverage of SUDs and mental health services with other healthcare services. However, despite the fact that Medicare accounts for approximately 20 percent of the nation’s health expenditures and covers nearly 64 million older adults and people with disabilities, it is not subject to the Parity Act.² This discrepancy has led to a wide range of Medicare treatment limitations for SUDs and mental health conditions that do not apply to other Medicare-covered medical services. For example, Medicare has a 190-day lifetime limit on inpatient psychiatric hospital services; in contrast, this limitation does not exist for hospitalization for other health conditions.

Perhaps it is no surprise, then, that Medicare mental health spending only constituted 4.6 percent of all mental health expenditures in 2014, the latest date for which data is available. This small share of Medicare spending cannot, however, be equated with a small share of mental health and substance use concerns experienced by older adults. Approximately 20 percent of older adults—some of whom are family caregivers—live with undiagnosed depression, and adults over age 65 have the highest rate of suicide in the nation.³ Moreover, among those older adults who die by suicide, 40 percent have seen their doctor within the week and 70 percent within the month of the suicide occurrence.⁴ Medicare must do better to provide robust access to the full range of mental health and substance use treatment services that beneficiaries need.⁵

Funding for Older Americans Act (OAA) Evidence-Based Mental Health Programs

In addition to clinical intervention for behavioral health conditions, various evidence-based programs and strategies exist that can be implemented in the community to address a range of concerns, such as depression, anxiety, posttraumatic stress disorder, and SUDs. These programs and strategies, already offered by the aging network in some areas, augment care provided by primary care and mental health practitioners. LCAO advocates for increased investments in Title III-D of the Older American Act (OAA) to scale these programs and strategies throughout the aging network, thereby reaching older adults at risk for or living with behavioral health conditions. Examples of these evidence-based programs and strategies follow:

² SAMHSA. “Behavioral Health Spending & Use Accounts 1986 – 2014.” 2016. 25 April 2022.

<https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4975.pdf#:~:text=%EF%82%B7%20In%202014%2C%20the%20%24186%20billion%20spent%20on,accounted%20for%2015%20percent%20of%20MH%20treatment%20spending.?msclkid=bd7b067ec4d311ec87c065e45bf100af>

³ Illinois Department of Public Health. “Suicide Prevention: Suicide in Older Adults.” 2016. 02 May 2022.

<https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/suicide-and-older-adults-050216.pdf>.

⁴ Illinois Department of Public Health. “Suicide Prevention: Suicide in Older Adults.”

⁵ A recent Legal Action Center and RTI study revealed that only 11 percent of Medicare beneficiaries with Substance Use Disorders received treatment from 2015 to 2019. See: William J.Parish, Tami L.Mark, Ellen M. Weber, and Deborah G. Steinberg. “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers.” American Journal of Preventive Medicine. 21 March 2022. 04 May 2022. [RTI-Substance Use Disorders Among Medicare Beneficiaires-2022](#).

1. HEALTHY IDEAS - Identifying Depression & Empowering Activities for Seniors
2. PEARLS - Program to Encourage Active, Rewarding Lives
3. SBIRT – Screening, Brief Intervention, and Referral to Treatment
4. WRAP – Wellness Recovery Action Planning Peer Support Program
5. CDSMP – Chronic Disease Self-Management Program

LCAO recommends doubling the annual investment in Title III-D from \$25 million to \$50 million with annual increases to enable wider dissemination and utilization of these vital programs.

Furthermore, LCAO supports the authorized, but not yet funded, Research, Evaluation and Demonstration Center at the HHS Administration for Community Living. One area of research for this Center could be to study the impact of OAA-funded programs on older adults with mental health conditions and/or SUDs. The recommended level of funding is \$75 million annually.

Integration

LCAO recommends greater federal investment in care models that provide services through (a) behavioral health and primary care integration and (b) by interdisciplinary care coordination and treatment teams composed of various providers. A strong and growing body of evidence demonstrates that integrated care models, such as Collaborative Care – which integrates depression care, other mental health care and SUD care into general medical settings – can improve substance use treatment delivery and outcomes for older adults.⁶

Crisis Response

Suicide is a preventable tragedy. While older adults comprise just 12 percent of the population, they constitute approximately 18 percent of fatal suicide.⁷ The suicide rate of men age 75 and older is considerably higher than other male age groups.⁸ Yet older adults and family caregivers in crisis may not, unfortunately, be able to wait for a clinical appointment and may need immediate crisis support. The current National Suicide Prevention Lifeline—predecessor to 988—tends to be understaffed by a patchwork of nonprofits managing several hotlines and utilizing counselors and volunteers.⁹ As a result, 300,000 callers to the National Suicide Prevention Lifeline ended up abandoning their unanswered calls in 2021.¹⁰ Moreover, not all

⁶ American Psychiatric Association. “Learn About the Collaborative Care Model.” 04 May 2022. <https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn>.

⁷ Kate Rope. “What to Know About Suicide Rates in Older Adults.” WebMD. 22 March 2021. 02 May 2022. https://docs.google.com/document/d/1fZWmA9pFVw32YBlMa2s9jEnNyE_tIsc924bOfAQv_U/edit.

⁸ Holly Hedegaard, Sally C. Curtin, and Margaret Warner. “Increase in Suicide Mortality in the United States, 1999–2018.” CDC. April 2020. 26 April 2022. <https://www.cdc.gov/nchs/products/databriefs/db362.htm>

⁹ Steve Eder. “As a Crisis Hotline Grows, So Do Fears It Won’t Be Ready.” *New York Times*. 17 March 2022. 23 March 2022. <https://www.nytimes.com/2022/03/13/us/suicide-hotline-mental-health-988.html>

¹⁰ Steve Eder. “As a Crisis Hotline Grows, So Do Fears It Won’t Be Ready.”

crises can be resolved with a phone call or a text conversation. Mobile crisis teams can deescalate a situation or provide support, but few are available 24/7 and few can reach an individual in less than an hour or include a clinician able to administer medications.¹¹

Consequently, LCAO encourages Congress to meet the President’s goal for providing the necessary resources for 988 and crisis response units. Meeting the nation’s high tide of mental health needs requires training opportunities that impart not only mental health and substance use crisis response and subject-matter expertise to service providers, but also tech tool competence to allow for proper administration and electronic texting capabilities. Scaling up 988 and mobile response crisis units should involve supporting and training individuals who have lived experience to enter the crisis response workforce even if they do not have formal licensure.. These peers can provide essential support to people in crisis. Additional funding to support these resources would go a long way toward meeting the following 2020 Substance Abuse and Mental Health Services Administration (SAMHSA) regional crisis response principles, some of which are listed below:

1. Operate a call center every moment of every day (24/7/365);
2. Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received.
3. Coordinate connections to crisis mobile team services in the region; and
4. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.¹²

As 988 launches in July, public education targeted to older adults will be key. A February 2022 Morning Consult/Trevor Project poll found that 69 percent of those surveyed had never heard of the 988 hotline.¹³ Making the public aware that the hotline can be used to discuss substance use concerns is especially needed, for example, given older adults’ struggles with opioids, other drugs, and alcohol. We urge Congress to ensure that 988’s advertising format and content is culturally and linguistically appropriate and geared toward older adults. We also recommend that Congress require SAMHSA to perform early and frequent evaluations of the program, which would enable adaptations and corrections and minimize harm.

Telemental Health

¹¹ Polina Krass, Evan Dalton, Molly Candon, and Stephanie Douplik. “Implementing The 988 Hotline: A Critical Window to Decriminalize Mental Health.” *Health Affairs Forefront. Health Affairs*. 25 February 2022. 14 March 2022. <https://www.healthaffairs.org/doi/10.1377/forefront.20220223.476040>

¹² Substance Abuse and Mental Health Services Administration. “National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.” 2020. 26 April 2022. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

¹³ Morning Consult and the Trevor Project. “U.S. Adults’ Knowledge on Suicide Prevention and 988.” April 2022. 22 April 2022. <https://www.thetrevorproject.org/wp-content/uploads/2022/04/988-poll-report.pdf>

LCAO expresses appreciation for Congress' use of the Consolidated Appropriations Act for Fiscal Year 2022 to further extend telehealth flexibilities for 151 days following the end of the COVID-19 Public Health Emergency (PHE). The bill, for instance, delays the in-person visit prerequisite for Medicare coverage of telemental health and puts off the in-person and geographic requirements for telehealth services generally. We urge Congress to remove these restrictions permanently.

We believe that all older adults should have access to telehealth for mental health and substance use services (as with other health care services) regardless of the modality, originating site of the service, or the location of a provider. We urge Congress to seek ways to verify the beneficiary-provider relationship to prevent fraud and ensure high-quality care in ways that do not impose additional barriers to care. We also urge Congress to bolster the physical and human infrastructure necessary to increase culturally responsive and equitable telehealth access. Among older adults who wish to use telehealth for mental health and substance use services and for whom it is clinically appropriate, many face access barriers such as (a) lack of smart devices, video-calling, or broadband; and (b) limited digital literacy or ability to use telehealth services. At the same time, we encourage policymakers to ensure that providers and plans cannot discriminate against any older adult or person with a disability who is unable or unwilling to receive services via telehealth.

Thank you for your consideration of our recommendations. LCAO looks forward to working with you to enact legislation providing the comprehensive mental health and substance use services that older Americans need.

A handwritten signature in black ink that reads "Katie Smith Sloan". The signature is written in a cursive, flowing style.

Katie Smith Sloan, LCAO Chair

cc: Leader Schumer
Speaker Pelosi
Leader McConnell
Leader McCarthy

Appendix A: Recommended Bipartisan Bills

Strengthening the Workforce

Mental Health Access Improvement Act (S. 828/H.R. 432) - These bipartisan bills would include mental health counselors and marriage and family therapists in the Medicare program as approved providers who could bill to provide counseling and therapy to Medicare beneficiaries. This bill is a step forward but leaves out some important providers, including substance use counselors.

The Promoting Effective and Empowering Recovery Services (PEERS) in Medicare Act of 2021 (H.R. 2767/S. 2144) - These bipartisan bills would expand access to peer support services for mental health and substance use disorders (SUDs). The legislation would ensure that primary care physicians can bill peer support treatment to Medicare to make this service more accessible. This legislation could be a first step toward more extensive incorporation of BH peer support services in Medicare..

Improving Access to Mental Health Act of 2021 (S. 870/H.R. 2035) - This bipartisan legislation would enable Medicare beneficiaries to access Health and Behavior Assessment and Intervention (HBAI) services from clinical social workers under Medicare Part B; would enable beneficiaries who are receiving SNF services under Part A to receive concurrent mental health services from clinical social workers under Part B; and would increase Medicare reimbursement rates for clinical social workers from 75 percent of the physician fee schedule (the current rate) to 85 percent (the rate paid to other nonphysician providers).

The PSLF Payment Completion Fairness Act (H.R. 7465) - This bipartisan legislation would simplify Public Service Loan Forgiveness for public service professionals, improve applicant success rate, and incentivize more Americans to become public servants by removing the provision requiring individuals to be currently employed in public service at the time of forgiveness.

The Mental Health Professionals Workforce Shortage Loan Repayment Act of 2021 (H.R. 3150/S. 1578) - This bipartisan legislation would forgive the loans of behavioral health care professionals working in areas where there are shortages of such professions as social workers who specialize in mental health conditions and SUDs and psychiatrists.

Integration

The Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) - This bipartisan bill would expand and improve access to evidence-based mental health and substance misuse care by supporting and investing in the implementation of integrated care in primary care practices.

Crisis Response

The Crisis Assistance Helping Out on The Streets (CAHOOTS) Act (S. 764) - This bill would build a more robust national mobile crisis response capacity.

The Behavioral Health Crisis Services Expansion Act (H.R. 5611/S. 1902) - These bipartisan bills would require all federally-regulated health plans to cover 988 services, a move which would provide needed, sustainable funding streams for the 988 program. S. 1902 would also require Medicare and Medicaid to cover emergency mental health and SUD services; currently too many older adults struggle to pay the relatively high costs associated with emergency behavioral health care.

Telemental health

The Protecting Access to Post-COVID Telehealth Act (H.R. 366) and the Telemental Health Care Access Act (S. 2061, H.R. 4058) - These bipartisan bills would permanently remove the statutory requirement around the in-person visit within 6 months following the use of telemental health services.