

November 29, 2019

The Honorable Richard E. Neal  
Chairman, Ways and Means Committee  
House of Representatives  
1102 Longworth House Office Building  
Washington D.C. 20515

The Honorable Kevin Brady  
Ranking Member, Ways and Means Committee  
House of Representatives  
1102 Longworth House Office Building  
Washington D.C. 20515

The Honorable Danny Davis  
House of Representatives  
2159 Rayburn House Office Building  
Washington, DC 20515

The Honorable Brad Wenstrup  
House of Representatives  
2419 Rayburn House Office Building  
Washington, DC 20515

The Honorable Terri Sewell  
House of Representatives  
2201 Rayburn House Office Building  
Washington, DC 20515

The Honorable Jodey Arrington  
House of Representatives  
1029 Longworth House Office Building  
Washington, DC 20515

**RE: House Ways and Means Committee Rural and Underserved Communities Health Task Force  
Request for Information**

Dear Chairman Neal, Ranking Member Brady and Representatives Davis, Wenstrup, Sewell and Arrington,

The National Council for Behavioral Health (National Council) appreciates the opportunity to respond to the House Ways and Means Committee's Request for Information (RFI) to inform the Rural and Underserved Communities Health Task Force. The National Council is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with our 3,300 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

We would like to take this opportunity to respond to the questions posed by the Task Force by discussing two specific policy proposals currently before the Congress. The first, the **Mental Health Access Improvement Act (H.R. 945/S. 286)**, is legislation that would allow marriage and family therapists and licensed mental health counselors to bill Medicare for their services. Medicare is currently the only payer that does not recognize these professionals leaving approximately 230,000 mental health providers unable to serve millions of Americans nationwide, including those in rural and underserved areas.

The second legislative item is the **Excellence in Mental Health and Addiction Treatment Expansion Act (H.R. 1767/ S.824)**. This legislation would extend and expand the ongoing and successful Certified

Community Behavioral Health Clinic (CCBHC) Medicaid demonstration program that was created in 2014. The 2014 law created an eight-state, two-year demonstration in which 66 CCBHCs were certified to participate. CCBHCs provide a comprehensive range of addiction and mental health services to the communities they serve. In return, CCBHCs receive a bundled Medicaid payment rate that allows them to build their capacity to serve new clients, reduce wait times, hire needed staff, and better serve their communities, including those in rural and underserved areas.

With that background, we wanted to answer the following questions from the Committee and Rural Health Task Force's Request for Information.

***2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?***

CCBHCs are required to provide an increased scope of integrated services, including evidence-based outpatient mental health and substance use services, 24-hour crisis care, primary care screening and monitoring and care coordination across health care settings. They must work with law enforcement officers, criminal justice systems, veterans' organizations, child welfare agencies, schools and other community organizations to ensure no one falls through the cracks. Clinics are held accountable for patients' improvement, while engaging patients wherever needed and leveraging technology for improved outcomes.

Specifically, the CCBHC payment model has allowed clinics to invest in technology tools to reach consumers outside the four walls of the clinics. CPC Behavioral Health (Eatontown, NJ) is using telehealth to increase access to child/adolescent psychiatry. Two CCBHCS - Burrell Behavioral Health (Springfield, MO) and Grand Lake Mental Health Center (Nowata County, OK) - now provide on-duty law enforcement officials with iPads and tablets to allow them to connect to a mental health counselor via telehealth in crisis situations in the field.

In total, over 3,000 new staff were hired to expand CCBHCs' treatment services and serve more people. These new staff include case managers and care coordinators who work with clients to ensure they are receiving proper care and treatment services for both their behavioral health condition as well as any underlying or cooccurring physical health condition. The care case managers at CCBHCs can provide that next level of care to address an individual's social determinants of health including housing instability, food insecurity and employment opportunities.

***6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?***

In total, CCBHCS have hired over 3,000 professionals to the behavioral health workforce. Grand Lake (Nowata County, OK) increased its client base by 134% since becoming a CCBHC. The sustainable

payment has allowed them to expand their service array to including housing, nutrition and employment services, in addition to occupational therapy and medication-assisted treatment. In rural communities like these, CCBHCs are the largest employers in the area and the jobs created play a critical role in a client's overall wellbeing. Red Rock Behavioral Health (Oklahoma City, OK) added 128 new jobs since becoming a CCBHC. These positions are at risk if the CCBHC program is not extended. By continuing this program to include other states that wish to participate, CCBHCs could continue to grow and plan long-term investments into building new programs, hiring new staff, and expanding access to services.

In addition to CCBHCs, the Task Force should prioritize the Mental Health Access Improvement Act (H.R. 945). MFTs and MHCs make up 40% of the mental health workforce but are ineligible to bill Medicare. 77% of U.S. counties have a severe behavioral health workforce shortage, leaving 80 million Americans lacking sufficient access to care. Many of these rural, underserved areas without any current Medicare providers do have practicing MFTs and/or MHCs, including counselors who have been trained and licensed to provide addiction services. There are twice as many of MFTs and MHCs in rural counties as social workers, six times the psychologists, and 13 times the psychiatrists.

***7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?***

In the first year alone, CCBHCs cared for nearly 400,00 people across urban, suburban, rural and frontier areas with serious mental illnesses and addiction disorders. In that same time patient caseloads increased by nearly 25 percent based on expanded staff capabilities and new programs, with the greatest increase coming from individuals seeking services for the first time. All 66 CCBHCs across the eight states have either launched new addiction treatment services or expanded the scope of their addiction care and 92 percent have expanded access to medication-assisted treatment (MAT) for opioid use disorders. Most CCBHCs (78 percent) can offer an appointment within a week after an initial call or referral; the national average is up to 48 days. H.R. 1767 would allow the current CCBHCs to continue and build on their success while opening the door for 11 other states to begin their journey down this same path.

Simultaneously, allowing qualified but previously ineligible MFTs and MHCs to directly bill Medicare for their services would immediately alleviate the strain on our nation's mental health and addiction workforce, adding an estimated 230,000 mental health providers to the Medicare network. These professionals play an important role they in delivering treatment, recovery and prevention services to seniors and people with disabilities, particularly in underserved, rural areas with a mental health workforce shortage. This simple change in H.R. 945 would immediately increase patients' access to needed care in their communities.

The National Council thanks the Committee and the Task Force for this opportunity to submit comments and provide additional information into ways to expand access and bolster the health care workforce in

rural and frontier communities. We believe that both the **Excellence in Mental Health and Addiction Treatment Expansion Act (H.R. 1767/S. 824)** and the **Mental Health Access Improvement Act (H.R. 945/S. 286)** are important and timely pieces of legislation that will have an immediate and lasting impact on the mental health and addictions crises our country is currently facing. We urge the Committee's and the Task Force's support of both bills as you continue to look for ways to improve access to care for millions of Americans living in rural and frontier communities.

The National Council appreciates the opportunity to provide comments on this issue. If you have any questions, please contact our Vice President of Policy and Advocacy, Reyna Taylor at [ReynaT@TheNationalCouncil.org](mailto:ReynaT@TheNationalCouncil.org) or (202) 774-1659. Thank you for your time and consideration.

Sincerely,



Charles Ingoglia, MSW  
President & CEO  
National Council for Behavioral Health