The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

RE: The National Coalition on Mental Health and Aging Response to the Senate Finance Committee's Request for Information to Improve Access to Behavioral Health Services

Dear Chairman Wyden and Ranking Member Crapo:

The National Coalition on Mental Health and Aging (NCMHA) appreciates the Senate Finance Committee's bipartisan commitment to address the urgent behavioral health care needs of all Americans, including older adults.

The 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 older adults and their families through education, research, and public awareness.

I. Background: Why Older Adult Mental Health Matters

The NCMHA is concerned that older adult mental health issues are neglected in many discussions on how to improve access to behavioral health care services. In the overall scope of the Senate Finance Committee's RFI, there is no reference to older adult mental health concerns.

The population of older adults 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%.[1]

[1] https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf

The aging of baby boomers means that within just a couple decades, older people 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.[2]

If the prevalence of mental health disorders among older adults remains unchanged, the number of older adults with mental health and/or substance disorders could reach 15 million people (and these numbers are conservative, according to an Institute of Medicine report[5]). That is staggering growth, and our public and private sector service systems are not prepared to handle this impending issue.[3,4]

Currently, up to 8 million older adults – nearly one in five – have one or more mental health or substance use conditions which present unique challenges for their care.[5] Unfortunately, only 4% to 28% of older adults 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.[6]

Mental health and substance use disorders are major impediments to living well in old age. They cause considerable personal suffering and make it difficult for older people to achieve their potential in old age. This is a population in critical need of education, targeted prevention, and early intervention.

Older adults with mental illness have the highest Medicare costs – 2 to 3 times the cost of other beneficiaries. Untreated mental and substance use disorders among older adults exacerbate health conditions, decrease life expectancy, and increase overall healthcare costs.[7,8,9]

---

[2] https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html

[3] 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.

[4] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

[5] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* Washington, DC: National Academies Press.

[6] 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.

[7] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

[8] Husaini, B.A., et. Al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. *PsychiatricServices,* 51, 1245-1247.

[9] Katon,W., Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research, 53*, 859-863.

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.[10]

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 older adults with mental health conditions in rural and frontier areas worsens by the day. The opioid epidemic, social isolation (especially during the COVID-19 pandemic) and related determinants of mental health are just a few factors that will magnify the problem of access to needed care for vulnerable seniors and place substantial pressure on caregivers and families.

Older adults 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.[11]

- Depression, one of the conditions most commonly associated with suicide in older adults, is a widely under-recognized and undertreated medical illness.[12]
- Many older adults who die by suicide — up to 75 percent — visited a physician within a month before death.[13]

Untreated mental health conditions among both older adults with physical disabilities and family caregivers are a major cause of avoidable placements in institutional settings.[14,15,16]
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.

Unfortunately, mental health disorders among older adults are all too often neglected in our society due to the following factors:

[10] Warner, J. P. (1998) Quality of life and social issues in older depressed patients. *International Clinical Psychopharmacology*, 13, Supplement 5, S19–24.
[11] Mortality Reports. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention. http://www.cdc.gov/ncipc/wisqars/
[12] Blazer, D. (2009). Depression in late life: Review and commentary. *FOCUS,* 7, 118-136.
[13] Luoma, J., Martin, C., & Pearson J. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *Am J Psychiatry.* 159 (6), 909-916.
[14] 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.
[15] 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.
[16] 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.

- *Ageism* – the false belief that mental health disorders, particularly depression and dementia, are normal in old age. This belief is held not only by older adults, family members, and service providers, but is also rampant within society at large.
- *Stigma* – the shame of having a mental health disorder. Stigma discourages older adults and their family members from acknowledging mental health needs and pursuing treatment, ultimately decreasing quality of life.
- *Ignorance* – the lack of education and understanding regarding age-related vulnerabilities and impact of mental health disorders on older individuals. Without education on the diversity and severity of behavioral conditions in later life, problems are not identified, treatment is not accessed, and recovery is not obtained.

It is imperative that we translate research findings into practice, invest in evidence-based practices and develop geriatric mental health workforce capacity and competency to meet the growing and unique needs of late life mental illness and substance use disorders. These investments are needed to improve the lives of older adults and their families and reduce overall costs to the health care system. In addition to the moral obligation we have to our older Americans, optimizing late life behavioral health benefits our families and communities in multiple ways:

- Healthy older adults make valuable contributions as employees in our workforce and as volunteers in communities and organizations.
- Family members can remain engaged in the workforce and personal pursuits as they do not need to prematurely leave the workforce to care for older loved ones.
- Unnecessary, premature and costly institutionalization can be delayed or avoided, and caregiver burden and symptoms of depression reduced with effective programs of counseling and support for caregivers of persons with dementia.[17,18]

II. RECOMMENDATIONS

In response to the Senate Finance Committee's Request for Information, we have followed the Committee's outline and focused on three areas for action: Strengthening the Workforce; Increasing Integration, Coordination, and Access to Care; and Ensuring Parity Between Behavioral and Physical Health Care, and Telemedicine. Our comments are from the perspective of addressing the needs of older adults with mental health conditions and substance use disorders (SUD).

[17] Mittelman MS, Haley WE, Clay OJ, Roth DL. Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease. Neurology. 2006 Nov 14;67(9):1592-9.

[18] Substantial literature confirms that family caregivers are the primary source of care in the community for persons with dementia and behavioral disturbances of persons with dementia are associated with caregiver depression including: Covinsky KE, Newcorner R, Fox P, et al. Patient and caregiver characteristics associated with depression in caregivers of patients with dementia. J Gen Intern Med. 2003;18(12):1006-1014.

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

The "Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness (EMPOWER) for Health Act of 2019 (H.R. 2781)" reauthorized 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 GWEPs educate and engage the broader frontline workforce and family caregivers and focus on opportunities to improve the quality of care delivered to older adults, particularly in underserved and rural areas. The GACAs represent an essential complement to the GWEP. Grounded in health professions education, GACAs ensure we can equip early career clinician-educators to become leaders in geriatrics training and research.

The EMPOWER for Health Act would allow current and future awardees to:

- Educate and engage with family caregivers by training providers who can assess and address their care needs and preferences.
- Promote interprofessional team-based care by transforming clinical training environments to integrate geriatrics and primary care delivery systems.
- Improve the quality of care delivered to older adults by providing education to families and caregivers on critical care challenges such as Alzheimer's disease and related dementias.
- Support clinician-educators engaged in geriatrics education and research to develop the next generation of innovators to improve care outcomes and care delivery.

The NCMHA recommends that Congress make this Act a priority for implementation moving forward with an appropriate level of funding to achieve the goals of the legislation.

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 essential that loan repayment programs also be extended to master's- and doctoral-level training programs for mental health professionals, such as psychologists, counselors, and social workers, who specialize in practice with older adults.

The shortage of geriatric psychiatrists in particular is at a crisis stage, and the number of inpatient geriatric psychiatric units at an all-time low. Urgent action is needed to reverse these trends.

Persistent disparities exist in the availability of behavioral health care services in underserved areas that contribute to poorer overall mental health status in these communities. 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 (HBAI) 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 Older Adult 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 older Americans in obtaining care for mental illness and substance use disorders.[19] 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. In 2017, the Centers for Medicare and Medicaid Services (CMS) introduced behavioral health integration billing codes allowing general medical providers to bill Medicare for mental health care planning and management services. However, uptake to date has been extremely low. For example, during 2017–2018, only 0.1 percent of Medicare beneficiaries with mental illness received a service billed to one of the new codes.[20] 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.[21] The 2015 Medicare Access and CHIP Reauthorization Act incentivized the model's adoption by making clinicians practicing in a recognized PCMH eligible for higher fee-for-service Medicare payments. 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.[22] ACOs were designed to improve behavioral health care management, coordination, and delivery through shared savings and losses (risk-based programs for providers) tied to the achievement of quality benchmarks and spending targets. However, recent evidence

---

[19] *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.

20 https://www.semanticscholar.org/paper/Use-of-Medicare%E2%80%99s-Behavioral-Health-Integration-in-Cross-Qin/d553045cbf52986637848d9091b0bb911091db22

21 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539809/

[22] National Association of ACOs, "Welcome," n.d.

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.

Medicare ACOs should be rewarded for meeting mental health quality metrics and ensure that specialty mental health providers are included in ACO networks. The absence of financial incentives explicitly tied to quality metrics and the lack of in-network mental health providers are the two most cited reasons for ACOs' failure to meaningfully improve the quality of mental health care they deliver to patients. Requiring ACOs to stratify general medical quality metrics by consumers' mental illness status also could help to incentivize high-quality general medical care for this group.

Inpatient Day Limits

Medicare beneficiaries are limited to 190 days of inpatient psychiatric hospital care in their lifetime. People with chronic mental illness, particularly younger beneficiaries who qualify for Medicare because of a disability, may exceed this limit and may be subject to high out-of-pocket costs for needed inpatient care. This is predominantly an issue for beneficiaries who are not dually eligible for Medicaid where state Medicaid programs pay for inpatient psychiatric services for most dual-eligible beneficiaries who have exceeded Medicare's 190-day limit. 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 (non-SNF) clinical social workers under Part B will likely increase access to evidence-based services and improve consumer outcomes.

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 tele-medicine services at select health care facilities, not at home. For this population subgroup, tele-mental health coverage has increased mental health service use.[23] Given that research showing tele-mental health services can improve consumer outcomes,[24] 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 COVID-19, with the majority of services, including group counseling, covered by Medicare and reimbursed at the

23 https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1461

24 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4582305/

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 November 2021, 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.

Cost-Sharing for Outpatient Mental Health Services

The 2008 Medicare Improvements for Patients and Providers Act (MIPAA) instituted a phase-out of unequal cost-sharing for mental health versus general medical outpatient services; as of January 2014, Medicare beneficiaries pay 20 percent coinsurance for both types of outpatient treatment. This policy change has been associated with increases in outpatient mental health follow-up care after a psychiatric hospitalization, particularly among Medicare enrollees living in areas where income and educational attainment are below average.[25]

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. This yearly preventive care–focused visit, introduced in 2011, is reimbursed at a higher rate and free to beneficiaries. Depression screening is one of the preventive services that can be included in the visit and is required for a beneficiary's initial wellness visit. While the annual wellness preventive visit has the potential to improve depression identification and treatment, studies show that uptake among Medicare beneficiaries overall has been low. Only 18 percent of Medicare fee-for-service beneficiaries and 25 percent of Medicare Advantage enrollees have received an AWV.[26]

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

25 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4757896/

26 www.aarp.org/content/dam/aarp/ppi/2019/05/annual-wellness-visits-among-medicare-advantage-enrollees.pdf

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 should be allowed to conduct the health risk Assessment and make referrals to needed services.[27]

Other improvements to the AWV that CMS should consider include an expansion of the providers, including aging network service providers, who can deliver the health risk assessment without oversight from a physician, funding a national awareness campaign, standardization of assessments to be used, e.g., PHQ-9, telehealth extension for AWV, and the addition of a social determinants of health assessment which is so important for Medicare beneficiaries with BH conditions, improved referral process, and compliance with follow-up activities that are part of the AWV.

Pre-Admission Screening and Resident Review Program (PASRR)

The federally mandated Pre-Admission Screening and Resident Review Program (PASRR) should be expanded to include all individuals with serious mental illnesses, intellectual/developmental disabilities, and/or related conditions applying for federally funded long-term care services and supports. PASRR currently applies only to individuals seeking admission to Medicaid certified nursing facilities.
Expanding the program to include to all types of long-term care would assist in decisions regarding placement and care planning. Rules should be adopted to require nursing facilities and residential settings to use PASRR data to develop person-centered care plans and provide for the services identified in the plan.

SAMHSA should require that PASRR data be included in the reporting requirements for the Community Mental Health and Substance Abuse and Prevention and Treatment Block Grant Programs. The expanded PASRR Program would also assist states in complying with Supreme Court Olmstead Decision requirements.

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

[27] 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

older adult 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.

Evidence-Based Programs and Evidence-Informed Practices for Older Adults with Mental Illness

Healthy IDEAS

Integrates depression awareness and management into existing case management services provided to older adults.

The Program to Encourage Active, Rewarding Lives (PEARLS)

PEARLS educates older adults about what depression is (and is not) and helps them develop the skills they need for self-sufficiency and more active lives. The program takes place in six to eight sessions over the course of four to five months in an older adults' home or community -based setting that is more accessible and comfortable for older adults who do not see other mental health programs as a good fit for them. PEARLS also allows for coordination with their current health care providers where appropriate.

Wellness Recovery Action Planning (WRAP)

Trained peer facilitators teach individuals with mental illness the skills, attitudes, and behaviors to self-manage their condition. The program has been implemented with a number of age groups.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an evidence-based practice for identifying and reducing problematic use of alcohol or other substances. It incorporates a public health approach of large-scale, universal prescreening often conducted in healthcare settings and follows with brief advice for those identified as moderate risk for substance use problems, brief treatment for those at moderate to high risk, or referral to treatment for those at highest risk.

Helping Older People Experience Success (HOPES)

Integrates psychiatric rehabilitation and health management to improve psychosocial functioning and to reduce the medical needs of older persons with mental illness.

IMPACT Care

Collaborative Care Model that is effective for reducing depression for older adults in primary care settings. It includes shared accountability for patient outcomes and processes of care amongst all providers and stakeholders.

Psychogeriatric Assessment and Treatment in City Housing (PATCH)

Drawing from the Assertive Community Treatment Model and the Gatekeeper Model, this program trains local workers to identify at-risk individuals, refer them for psychiatric follow-up and links them with a multi-disciplinary provider team.

Mental Health First Aid

Mental Health First Aid for Older Adults teaches how to identify, understand, and respond to signs of mental illnesses and substance disorders in older adults, and how to refer them to appropriate care.

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.

Medicare Advantage Mental Health Provider Networks

Medicare Advantage (MA) beneficiaries often lack access to in-network behavioral health providers and instead turn to higher-cost out-of-network care. One analysis of physician networks in Medicare Advantage health maintenance organizations (HMOs) and local preferred provider organizations (PPOs) offered in 20 counties across the U.S. in 2015 found that, on average, Medicare Advantage networks included only 23 percent of psychiatrists in a county — a smaller share than for all other 27 physician specialties examined.[28] In 2014, nearly 30 percent of all psychotherapy services received by Medicare Advantage beneficiaries were out-of-network.[29] These issues decrease access to appropriate care and/or disrupt continuity of care which is so important for older adults with mental illness.

Improvements are needed in mental health provider networks in Medicare Advantage. 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.

Older adults often sign on to these plans with the promise of no or lower premiums, as well as added benefit compared to fee-for-service. Once they've enrolled, if they are in need of mental health services, they often learn that the in-network providers lists are outdated and inadequate to meet the need. Further, networks can also be difficult for mental health providers to get on. The same problems exist for substance abuse treatment providers. This doesn't appear to meet the "equal or superior to traditional Medicare benefits" requirement of MA plans and flies in the face of the spirit of mental health parity laws. High coinsurance and deductible costs for plans geared to low-income recipients who can't afford them cause members to forgo behavioral health services altogether, putting them at risk.

Prescription Medication Coverage

Antidepressants and antipsychotics are two of six "protected classes" of drugs in Medicare Part D, which means they must be covered. The 2018 proposed Medicare Advantage and Part D Drug Pricing Rule would have allowed Part D plans to exclude these protected drug classes from their formularies if prices increased beyond a set threshold.[30] However, the final rule issued in May 2019 did not implement this change.[31] Evidence demonstrates that the protected-class status for antidepressants and antipsychotics has raised drug costs for both the Medicare program and its

28 https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/

29 https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05226

30 https://www.federalregister.gov/documents/2018/11/30/2018-25945/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocket-expenses

31 https://www.federalregister.gov/documents/2019/05/23/2019-10521/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocket-expenses

beneficiaries. However, it is possible that in the absence of protected status, Part D plans might exclude drugs in these classes as a way to avoid high-need, high-cost enrollees.

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 older adults. For example, the current Build Back Better proposal (1) cap out-of-pocket costs for Medicare Part D beneficiaries at $2,000 each year and better align incentives to lower prices; (2) require the Secretary of Health and Human Services to annually negotiate with drug manufacturers for the highest priced and most commonly used prescription drugs; and (3) require drug manufacturers who increase their prices faster than inflation to pay back that excess amount to the federal government. The proposed changes would significantly impact older adults with mental illness who rely on medications to manage both their mental health and other chronic conditions.

Congress Should Provide Funding to Support Research and Development of Prevention Programs to Address Older Adult Suicide.

The Centers for Disease Control and Prevention (CDC) reports that the suicide rate of older adults aged 75 and older is 16.3 per 100,000 which is more than the national average for all age groups. The highest rate for all populations and genders is males over 75 at 36 per 100,000 which is more than two and one half times the overall national rate for all populations.[32] More research is needed on the prevention of older adult suicide and what works most effectively in reducing suicide among older adults. Few programs have been developed, evaluated, and disseminated.

Access to mental health treatment is critical to preventing suicide. As discussed previously, workforce shortages and other barriers significantly impact access to mental health providers.

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

All older adult behavioral health services provided should be linguistically, culturally, ethnically, and age appropriate.

A dramatic transformation is occurring in the U.S. resulting in a culturally diverse older adult population. The older adult African-American and Hispanic population is projected to increase by 160% in the next two decades. The older immigrant population increased from 2.7 million to 4.6 million in the past 20 years. Further, there is estimated 1.75 – 4 million LGBT older adults in the U.S.[33]

[32] https://www.cdc.gov/nchs/products/databriefs/db362.htm

[33] https://www.apa.org/pi/about/newsletter/2018/06/older-adult-mental-health

African-Americans and Hispanics are overrepresented in many subgroups at high risk for the development of mental health disorders, and they have less access to mental health services than Whites, are less likely to receive needed services, and often receive a lower quality of care.

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 older adult requires long-term care, there are only 17 nursing homes for 567 Federally recognized tribes.[34]

Increased support is needed for the behavioral health services that are aligned with the preferences of older adults. For example, approximately 50% of older adults state a preference for counseling services over medication management; with older African Americans particularly inclined toward counseling services.[35]
An increasingly diverse aging population requires a culturally competent geriatric mental health workforce. Culture and diversity should be viewed as a strength and providers should build upon the skills older adults have developed over a lifetime of experience in building support networks.

Technologies hold the promise for rural older Americans. However, there is uneven access to technology for some members of the older population, including those aged 75+ and those of lower socio-economic status, who do not have access to broadband, technology, or the skills to use technology.

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.

[34] https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/the-tribal-nursing-home-collaborative

[35] 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.

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 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.[36]

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 older adults 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.

Telehealth services allow providers to serve more older adults due to reduced travel time to homebound older adults; improve access to care; and reduce cancellations due to mobility and health concerns; weather and transportation barriers. Now that the benefits of telehealth are so abundantly clear, these services should be made permanent. Audio-only services should be offered as an option to those who need or prefer it, while ensuring that all clinicians have the capacity to provide video-based services as well. The proposed requirement for an in-person visit every six months after the initiation of telehealth services may present a treatment barrier that will decrease access to care given the lack of providers and transportation, especially in rural areas, in addition to the other barriers noted above. The decision regarding when and whether to schedule an in-person session should be a clinical decision made between the clinician and their client and not legislated.

Opportunities for Improvement in the Post COVID-19 Era

With the approaching demographic change, we will witness an unprecedented increase in the number of older adults 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.

36 Hubley, S, Lynch, SB, Schneck, C, et al, "Review of Key Telepsychiatry Outcomes" World Jour of Psychiatry. 2016;(2):269-82.

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.

Sincerely,

*Joel E. Miller*JEM

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