

March 20, 2023

The Honorable Bernard Sanders
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On behalf of the Mental Health Liaison Group (MHLG) Workforce Working Group, thank you for the opportunity to provide a response to the request for information (RFI) on the healthcare workforce shortage. The Working Group is composed of organizations that drive policy and advocacy on behalf of multiple healthcare provider types and patient populations, with a focus on mental health and substance use care.

Despite the ever-increasing demand for mental health and substance use services, for years, the United States has faced a significant behavioral health workforce shortage.ⁱ Over 160 million people across the nation live in Mental Health Professional Shortage Areas (HPSAs) – with an additional 8,000 providers estimated to be needed to fill this gap.ⁱⁱ A recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA) demonstrates how these shortages affect patients' access to care: 35% of individuals with a serious mental illness did not receive services, and 93% of individuals who needed substance use treatment did not receive it, in 2021.ⁱⁱⁱ

Findings from a recent nationwide study of providers' experiences by the National Council for Mental Wellbeing underscore how severely this crisis is affecting the field: 65% of providers reported that their caseload increased since the beginning of the COVID-19 pandemic, and approximately 80% say that the workforce shortage is a major/moderate concern for both the industry and society as a whole.

Barriers to Entering the Workforce

As evidenced by the sheer volume of Mental Health HPSAs, there is a distinct gap on the supply side of the mental health and substance use workforce. The return on investment may not be as clear for those considering working in behavioral health; the salary for many professions within the behavioral health workforce may not be considered competitive due to the physical, mental, and emotional labor required for the position.^{iv} ^v Additionally, with minority populations being underrepresented in the workforce, there is not always mentorship or support available to encourage other demographically similar individuals to enter the behavioral health workforce. This, in turn, can lead to patients choosing not to seek care due to a lack of access to culturally diverse and/or culturally competent providers.^{vi}

Increasing funding for and expanding the reach of national loan repayment programs (LRPs) would be an excellent start to increasing the pool of mental health professionals and reducing these workforce barriers. Behavioral health professionals are currently eligible for the following national LRPs: the National Health Service Corps (NHSC) LRP, the NHSC Substance Use Disorder Workforce LRP, the NHSC Rural Community LRP, and the Substance Use Disorder Treatment and Recovery (STAR) LRP. All of the aforementioned LRPs are administered by the Health Resources and Services Administration (HRSA). LRPs help address the geographic maldistribution of the workforce and incentivize joining the workforce for individuals who otherwise may be deterred by the cost of education and training.^{vii}

Providers who participate in federal LRPs are a quickly growing population; the number of behavioral health providers in community clinics who participated in the NHSC grew by 96% from 2013 to 2017.^{viii} Additionally, over 60% of NHSC-involved mental health professionals continued to practice in

underserved areas four years after their commitment, demonstrating the effectiveness of the program in helping to retain providers.^{ix}

Two nuanced NHSC-related provisions, the number of hours dedicated to providing services to patients outside the clinic walls and the types of clinics that qualify as eligible sites, are of particular concern to the Working Group. Of the minimum 20 hours a week that must be spent providing patient care, only 8 can count toward performing clinical-related administrative activities or in an alternative setting (e.g., hospitals, nursing homes, and shelters) as directed by the approved sites. However, certain types of clinics, such as Certified Community Behavioral Health Clinics (CCBHCs), have seen significant positive impacts from increasing the amount of patient care that is provided in the communities they serve. These types of activities would not traditionally be included under the “other activities” as listed in the requirement for NHSC eligibility yet could lead to significantly improving access to and quality of care. In a 2022 study of CCBHCs nationwide, 100% reported taking steps to improving access to care and reducing health disparities, including serving people of color or other historically marginalized populations. 94% of clinicians have created training for staff on culturally sensitive/competent care, and 84% have been able to increase outreach or access for people who have been traditionally underserved. While Critical Access Hospitals can provide inpatient services for up to ten beds for psychiatric and rehabilitation units, this does not meet the needs of patients nationwide. These inpatient care facilities also face severe workforce shortage issues, and this expansion would help meet those needs by allowing NHSC-eligible individuals to provide care in these invaluable settings.

Another area where the Committee should consider providing support is increasing access to tuition assistance, as opposed to solely loan repayment. While the Nurse CORPS has a Scholarship Program administered through HRSA, there is no comparable option for the mental health and substance use fields. We urge the Committee to work with HRSA to create a program for students enrolled in certain behavioral health programs at accredited United States educational institutions, where participants receive tuition awards with a requirement to work in an NHSC Health Care Site or something similar upon graduation. Loan repayment can support the financial wellbeing of employees after they have taken on this significant burden but may still be inaccessible for those who are unable to take out student loans at the onset of their education.

Barriers to Accessing Care

The workforce is disproportionately located around urban areas, leaving a distinct lack of access to lifesaving mental health and substance use care in rural communities.^x We urge the Committee to address this issue by (a) broadening the types of mental and behavioral health providers eligible to enroll and subsequently seek reimbursement for rendered services from Medicare and (b) more fully and more effectively utilizing the mental and behavioral health workforce we already have by allowing them to provide the full range of Medicare-covered services within their scope of licensure.

The Working Group is grateful for the inclusion of the Mental Health Access Improvement Act that recognized mental health counselors and marriage and family therapists as Medicare providers in the Consolidated Appropriations Act, 2023, adding an estimated 225,000 Medicare-eligible providers to the behavioral health workforce. Nearly one-in-five older adults experience a mental illness or substance use disorder. Allowing mental health counselors and marriage and family therapists to serve Medicare enrollees with behavioral health disorders will significantly increase the number of providers able to address the nation’s growing patient population, and we look forward to working with Congress and the Administration further to implement this Medicare workforce expansion.

One other key piece of legislation would immediately increase access to lifesaving mental health and substance use care for Medicare beneficiaries in a similar manner. The Promoting Effective and Empowering Recovery Services (PEERS) in Medicare Act allows for the participation of peer support specialists in the provision of integrated behavioral health services to Medicare beneficiaries. This legislation will allow peer support specialists to work alongside Medicare mental and behavioral health providers to expand access to care. Additionally, the legislation provides a definition of peer support specialists in the Medicare program.

Another critical piece of legislation, the Improving Access to Mental Health Act, would allow Medicare to more fully and effectively utilize the services of enrolled clinical social workers to increase Medicare beneficiaries' access to care. The legislation would allow clinical social workers to bill independently in Skilled Nursing Facilities and provide vital health and behavior assessment and intervention (HBAI) services. Unlike psychiatrists and psychologists, clinical social workers currently cannot be reimbursed by Medicare for HBAI services even though the Centers for Medicare and Medicaid Services has acknowledged that these services are fully within clinical social workers' scope of practice. The legislation also would help address recruitment and retention difficulties by increasing clinical social workers' reimbursement from 75% to 85% of the physician fee schedule, aligning their reimbursement with that of other non-doctoral level health professionals enrolled in Medicare.

Barriers to Retaining the Workforce

The behavioral health workforce faces significant barriers to retaining staff, outpacing several other provider types. The mental health and substance use sectors of the healthcare workforce face relatively high rates of turnover (i.e., SAMHSA reported an average turnover rate of 32% in the substance use space).^{xi} For comparison, physicians' turnover rate is considered a concern at around 7%.^{xii} The high turnover rate results in an annual cost of \$100-200,000 for a large organization, taking into account the minimum cost of replacing a coworker at 30% of their annual salary.^{xiii} In a recent report, Maryland administrators found that the top reasons for turnover, starting with the most pressing, were: salary, burnout, insufficient career growth potential, and administrative burden.^{xiv}

The unprecedented increase in demand for services and the associated impact on provider wellbeing and burnout have pushed already concerning workforce shortages to crisis levels. In order for providers to have more flexibility to address workforce wellness and retention, we recommend that the Senate HELP Committee add specific language to the FY24 committee report that among existing SAMHSA grants, SAMHSA may allow providers more flexibility to build capacity to address workforce wellness and workforce retention - including burnout prevention strategies and allowing investments infrastructure, including technologies, that reduce staff burden and increase clinical impact.

Health Equity

While rates of mental illnesses in Black/African Americans (B/AAs) are similar to those of the general population, only 26.4% of Black and Hispanic males ages 18 to 44 who experienced daily feelings of anxiety or depression were likely to have used mental health services, compared with 45.4% of non-Hispanic White males who also reported feelings of anxiety and depression. Studies have shown mental health treatment can be more effective when it aligns with the culture of the client and when therapists demonstrate multicultural competence.^{xv}

A recently published paper by the National Council for Mental Wellbeing, *Recruitment and Retention of African American Men in the Mental Health and Substance Use Workforce*, addresses health equity within the workforce and its importance.^{xvi} The paper makes several recommendations the Committee can consider, including supporting community education/stigma reduction programs. Mental health has often been a taboo topic in B/AA households, and stigma plays a significant role in why people do not seek treatment. Ensuring communities have accurate information about mental health and substance use challenges is critical to their health and wellbeing. The views of community members can shape how other individuals see the benefits of mental health and substance use services and the appropriateness of becoming a mental health and substance use professional. Community education and addressing stigma within the B/AA community can improve access to care and increase interest in mental health and substance use careers. Creating public education programs and anti-stigma campaigns focused on mental health and substance use within B/AA communities can help normalize conversations around mental health and substance use challenges and potentially spark greater interest in mental health and substance use careers.

Certified Community Behavioral Health Clinics (CCBHCs)^{xvii}

Faced with decades of underfunding, ongoing struggles to recruit and retain staff, and dual mental health and substance use crises nationwide, the behavioral health system has long needed significant investment and transformation to meet the true needs of communities across the country. The CCBHC model is delivering the resources our nation needs to change the care landscape. CCBHCs are clinics – either certified by their states as CCBHCs or recipients of a federal CCBHC grant – that receive flexible funding to expand the scope of mental health and substance use services in their community. They serve anyone who walks through the door, regardless of ability to pay.

The CCBHC model was originally implemented in eight states through a Medicaid demonstration program, with two states added to the demonstration in 2020. Since 2018, grants from SAMHSA have funded clinics in dozens of states to take on the activities and services of a CCBHC. These grants have proven to be a vital springboard to CCBHC implementation, positioning clinics and states for further delivery system transformations as they implement the CCBHC model in their Medicaid programs. Under the 2022 Bipartisan Safer Communities Act, the demonstration will expand to include 10 new states every two years, starting in 2024 – and will ultimately offer all states the opportunity to translate their grantees' work into a new, sustainable model of care.

In the midst of the ongoing mental health and substance use workforce shortage, clinics have struggled to hire and retain sufficient staff to meet their communities' needs, often losing staff to other employers or fields that can offer more competitive salaries. However, CCBHCs and grantees have been able to leverage their Medicaid payment structure and/or grant funding to recruit and retain highly qualified staff. The most common strategy CCBHCs and grantees are using to mitigate the effects of the workforce shortage is raising salaries or offering bonuses (92%). In a 2022 study of CCBHCs across the country, clinics responded that their CCBHC funding has enabled them to offer more competitive pay relative to other providers and industries in their area.

Beyond addressing staff pay, the vast majority of CCBHCs and grantees are also actively engaged in a variety of other strategies to mitigate the effects of the workforce shortage, including engaging in staff wellbeing efforts, revamping employee benefits, and other strategies to improve staff satisfaction and retention (86%). Other strategies include partnerships with clinician training programs (62%), revising job descriptions and care teams to allow staff to practice at the top of their license (59%), and enhancing

the provision of integrated behavioral health and primary care so more needs can be addressed in a single visit (57%). 46% of respondents serve as an NHSC-eligible site for loan repayment, and 35% participate in other kinds of LRPs.

Numerous respondents shared comments about the impact of CCBHC status on workforce retention. By providing a source of funding for critical client care activities such as outreach, client engagement, care coordination, and internal team consultation/support, the CCBHC model supports flexibility in how staff engages with clients and with one another. Many respondents commented that this contributes to a more desirable working environment and has reduced staff turnover.

The Importance of Increasing the Behavioral Health Workforce

It is significantly less costly to have a supported, comprehensive workforce that has the resources to treat all individuals in need and to have those professionals stay in the workforce.^{xviii xix} The pervasive behavioral health workforce shortage has led to a significant barrier to accessing lifesaving services for people experiencing behavioral health conditions. Mental Health HPSAs experience a suicide rate 6% higher than the rest of the country.^{xx xxi} Bolstering and maintaining the behavioral health workforce is one of the most pressing issues facing our nation.

The Working Group appreciates the opportunity to respond to the Request for Information and urges the Committee to prioritize policy solutions that address the challenges facing those interested in entering the field, as well as the challenges faced by those who are currently participating members of the behavioral health workforce. We welcome any questions or further discussion about the recommendations described here. Please contact the Working Group co-chairs Reyna Taylor (ReynaT@thenationalcouncil.org) and Elizabeth Cullen (Elizabeth.Cullen@JewishFederations.org). Thank you for your time and consideration.

Supporting Organizations

American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Counseling Association
American Foundation for Suicide Prevention
Association for Ambulatory Behavioral Healthcare
Association for Behavioral Health and Wellness
Centerstone
Depression and Bipolar Support Alliance
Inseparable
Jewish Federations of North America
National Alliance on Mental Illness
National Association of Social Workers
National Council for Mental Wellbeing
Network of Jewish Human Service Agencies

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- ⁱ HRSA. "Health Workforce Shortage Areas." 2023. Web.
- ⁱⁱ HRSA. "Health Workforce Shortage Areas." 2023. Web.
- ⁱⁱⁱ Substance Abuse and Mental Health Services Administration. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health." 2022. Web.
- ^{iv} Mental Health America. "The Peer Workforce."
- ^v Center on Budget and Policy Priorities. "Medicaid is Key to Building a System of Comprehensive Substance Use Care for Low-Income People." 2021. Web.
- ^{vi} Salsberg, Edward et al. "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce."
- ^{vii} University of Michigan School of Public Health Behavioral Health Workforce Research Center. "Behavioral Health Provider Geographic Distribution and Reimbursement Inequities." 2019. Web.
- ^{viii} Han, Xinxin, and Leighton Ku. "Enhancing Staffing in Rural Community Health Centers Can Help Improve Behavioral Health Care." *Health Affairs* 38.12 (2019): 2061-2068. Web.
- ^{ix} Olfson, Mark. "Building the Mental Health Workforce Capacity Needed to Treat Adults with Serious Mental Illnesses."
- ^x Andrilla, Holly et al. "Geographic Variation in the Supply of Selected Behavioral Health Workers." *American Journal of Preventive Medicine* 54.6.3 (2018): S199-S207. Web.
- ^{xi} Sherman, Laura et al. "Behavioral Health Workforce: Quality Assurance Practices in Substance Abuse Treatment Facilities." SAMHSA. 2017. Web.
- ^{xii} Brabson, Laurel et al. "Workforce Turnover in Community Behavioral Health Agencies in the USA: A Systematic Review with Recommendations." *Clinical Child and Family Psychology Review* 23.3 (2020): 297–315. Web.
- ^{xiii} Ibid
- ^{xiv} Maryland Department of Health. "Maryland Behavioral Health Workforce Survey Results Summary." 2020. Web.
- ^{xv} Soto et al. "Cultural Adaptions and Therapist Multicultural Competence: Two Meta-Analytic Reviews." *Journal of Clinical Psychology*. (2018). Web.
- ^{xvi} National Council for Mental Wellbeing. "View from the Field: Recruitment and Retention of African American Men in the Mental Health and Substance Use Workforce." (2022). Web.
- ^{xvii} National Council for Mental Wellbeing. "2022 CCBHC Impact Report." (2022). Web.
- ^{xviii} Raven, Maria C. et al. "Substance Use Treatment Barriers for Patients with Frequent Hospital Admissions." *Journal of Substance Abuse Treatment* 38.1 (2010): 22–30. Web.
- ^{xix} Ibid
- ^{xx} Olfson, Mark. "Building the Mental Health Workforce Capacity Needed to Treat Adults with Serious Mental Illnesses."
- ^{xxi} Ku, Benson et al. "Associations Between Mental Health Shortage Areas and County-Level Suicide Rates Among Adults Aged 25 and Older in the USA, 2010 to 2018." *General Hospital Psychiatry* 70 (2021): 44–50. Web.