Introduction

Behavioral health providers across the nation are working hard to meet their communities’ needs. Despite their efforts, rising suicide rates, the ongoing opioid crisis and other urgent challenges remind us that many barriers remain to achieving the goal of granting every American access to comprehensive mental health and substance use disorder care.

Policymakers in many states have been slow to adopt solutions that would support community providers in expanding access to services, highlighting the need for additional tools advocates can use to make the case for improved funding, a more robust workforce and other critical policy changes. That’s why the National Council for Behavioral Health produced the Advocacy Toolkit, funded by Cohen Veterans Network, as a part of the America’s Mental Health Campaign. This campaign was created to raise public awareness of mental health and substance use disorder care access gaps and potential solutions, promote effective models for delivering community care and advocate for the expansion of the mental health and substance use disorder workforce.

This toolkit provides data and resources that can be used to support the multitude of initiatives stakeholders are advocating for in their states. It also provides resources to support advocacy on two current federal initiatives that will expand access to services: the Certified Community Behavioral Health Clinic (CCBHC) program and the expansion of the behavioral health workforce in Medicare.

Legislation to advance CCBHCs and the expansion of the mental health and substance use disorder workforce addresses the barriers of cost, distance, knowledge gaps, stigma and wait times, while making positive changes in the opioid crisis, elevated suicide rates and untreated serious mental illness (SMI). However, they are not the only two policies that will increase access to care. We encourage readers to use the data and tools this kit provides in support of their advocacy for any policies at the local, state or federal level that will enhance access to care. As state-level laws, regulations and restrictions vary, not all data and advocacy points will be relevant for every state. The National Council encourages advocates to select the resources that will best benefit their needs.

A note about the data: The America’s Mental Health 2018 survey was launched in the summer of 2018. It queried 5,000 Americans about their attitudes and access to “mental health care.” In the context of this survey, the term “mental health” was defined for participants as being inclusive of substance use disorders and as pertaining to health conditions that affect a person’s emotional, psychological and social well-being, such as:

- Anxiety disorders (e.g., generalized anxiety disorder, panic disorder, some phobias)
- Mood disorders (e.g., depression, bipolar disorder)
- Psychotic disorders (e.g., schizophrenia)
- Addictions (e.g., substance use disorders)
- Eating disorders (e.g., anorexia, bulimia)
- Post-traumatic stress disorder (PTSD)
- Obsessive-compulsive disorder (OCD)
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The Need: Greater Access to Mental Health and Substance Use Disorder Care

Cohen Veterans Network and National Council for Behavioral Health partnered to produce America’s Mental Health 2018, a survey of 5,000 American adults along with a secondary analysis of state mental health and substance use disorder resources. The survey asked Americans about their attitudes toward mental health, defined for respondents as being inclusive of substance use disorders. It found that while 76 percent of Americans considered mental health as important as physical health, five key barriers often prevent people from getting the care they so desperately need.

- **Cost** — One in four Americans have had to choose between getting mental health treatment and paying for daily necessities.ii
- **Distance** — Nearly half (46 percent) of American adults have had to, or know someone who has had to, travel more than one hour roundtrip to their most recent mental health care appointment.iii
- **Knowledge Gaps** — 46 percent of those who have never sought treatment would not know where to go if they needed to seek mental health services for themselves, a family member or a friend.iv
- **Stigma** — Nearly one in three Americans has worried about others judging them when they told them they have sought mental health services, and 52 percent have tried to “grin and bear it” instead of seeing a doctor when feeling depressed or mentally unstable.v
- **Wait Times** — 96 million American adults (38 percent) have had to wait longer than one week for mental health services.vi

The high cost and, in many cases, lack of coverage, long distances to clinics, lack of public knowledge leading to stigma and long wait times have made it unreasonably hard for many people to access care. The difficulties compound when individuals seek both mental health and substance use disorder treatment, as care for both are often delivered in silos that inhibit coordination and decrease access. Lack of care leads to greater rates of hospitalization and more crisis situations, thus exacerbating individuals’ ill health, harming communities and costing the government more money. We need to find a better path forward.

The following sections include data and infographics that can be used to support a variety of advocacy initiatives targeted at increasing access to care. For advocates with an interest in the Certified Community Behavioral Health Clinic (CCBHC) program and expanding the behavioral health workforce, we provide specific templates and resources to advance the relevant federal legislation.
Spread the Word

Shareable Data and Infographics

To help policymakers understand common barriers to accessing care, use these infographics on your website, on social media or in fact sheets, presentations or other educational material. Click these graphics to download the images. We encourage you to choose the most relevant images and data points in support of your state’s most pressing advocacy initiatives.
State Specific Data from America’s Mental Health Survey

Use data from America’s Mental Health 2018 to help you talk about your state’s specific needs when engaging with legislators and other stakeholders for your state’s most pressing advocacy initiatives. You can use it to highlight the need for various programs and policies touching on the availability of providers, facilities and funding.

The following data from America’s Mental Health 2018 is an analysis of multiple data sets drawn from the Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration’s (HRSA) Data Warehouse, United Health Foundation’s America’s Health Rankings and Statista. Scores are grouped into three categories, each representing a composite number that broadly reflects the availability of providers, facilities and funding in each state. Scores range from 0 to 100, with 100 indicating that there are sufficient resources to fully meet the need for mental health and substance use disorder care within the state.

It is important to note that no state scored 100 in any category. This means that significant access gaps remain in every state, with many experiencing particularly acute shortages of providers, facilities and funding. Additionally, the scores did not account for other barriers to timely care such as insurance coverage of the full scope of services, inclusion of services in state Medicaid plans, common utilization restrictions such as prior authorization and fail-first policies or other barriers that may prevent people from accessing care even when providers or facilities are available in their community. Advocates are encouraged to highlight these barriers alongside your state’s scores when presenting information to policymakers.

Chart Reading Key

Providers — Measures the degree to which a state has adequate behavioral health providers1 to meet at least a minimum level of sufficiency for the need. Zero indicates no access available for patients and 100 indicates there are enough providers to fully meet their communities’ needs. The score accounts for:

- The number of individuals per provider.
- The number of psychiatrists available to serve the population of the area, group or facility divided by the number of psychiatrists that would be necessary to eliminate the mental health Health Professional Shortage Area (HPSA).
- The number of practitioners needed to remove HPSA designation.

Please note that this score does not account for other metrics of access to providers such as inclusion in insurance networks or wait times. No state scored 100 in this category.

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1 The term “behavioral health providers” includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care. They may provide substance abuse disorder care but that was not specifically measured within this dataset.
**Facilities** — Measures how many mental health facilities and number of patients are being served in a state. Zero indicates no access available for mental health patients and 100 indicates there are enough mental health resources to meet the full need for services. **No state scored 100 in this category.** The score accounts for:

- The number of mental health facilities including mental health treatment-only facilities and facilities that offer programs for persons with co-occurring mental health and substance use disorders.
- The percentage of patients who were served per 1,000 in the general population.

**Funding** — Measures the amount of federal and state resources dedicated to mental health and substance use disorder treatment in a state. Zero indicates that state/federal governments do not provide financial resources to fund mental health treatments and 100 indicates that they provide enough resources to support mental health patients relative to their need based on available data. **No state scored 100 in this category.** The score accounts for:

- Utilization of Medicaid funding (state rate).
- Both state mental health agency expenditures for community mental health (including primary prevention, evidence-based practices for early serious mental illness and other 24-hour care) and state expenditures from other state sources.
- State dollars dedicated to public health and federal dollars directed to states by the Centers for Disease Control and Prevention (CDC) and Health Resources Services Administration per person.
- Active HRSA 2018-awarded grants to improve and expand health care services for underserved people.

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### State Data Chart

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Example: How to Use Data Points for Advocacy

The following example shows how you can use the America’s Mental Health 2018 data to frame advocacy “ask” materials (e.g., draft talking points, advocacy letters) for mental health and/or substance use disorder related advocacy initiatives.

### Example Case 1

You are lobbying your state legislature to establish a loan forgiveness program to attract more mental health and substance use disorder treatment professionals to the state. This is how you might use the America’s Mental Health 2018 data to present your case:

96 million American adults (38 percent) have had to wait longer than one week for mental health and/or substance use disorder services. In addition, nearly half (46 percent) have had to, or know someone who has had to, travel more than one hour roundtrip to their most recent mental health care appointment. The shortage of substance use and mental health professionals in our state directly contributes to long wait times and difficulty seeking care. In an analysis of data performed by Cohen Veterans Network and the National Council for Behavioral Health, our state scored 26 out of 100 in our ability to provide enough treatment professionals to meet our communities’ needs. This dismally low score reflects our state’s high number of health professional shortage areas, lack of practicing psychiatrists and other core behavioral health providers and high level of unmet need for services, making our state one of the most under-resourced in the country. [Provide advocacy materials and specific requests related to the loan forgiveness program.]

### Example Case 2

You are lobbying your state legislature to appropriate additional funding for programs that provide financial assistance to residents seeking substance use disorder and mental health services. This is how you might present your case:

One in four Americans have had to choose between getting mental health treatment and paying for daily necessities. High costs are one of the most critical barriers to accessing care in our state, making it imperative that we support our friends and neighbors by providing access to services regardless of their ability to pay. In an analysis of data performed by Cohen Veterans Network and the National Council for Behavioral Health, our state scored 70 out of 100 on the extent to which the funding we appropriate for services meets the full needs in our communities. This means we have a long way to go in ensuring every state resident can access care. [Provide advocacy materials and specific requests related to the funding request.]
Selected Federal Policy Solutions

States and the federal government are considering many proposed policy changes to increase access to mental health and substance use disorder care. The data in this toolkit can be used to assist advocates working to enact numerous initiatives. There are many important initiatives before Congress and state legislators and this toolkit is not meant to encompass all policy changes that deserve consideration. Here, we provide specific resources for two policies that are gaining increasing attention before Congress: the CCBHC demonstration and legislation to increase the mental health and substance use disorder workforce serving seniors and low-income Americans living with disabilities.

CCBHCs

America is experiencing an ongoing mental health crisis. Only 43.1 percent of all people living with serious mental illnesses like schizophrenia, bipolar disorders and major clinical depression receive behavioral health care,\(^4\) and only one in 10 Americans with a substance use disorder receives treatment in any given year.\(^\text{xii}\) Meanwhile, decades of funding cuts have left treatment providers struggling to hire staff and expand programs to meet the needs in their communities.\(^\text{xii}\) In 2014, Congress enacted the bipartisan **Excellence in Mental Health Act**, which established the CCBHC demonstration program with the aim of improving the quality of substance use disorder and mental health care and filling the gap in the unmet need for care.\(^\text{xiii}\)

CCBHCs provide a comprehensive range of substance use disorder and mental health services to vulnerable individuals. In return, CCBHCs receive a Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs must provide nine types of services, with an emphasis on providing both mental health and substance use care, 24-hour crisis care, evidence-based practices and care coordination, thus expanding mental health and substance use disorder treatment access through a mandated increase in accountability, capacity, cost savings, coverage, efficiency, sustainability and standard of care.\(^\text{xiv}\) In contrast to the current piecemeal reimbursement system that leaves many clinics unable to cover their operating costs, the enhanced payment rate provides clinics with a more sustainable financial footing as they serve more consumers in their communities.

Sixty-six CCBHCs launched in eight states (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania) in 2017.\(^\text{xv}\) Early results\(^\text{xvi}\) from the two-year program demonstrate how CCBHCs are advancing access to mental health and substance use disorder care. As the nation considers what steps should be taken to address the ongoing mental health and substance use disorder challenges, the CCBHC model deserves to be expanded so more communities can transform their capacity to serve people living with mental illness and substance use disorder. Legislation currently before Congress\(^5\) would extend the original eight-state, two-year demonstration project and expand the program to include the other 11 states that applied but were not chosen to participate. This legislation is the next step toward having CCBHCs operate in every state in the nation. Even if your state is not directly benefitting from the CCBHC demonstration currently, supporting this legislation now ensures that your state will have a chance to be a part of the potential expansion in the future.

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\(^1\) In the 116th Congress (2019-2020), legislation to expand the CCBHC demonstration is the Excellence in Mental Health and Addiction Treatment Expansion Act (S. 824/H.R. 1767).
Behavioral Health Workforce Expansion

In 2017, there were 12 million people simultaneously enrolled in Medicare and Medicaid. Of these dually eligible individuals, 41 percent have at least one mental health diagnosis. In addition, it is estimated that there are 49.2 million American adults over the age of 64. Older adults have an elevated need for mental health and substance use disorder services, yet are the least likely to receive them. Lack of steady access to care for these groups has caused higher hospitalization rates, costing the country billions in Medicare dollars. Providing these populations access to localized, Medicare billable mental health and substance use disorder treatment practitioners is critical to reducing hospitalizations, saving money and closing the access gap.

Legislation supporting mental health practitioner reimbursement in Medicare would allow marriage and family therapists (MFTs) and licensed mental health counselors (LMHCs), many of whom are licensed to provide substance use disorder services, to directly bill Medicare for their services rendered to this population. These professionals are currently excluded from Medicare even though they receive similar training, undergo similar credentialing and provide similar services to other types of professionals that participate in Medicare.

MFTs and LMHCs make up approximately 200,000 of America’s mental health and substance use disorders treatment professionals. These individuals are often found in community behavioral health settings providing direct care services to patients, including in places without access to other types of treatment professionals. In fact, half of all U.S. counties have no practicing psychiatrists, psychologists or social workers; however, many of these rural and underserved areas do have practicing MFTs and/or LMHCs. Permitting these professionals to directly bill Medicare for their services will dramatically expand access to care for older adults and low-income Americans with disabilities, immediately alleviating much of the strain on the nation’s mental health and substance use disorder treatment workforce and improving access to care.

Explaining the Impact of CCBHCS and Medicare Workforce Development on Current National Priorities to Policymakers

Among the challenges currently at the top of lawmakers’ minds are rising suicide rates, addressing untreated mental illness and the opioid crisis. The two federal policy changes highlighted here will help address these issues:

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6 In the 116th Congress (2019-2020), legislation supportive of mental health practitioner reimbursement in Medicare is the Mental Health Access Improvement Act (S.286/H.R.945).
7 For states currently ineligible to participate in the federal CCBHC demonstration, there are opportunities to implement the CCBHC model using a state-driven approach such as via a Medicaid waiver or State Plan Amendment. The data and resources presented here are also relevant for advocacy campaigns to promote these state-led approaches.
Addressing the Opioid Crisis

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<tr>
<td>Nationwide, only 36 percent of substance use treatment facilities offer access to one or more types of medication-assisted treatment (MAT) due in part to funding shortfalls that prevent the hiring of prescribers. All CCBHCs have either launched new substance use disorder treatment services or expanded the scope of their substance use care, and 92 percent have expanded access to MAT for opioid use disorders.(^{xiv})</td>
<td>Medicare pays for one in three opioid hospitalizations.(^{xxv}) Marriage and family therapists and licensed mental health counselors who are trained in substance use disorders can serve in treatment facilities, getting people help before they end up in the emergency room. Allowing Medicare beneficiaries access to this vital workforce would instantly expand their community-based addiction service options while simultaneously reducing costly opioid-related hospitalizations.(^{xxvi})</td>
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Addressing Rising Suicide Rates

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<td>Early intervention is key in suicide prevention. Long wait times and inconsistent care accessibility for people facing suicidal thoughts can be deadly. Community crisis services can provide necessary assessment, screening, triage, counseling and referral services to individuals in crisis. All CCBHCs offer 24/7 access to crisis care, including mobile crisis teams, ensuring timely access to care.(^{xxvii})</td>
<td>Individuals age 65 and older have a suicide rate that exceeds the rest of the population. Yet, they are the least likely to receive mental health services, with only one in five receiving needed therapy.(^{xxviii}) Allowing additional providers to serve Medicare enrollees with mental health issues would offer instant access to millions.</td>
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Addressing Untreated Mental Illness

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<td>CCBHCs are available to any individual in need of care, regardless of ability to pay,(^{xxix}) including people with serious mental illness, opioid use disorders, serious emotional disturbances, long-term chronic substance use disorders and complex health profiles.(^{xxx}) Expanding CCBHCs would ensure local access for individuals living with SMI.</td>
<td>Removing Medicare’s exclusion of marriage and family therapists and licensed mental health counselors will dramatically expand access to care for older adults and people with disabilities. Allowing qualified, previously ineligible providers to directly bill Medicare for their services would add over 200,000 mental health providers to the Medicare network.(^{xxxi})</td>
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How to Get Involved and Stay Current

For the latest updates on legislation in support of CCBHCs and Medicare workforce expansion, along with current opportunities to take action, visit the [America’s Mental Health Campaign](#) website.
Advocacy

Resources

for Expanding CCBHCs
Populations Helped: CCBHCs Support...

What issues do your lawmakers care most about? Look below for examples of how to explain the impact of the CCBHC model on various entities and populations. Advocates can copy and paste the most relevant information into letters, fact sheets, websites, or other communications.

- **Clinics** — In order to keep their doors open, mental health and substance use disorder treatment clinics need sustainable funding streams that will enable them to hire and retain ample staff with diverse disciplines that cover all the needs of the populations they serve. CCBHC status applies a funding model that addresses these concerns and gives clinics the opportunity to build more comprehensive staff teams. In addition, the CCBHC model provides financial resources for clinics to augment efficiency, leading to an increased capacity to serve more clients, more quickly.

- **Rural Communities** — Rural communities often lack locally-based mental health and substance use disorder treatment services. An individual in crisis may not be able to get to an appointment several hours away, let alone make the journey in a time of crisis only to be turned away due to lack of capacity. CCBHCs use technological advancements to help extend reach and, in some cases, use mobile response teams to reach those unable to make the trip.

- **Urban Communities** — Clinics in areas of dense population often need more hands on deck to care for the volume of clients they serve. The CCBHC model ensures enough funding to hire staff that suits population size and need, including staff with needed languages and competencies to serve diverse populations.

- **Law Enforcement** — Too often, law enforcement is on the front line of responding to individuals experiencing a mental health or substance use crisis. Lack of care coordination with local law enforcement and other crisis response agencies creates undue burden on a workforce that is not trained for mental health interventions. This not only diverts them from aiding the populations they exist to serve, but also leads to elevated incarcerations. CCBHCs’ mandated crisis response and care coordination models help reduce the burden of crisis response for law enforcement officers, saving them time that may otherwise be spent transporting individuals to hospitals or emergency departments.

- **Hospitals** — People living with serious mental illness or substance use disorders have high rates of hospitalization and emergency room visits. During and post-hospitalization represents a critical intervention period when an assertive care transition strategy can help patients initiate or re-engage in treatment with the goal of reducing future hospital stays. These preventable visits are also a major driver of costs in the health care system. Unfortunately, traditional funding streams provide little support for partnerships, care coordination activities and engagement activities that are known to improve outcomes and reduce hospitalizations outside the four walls of a clinic. CCBHCs receive financial support for these activities and have demonstrated their ability to reduce hospitalizations, emergency department visits and readmissions.

- **Consumers** — Consumers want to know they are getting access to a full range of comprehensive, evidence-based services that are coordinated with other care providers and held accountable for quality reporting. Standardized quality measures and a required robust array of services ensure that consumers know what to expect when they walk through the doors of a clinic.

- **State and Federal Government** — Medicaid pays for roughly 25 percent of all mental health and addiction care in the country and government payers want to make sure they’re getting value for the dollars they invest. The CCBHC demonstration defines an array of services known to produce good outcomes and reduce expensive utilization.
Advocacy Talking Points — CCBHCs

When evaluating whether to support a program, legislators may have different interests and considerations. Select from the following talking points to build your most persuasive argument.

Ask for Congress — Extend and expand the CCBHC program so that more Americans can benefit from its positive outcomes.

Ask for State Policymakers — Take advantage of any opportunity to implement CCBHCs in your state.

- **Accountability** — CCBHCs are required to report on nationally standardized quality metrics, while CCBHC states report on additional quality and cost measures. Nationally, 79 percent of CCBHCs report using these quality measures to improve clinical practice.xxxiv

- **Capacity** — 100 percent of CCBHCs have hired new staff, including psychiatrists and staff with an addiction specialty focus. As a result, CCBHCs report an average increase of up to 25 percent in patient caseload.xxxv CCBHCs have cared for an estimated 300,000 people with mental illnesses and substance use disorders — most of whom are engaged in services for the very first time.xxxvi

- **Cost Savings** — Estimated savings of guiding one high-resource user to care coordination is $39,000 per year. CCBHCs are required to coordinate care with hospitals, schools, criminal justice agencies and other providers to improve health outcomes and reduce use of emergency room and inpatient facilities and achieve maximum savings.xxxvii

- **Coverage** — While one in four Americans have had to choose between getting mental health (including substance use disorder) treatment and paying for daily necessities,xxxviii CCBHCs are available to any individual in need of care, regardless of ability to pay.xxxix

- **Distance** — 46 percent of American adults have had to, or know someone who has had to, travel more than one hour roundtrip to their most recent mental (including substance use disorder) health care appointment.xl Meanwhile, 73 percent of CCBHCs have adopted innovative technologies such as telepsychiatry to support care delivery.xli

- **Sustainability** — In traditional care models, services are often supported by grant funding that is limited in scope and not sustainable. CCBHCs establish a sustainable payment model that mitigates the reliance on time-limited grants.xlii

- **Standard of Care** — CCBHCs are required to provide a comprehensive array of evidence-based services, including 24/7 crisis services, integrated health care, care coordination, MAT and peer and family support.xlii

- **Wait Times** — 38 percent of Americans report having to wait a week or more to access mental (including substance use disorder) health servicesxliv and average wait times for community-based behavioral health clinics from referral to first appointment average 48 days nationally. However, 57 percent of CCBHCs have implemented same-day access protocols and 78 percent of CCBHCs can offer an appointment within a week or less after an initial call or referral and for routine needs.xlv
Letters to Your Legislators — CCBHCs

Use this letter template to urge lawmakers to support CCBHCs and the implementation of CCBHC clinic models in your communities. For additional letter templates in response to the latest federal developments, visit the National Council’s website.

*Place Letter on Official Organizational Letterhead*

The Honorable [Legislator]
[Title]
[Legislative Body]
[Address]

Dear [Legislator]:

[Organization] is writing to urge you to support the community behavioral health treatment system by investing in Certified Community Behavioral Health Clinics (CCBHCs). As an association representing [number] behavioral health providers who serve more than [number] people in [state], [organization] cares deeply about ensuring that individuals living with mental health and substance use disorders have access to high-quality, evidence-based treatment.

We urge Congress to build on the momentum that it established through the bipartisan Excellence in Mental Health Act, originally passed into law in 2014, creating a two-year, eight state demonstration of CCBHCs that offer a robust array of services to any individual in need of care, regardless of their ability to pay. Since CCBHCs began their systems transformation in 2017, they have been filling the gap in unmet need for substance use disorder care, forging new relationships within their communities and increasing access to mental health and substance use disorder treatment across the country. They are required to provide nine types of services, with an emphasis on provision of 24-hour crisis care, utilization of evidence-based practices, care coordination and integration of mental health, substance use and physical health care. Certification requirements also dictate that CCBHCs coordinate care with partners in the criminal justice system and veteran’s organizations.

[Incorporate data that reflect the needs of your communities and illustrate how CCBHCs are filling those gaps, for example:] Results from the CCBHC demonstration show its success in increasing access to much needed evidence-based treatments for opioid disorders such as medication-assisted treatment (MAT). In Western New York State, more than 1,000 people in Erie County died of opioid overdoses over the last five years. According to media reports, local police chiefs reported a 60 percent reduction in overdose calls in 2018. Authorities specifically credit a CCBHC in the City of Buffalo that is providing MAT for people battling opioid addiction within 24 to 48 hours after an initial assessment. In communities where CCBHCs are up and running, sheriffs and police officers now have access to on-the-ground support from trained mental health and substance use disorder professionals, alleviating the burden of front-line officers and helping people get access to the correct level of treatment.

We encourage you to invest in the promising CCBHC model as a means to address the opioid epidemic and the broader behavioral health crisis in America by supporting legislation to extend and expand the model. Thank you for your leadership in addressing this critical issue.

Sincerely,

[Signature]
Slides and Supportive Resources

Interested in teaching others how CCBHCs will help relieve the access crisis? Click the images below to download slides and talking points to talk about CCBHCs as a solution!

Lack of access to mental health care has a high cost.

76% of Americans think mental health is just as important as physical health.
Advocacy Resources for Expanding the Medicare Behavioral Health Workforce
Populations Helped: Expanding the Medicare Behavioral Health Workforce Supports...

What issues do your lawmakers care most about? Look below for examples of how to explain the impact of expanding the Medicare behavioral health workforce on various entities and populations. Advocates can copy and paste the most relevant information into letters, fact sheets, websites, or other communications.

- **Clinics** — Community mental health and substance use disorder clinics hire a wide range of professionals, including MFTs and LMHCs, who meet important needs among their clients. Yet, for clients who are enrolled in Medicare, the clinic cannot draw down reimbursement for these professionals. This means clinics are faced with the difficult choice of denying access to MFTs or LMHCs for their Medicare-enrolled clients or providing the services without any reimbursement, attempting to make up the shortfall by cobbling together other funding. Allowing MFTs and LMHCs to directly bill Medicare for their services will help clinics improve the scope and quality of care offered to their Medicare-enrolled clients, including seniors and people with disabilities.

- **Rural Communities** — Rural communities have a significant senior population and yet not enough mental health and substance use disorder care access. Allowing MFTs and LMHCs already working in rural populations to bill Medicare would instantly help fill that access gap.

- **Urban Communities** — According to HRSA’s HPSA quarterly report, less than a third of the need for mental health care providers is being met across the country. If MFTs and LMHCs are kept from being able to bill Medicare, this gap only gets wider for those who have Medicare, including seniors and people with disabilities. MFTs and LMHCs make up 40 percent of the workforce, many of whom are trained to provide substance use disorder care, and they can help expand access to treatment for many, if properly reimbursed and funded.

- **State and Local Governments** — Senior populations that have no other access to mental health and substance use disorder care often end up hospitalized, which is very costly to the government. Allowing MFTs and LMHCs to bill Medicare expand access to services, thus improving outcomes, while lowering the likelihood of emergency service use.

- **People with Disabilities** — Many individuals with the most serious mental illnesses are dually eligible for both Medicaid and Medicare. These individuals have complex needs that are best met with an adaptive array of services provided by a full array of professionals, including MFTs and LMHCs. Medicare’s policy of denying coverage for MFT and LMHC services restricts access to care for a population that experiences high rates of health service utilization—including costly hospitalizations and emergency department visits—when their needs are not addressed in a timely manner. By expanding access to MFT and LMHC services in Medicare, Congress can ensure that this vulnerable population is able to access timely services and ongoing health management support for their chronic conditions.
Advocacy Talking Points — Medicare Behavioral Health Workforce

When evaluating whether to support a bill, legislators may have different interests and considerations. Select from the following talking points to build your most persuasive argument.

Ask for Congress — Support legislation to allow marriage and family therapists (MFTs) and licensed mental health counselors (LMHCs) to directly bill Medicare for their services.

- **Access** — Nearly half (46 percent) of American adults have had to, or know someone who has had to, travel more than one hour roundtrip to their most recent mental health care appointment because services are not available in their community.¹ Approximately 77 million people live in 3,000 mental health professional shortage areas across the U.S.,² many in locations with practicing MFTs and LMHCs. Allowing MFTs and LMHCs to bill Medicare for their services would alleviate the Medicare behavioral health workforce shortage, open access to providers in the community and help individuals get connected to more localized care.

- **Cost Savings** — When people can’t access timely care in their communities, all too often their conditions deteriorate, leading to costly hospitalizations or other adverse outcomes. Allowing Medicare beneficiaries access to MFTs and LMHCs can improve access and lower the overall cost of care.

- **Consistency with the Medicare Benefit** — Medicare behavioral health workforce expansion legislation would not change the Medicare mental health benefit or modify states’ scope of practice laws; instead, it would allow Medicare enrollees access to medically necessary covered services provided by mental health and addiction professionals who are properly trained and licensed.³

- **Ensuring a Qualified Workforce** — MFTs and LMHCs must obtain a master’s or doctoral degree, have two years’ post-graduate supervised experience and pass a national exam to obtain a state license,⁴ requirements comparable to those placed on Medicare-covered clinical social workers. All 50 states license MFTs and LMHCs; these professionals and their services are covered by other federal programs like TRICARE and the Department of Veterans Affairs.⁵

- **Workforce Capacity** — 96 million American adults have had to wait longer than one week for mental health services.⁶ Allowing qualified, previously ineligible providers 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.⁷
Letters to Your Legislators — Medicare Behavioral Health Workforce

Use this letter template to urge lawmakers to support the expansion of the Medicare behavioral health workforce. For additional letter templates in response to the latest federal developments, visit the National Council’s website.

*Place Letter on Official Organizational Letterhead*

The Honorable [Legislator]
[Title]
[Legislative Body]
[Address]

Dear [Legislator]:

[Organization] is writing to urge you to support legislation to strengthen the behavioral health workforce by allowing marriage and family therapists (MFTs) and licensed mental health counselors (LMHCs) to bill their services to Medicare. These professionals are currently excluded from Medicare even though they receive similar training, undergo similar credentialing and provide similar services as other provider types that do participate in the program. As an association representing [number] behavioral health providers who serve more than [number] people in [state], [organization] cares deeply about ensuring that there is a robust workforce in place to support individuals living with mental health and substance use disorders across the country.

[Incorporate data that reflect the needs of your communities and illustrate how expanding the behavioral health workforce could fill those gaps, for example:] Older adults and low-income Americans with disabilities have an elevated need for access to mental health and substance use disorder treatment services; yet are among the least likely to receive the care they need. In fact, individuals age 65 and older die by suicide at a higher rate than the general population, but only one in five receive needed mental health services. Lack of access to behavioral health care for these groups has caused higher hospitalization rates, costing the country billions in Medicare dollars. Allowing qualified, previously ineligible providers to directly bill Medicare for their services would add an estimated 230,000 mental health providers to the nationwide Medicare network. Providing Medicare enrollees with access to community-based mental health and addiction providers is critical to reducing hospitalizations, saving money and closing the access gap.

We encourage you to invest in strengthening the behavioral health workforce as a means to address the current behavioral health crisis in America by supporting legislation to allow MFTs and LMHCs to bill their services to Medicare. Thank you for your leadership in addressing this critical issue.

Sincerely,

[Signature]
Slides and Supportive Resources

Interested in teaching others how the Medicare workforce expansion will help relieve the access crisis? Click the images below to download slides and talking points for talking about this as a solution!

[Inclusion makes a difference image]

Licensed professional counselors and mental health therapists make up roughly **40% of the licensed mental health workforce**.

50% of rural counties in America have no clinicians, leaving **30 million people without access to treatment**.

Legislation before Congress would **add these professionals** to Medicare, instantly expanding the mental health and addiction workforce.
Legislator List and Additional Resources

This section provides additional advocacy tools to support your efforts in any policy priorities.

Federal Legislator and Staff List:

- Check the America's Mental Health Campaign page to download the most recent legislator list.

General Advocacy Advice and Tips:

- The National Council’s Advocacy Handbook provides tips on how to be an effective advocate, including advice on running an effective meeting with a legislator, staying connected to Members of Congress at in-district events, and more.

Congressional Legislative Budgeting and Appropriations Process 101:

- 14 Steps to the Federal Budget Process Timeline
  - The Capitol Hill news outlet CQ has provided a helpful timeline identifying when each step of the budgeting and appropriation process occurs each year. Advocates should note that this timeline represents “regular order” – but deadlines are often delayed when committees or each chamber are unable to strike deals on disputed issues.

- A Guide to the Federal Budget Process
  - This Washington Post infographic provides a high-level overview of the federal budget and appropriations process. Advocates who work on federal funding for mental health and substance use disorder treatment should have a sound understanding of the steps involved in order to target their advocacy most effectively.

- Health Care Budget Resources and Appropriation Resources
  - The Coalition for Health Funding has collected detailed documents related to each year’s budgeting and appropriation process, stretching back several years. These pages include links to the current years’ documents as they become available.

- Overview of the Legislative Process
  - For detailed summaries of each step in the legislative process, check out this video series from Congress.gov. Additional links on this page provide access to a glossary of commonly used terms and FAQs for using the Congress.gov site to track pending legislation.

- The Legislative Process
  - This resource from Congress.org provides a step-by-step explanation of how a bill moves from introduction to enactment. Each step in the process is an opportunity for advocacy!
Legislator List and Additional Resources

Planning a Lobby Day:

- **Lobby Day: A Guide to Success**
  - Quorum, a Washington, D.C.-based advocacy support firm, has created a lobby day overview page that makes the case for hosting a lobby day and provides broad suggestions on how to bring additional visibility to your event.

- **National Association of Social Workers — Lobby Day Toolkit**
  - This thorough toolkit from the National Association of Social Workers includes detailed advice on what to do before, on, and after a lobby day. It also includes a sample scheduling form, fact sheet, letter from the CEO, talking points and dos and don’ts. Page 22 also includes a helpful legislative glossary.

- **Organizing a Lobby Day: Tips for Small Associations**
  - This article from the online advocacy and analytics platform Muster provides some specific information and considerations for small associations.

- **Planning a Successful Lobby Day**
  - This comprehensive toolkit from Physicians for a National Health Program details each step in planning a lobby day, including a timeline, sample email to schedulers/phone script, what to include in participant folders and how to follow up after the lobby day.
Resources


11. Ibid.


xvi In April 2018, the National Council for Behavioral Health surveyed CCBHCs about the impact of their addiction services in the program to date. Fifty-two of the 66 participating CCBHCs across the United States provided responses, with representation from each of the eight CCBHC states. This report highlights addiction service impacts of the CCBHC initiative as of April 2018.


xxxviii Ibid


