



AMERICAN COUNSELING ASSOCIATION

February 27, 2012

Jonathan Woodson, MD  
Assistant Secretary of Defense for Health Affairs  
Director, TRICARE Management Activity  
Skyline 5, Suite 810  
5111 Leesburg Pike  
Falls Church, VA 22041-3206

RE: Office of the Secretary, Department of Defense  
DOD-2011-HA-0134  
RIN 0720-AB55

Dear Assistant Secretary Woodson:

On behalf of the American Counseling Association (ACA), I am writing to share our comments on the Department of Defense (DoD) interim final rule (76 FR 80741-80744) establishing qualification criteria and rules for the participation of licensed professional mental health counselors within the TRICARE program. ACA is the nation's oldest and largest nonprofit membership organization representing professional counselors.

There are more than 120,000 licensed professional counselors nationwide, authorized under licensure laws enacted in all 50 states and other U.S. jurisdictions to practice independently. Licensed professional counselors meet education, training, and examination requirements similar to—and in many cases, more stringent than—those of marriage and family therapists and clinical social workers, both of whom have been recognized as independent providers by TRICARE for more than 20 years. For just as long, private sector health plans have regularly covered licensed professional counselors as independent providers of outpatient psychotherapy.

We are pleased that DoD is finally moving to allow licensed professional counselors to practice independently. It has been more than a decade since Congress began explicitly asking DoD to explore this issue, and nearly seven years since the completion of a demonstration project allowing independent practice for counselors found that it resulted in beneficiaries reporting having better access to services. TRICARE continues to have difficulty with shortages of mental health service providers, as noted recently by the Government Accountability Office (GAO, "Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra," June, 2011). In citing this issue, the GAO report noted that mental health care provider shortages are not specific to TRICARE. However, when compared to private sector health plans, requiring physician referral and supervision for beneficiaries to access counselors *is* specific to TRICARE.

We applaud DoD for its intention to encourage greater participation of mental health counselors in the TRICARE program and to improve access to quality mental health treatment for beneficiaries. We also strongly support the inclusion in the rule of a transition period, during which counseling degrees from regionally accredited institutions are accepted. Despite this important component, however, we believe that as currently written the interim final rule will fail to increase counselors' participation in TRICARE.

Before describing specific recommendations, we would like to stress an important point of context, drawn from the Institute of Medicine (IOM) report ("Provision of Mental Health Counseling Services under TRICARE") which informed the interim final rule. As IOM stated in the report:

An earlier IOM report (2006) [*Improving the Quality of Health Care for Mental Health and Substance-use Conditions*] indicated that there are serious deficiencies in the health and behavioral health infrastructure that affect quality of care. It found that the education of all health professionals was lacking. The report specifically noted that "not all M/SU [mental health and substance use] clinicians are educated about evidence-based care or receive training in the use of evidence-based clinical practice guidelines" and "quality improvement strategies have received little attention in M/SU education." (pp 8-9)

IOM's report also states, at the very beginning of its statement of conclusions and recommendations:

Education, accreditation, licensure, certification, and clinical experience requirements for mental health professional are components of a quality-management system. However, they have little specificity with regard to knowledge of and experience with particular health problems or evidence-based practices. That generally limits the confidence that can be placed in the preparation of *any* [emphasis in original] of these professionals to diagnose and treat disorders that may be found in the TRICARE beneficiary population. Research regarding the quality of care for M/SU conditions indicates that there are widespread deficiencies in the training of providers and in the infrastructure that supports their practice.

The committee did not identify any evidence that distinguishes mental health counselors from other classes of practitioners in ability to serve in an independent professional capacity or to provide high-quality care consistent with education, licensure, and clinical experience. Its research instead points to the need for a comprehensive quality-management system that facilitates the proper diagnosis of and treatment for disorders in the TRICARE beneficiary population by all mental health practitioners. (pp 9-10)

IOM looked for any evidence it could find that licensed counselors practicing today were any less effective or clinically competent than other types of mental health providers. It found none. Unfortunately, though, IOM's skepticism regarding *all* mental health professionals' training, combined with their charge to examine *only* the qualifications and credentialing of licensed mental health counselors, have fostered a situation where the counseling profession is being held to a higher standard and level of scrutiny than all other mental health professions.

IOM made two recommendations to DoD. The first was regarding the high bar it proposed setting for licensed professional counselors to practice independently within TRICARE. The second recommendation was that TRICARE put in place "a comprehensive quality-management system for all mental health professionals," including "well-defined scopes of practice and clinical privileging of all mental health-care providers in the direct- and purchased-care systems" (p. 211). We believe that a quality-management system for all mental health professionals, built upon a combination of full professional licensure and specific requirements for post-licensure education and training focused on serving the TRICARE beneficiary population, would be more effective, more inclusive, and easier to administer than overly detailed qualification criteria applied for only one profession.

We urge DoD to make the following changes to the rule, without which we believe TRICARE will reduce, rather than increase, the number of highly qualified mental health providers available to beneficiaries.

1. Recognize all counseling degrees from accredited programs, and not only those with the exact title "mental health counseling." This is especially important throughout the transition period proposed to extend until January 1, 2015. Both the Army Substance Abuse Program (ASAP) and the Department of Veterans Affairs (VA) have recently adopted standards recognizing licensed professional counselors, and neither of these standards excludes counselors with graduate degrees with other titles, such as "professional counseling", "community counseling", "rehabilitation counseling", or others. There are tens of thousands of effective, highly qualified licensed professional counselors, with years and years of experience as independent mental health service providers, with graduate degrees obtained with titles other than "mental health counseling." We note that for the other two master's level mental health professions, TRICARE recognizes all social work degrees, regardless of specialization, as well as degrees in fields related to, but not necessarily in, marriage and family therapy.
2. Extend the transition period, during which TRICARE will certify counselors with degrees from regionally-accredited institutions who are fully licensed by their state and have passed the National Clinical Mental Health Counseling Exam (NCMHCE), through at least December 31, 2016. We believe this is needed to avoid locking out students beginning their graduate education in counseling. A large number of counselor graduate programs require completion of 60 graduate semester hours, which for many students takes three years to complete. Whether their degree is completed in two years or more, following graduation counselors must spend at least two years--if not longer--accumulating the thousands of hours of post-master's supervised experience necessary for state licensure. If DoD retains the provision in the interim final rule recognizing only counseling degrees obtained from programs accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP), and does not allow an alternative route to recognition for counselors with other degrees after the transition period ends, virtually no counseling students who have just started degree programs at

non-CACREP accredited schools would be able to meet the transition period requirements by the end of 2015.

The large majority of licensed professional counselors did not graduate from CACREP-accredited programs. In 2011, ACA studied the records of professional mental health counselors licensed by the State of New York, and we found that no more than 13% of licensees had a degree from a CACREP-accredited program. (If the requirement that only "mental health counseling" degrees was also applied, this number would shrink further.) Also, the survey did not show a significant, current, upward trend in the number of licenses being granted to graduates of CACREP-accredited programs.

3. Expand recognition of supervised experience to include all supervision recognized by the state licensure board in which the counselor is licensed. The requirement in the interim final rule which recognizes only supervision provided by a licensed mental health counselor, and the requirement that only supervision "conducted in a manner that is consistent with the guidelines for supervision of the American Mental Health Counselors Association" (AMHCA) is recognized, will screen out many licensed professional counselors from participating in TRICARE.

It would be difficult for licensed professional counselors to go back and attempt to retroactively determine how many of the thousands of hours of supervised experience they have obtained, in most cases years ago, were obtained in a manner consistent with AMHCA guidelines. It is our understanding that AMHCA's guidelines for supervision are still in development, and are not widely used. Consequently, there is no consistent documentation that has ever been done by state licensure boards, by AMHCA itself, or by other third parties, as to which supervision hours obtained by a counselor have and have not been obtained consistent with AMHCA guidelines. We cannot imagine how TRICARE intermediaries or TRICARE staff could possibly evaluate and verify whether or not mental health counselors' supervision hours met this requirement. This requirement by itself, if taken at face value, could place such an inordinate burden on counselors considering becoming TRICARE providers that the vast majority would simply choose not to.

Regarding the issue of who is providing the supervision, many state licensure laws recognize other professionals, such as psychologists, social workers, and psychiatrists, as supervisors. For many licensed professional counselors, supervision by fully licensed members of other mental health professions is the only option. Even today, social work licensure laws recognize supervision provided by other mental health professionals as a matter of course, or in situations (such as geographic necessity) approved by the social work licensure board. TRICARE has for decades taken the position that physicians can supervise counselors, and that all other mental health professionals are qualified to practice independently. Consequently, we see no reason why counselors who have spent years meeting the supervision requirements which apply in their state in order to become licensed should be forced to go back and start this process over simply to see TRICARE beneficiaries. Many counselors will simply choose not to participate rather than "do over" their supervision hours.

In proposing to require that counselor supervision hours meet a national standard, we are curious why TRICARE chose to adopt AMHCA's standards. There are several other national supervision standards proposed by counseling-related organizations, including the American Association of State Counseling Boards (AASCB), the Association for Counselor Education and Supervision (ACES), the Council for Accreditation of Counseling and Related Educational Programs (CACREP), and the National Board for Certified Counselors (NBCC). We can only assume that TRICARE evaluated each of these national standards and decided they were not worthy of recognition.

4. Consider removing the stipulation that only counseling degrees from CACREP-accredited programs will be recognized after the transition period. While the number of counselor education programs accredited by CACREP is growing, CACREP is not the only third-party accreditation party for counseling programs, nor is it the only arbiter of program quality. There are high-quality counselor education programs that are not CACREP-accredited, such as at Johns Hopkins University, to cite one local example.

As noted earlier, the large majority of licensed professional counselors did not graduate from CACREP-accredited programs. We understand DoD's interest in establishing minimum standards for provider training, and we share the goal of doing so more generally, on behalf of the broader counseling profession. However, the CACREP accreditation requirement could prevent a large proportion of counselors from being able to participate in TRICARE.

5. Allow mental health counselors who meet TRICARE's certification criteria to begin practicing independently immediately upon certification, instead of waiting until the end of the transition period. TRICARE beneficiaries need better access to mental health providers now, not three or more years from now. Requiring licensed professional counselors to achieve certification, and then *continue* to operate only under physician referral and supervision, will make many question whether it is worth their time and effort. As currently written, the interim final rule wouldn't begin increasing access to mental health counselors for more than two years.
6. Consider adding an alternative route to recognition and independent practice for counselors not meeting narrow requirements on type of degree conferred or supervision hours obtained. As an example, TRICARE could allow independent practice for counselors who meet all of the following requirements:
  - a) Licensure by their state for independent practice;
  - b) At least 3 years of practice experience as an independent provider of outpatient psychotherapy;
  - c) Passage of the National Clinical Mental Health Counselor Examination (NCMHCE); and
  - d) Completion of a minimum number of hours of post-master's coursework in

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military culture and in identifying and addressing the behavioral health needs of military personnel, veterans, and their families.

We believe criteria like these would be more inclusive of potential TRICARE providers, easier to administer for TRICARE intermediaries and staff, and more conducive to improving quality of care.

We urge TRICARE to amend the interim final rule in order to make real progress toward the goal of increasing access to care for beneficiaries. We would appreciate the opportunity to work with TRICARE Management Activity staff on issues relating to the interim final rule, and on subsequent initiatives to increase mental health counselors' participation in the program.

Thank you for the opportunity to comment on the interim final rule.

Sincerely,

A handwritten signature in black ink that reads "Richard Yep". The signature is written in a cursive, flowing style.

Richard Yep, CAE  
Executive Director  
American Counseling Association