AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

January 31, 2022

The Honorable Richard Hudson
2112 Rayburn House Office Building
House of Representatives
Washington, DC 20515

The Honorable Jim Banks
1713 Longworth House Office Building
House of Representatives
Washington, DC 20515

The Honorable Tom Cole
2207 Rayburn House Office Building
House of Representatives
Washington, DC 20515

Dear Representatives Hudson, Banks and Cole:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing over 37,400 psychiatric physicians who treat mental health and substance use disorders, I write to respond to the Healthy Futures Taskforce Security Subcommittee's Request for Information (RFI). The APA applauds the steps you and your colleagues in Congress have taken over the past few years to invest in and expand mental health services and substance use disorder (MH/SUD) care, including the provision of additional resources during the COVID-19 Public Health Emergency. We appreciate your timely focus on identifying additional legislative steps Congress should take to improve access to effective, evidence-based MH/SUD care and services. Your focus on this area is a necessary and logical next step toward a sustained effort to address the MH/SUD crises that have been exacerbated by the pandemic. Our answers focus specifically on questions pertaining to MH/SUD care in the Public Health section of the RFI.

(Number 10) Community Health Centers (CHCs) play an essential role in the provision of health services to disadvantaged and low-income populations, regardless of their ability to pay. In 2019, nearly 30 million Americans, and 1 in 5 rural Americans, received services from a CHC. How can Congress better utilize CHCs to deliver high-quality, low-cost to Americans?

Community Health Centers (CHCs) are integral in all communities, particularly in those that are medically underserved. CHCs provide access to necessary mental health and substance use disorder services, as they employ and retain qualified mental health professionals that deliver high-qualify treatment at a low cost. To help CHCs continue to retain these professionals, Congress should support practices that would increase the mental health and substance use disorder workforce. That is why APA supports the Medicaid Bump Act (S. 1727/ H.R. 3450), which would incentivize states to expand

their Medicaid coverage of mental health and substance use treatment services by providing a corresponding raise in the Federal Medical Assistance Percentage (FMAP) matching rate to 90 percent for behavioral health services. Increasing Medicaid reimbursement rates for mental health and/or substance use disorder (MH/SUD) services would positively impact the mental health and substance use treatment workforce, which would increase the behavioral health system's ability to hire and retain these professionals. In addition to increasing FMAP Medicaid reimbursement, APA supports the continuation and expansion of the Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration program. CCBHCs offer services that improve access to health care and provide treatment to those with serious, complex mental illnesses and substance use disorders. CCBHCs also employ an integrated community-based approach to behavioral health that emphasizes coordination between hospitals, emergency rooms, and law enforcement.

How can Congress assist CHCs in providing improved care coordination services to patients?

To assist with improved care coordination for CHCs and to address the ongoing mental health impact from the COVID-19 pandemic, Congress should work to better integrate primary care with behavioral health services. That is why APA supports H.R. 5218, the Collaborate in an Orderly and Cohesive Manner Act, introduced by Reps. Lizzie Fletcher (D-TX) and Jamie Herrera Beutler (R-WA) which creates a grant program that assists primary care practices with integrating behavioral health care into the primary care setting. Specifically, the Collaborative Care Model creates a three-person team comprised of a primary care provider (PCP), a behavioral health care manager, and a psychiatric consultant who work together to address mental health conditions and substance use disorders within the primary care setting. This patient care team works on early identification and treatment of mental health and substance use disorder needs before they become a crisis. Specifically, this model emphasizes care coordination as the care manager keeps track of patient progress and coordinates treatment plans with the PCP and the psychiatrist to ensure that care is person-centered and measurement based. The Collaborative Care Model is evidence-based and supported by over 90 research studies. Because the model is widely supported by patients, doctors, social workers, insurance companies, employer groups and mental health advocates APA urges the Healthy Futures Task Force to support the Collaborate in an Orderly and Cohesive Manner Act, H.R. 5218 to improve integration between behavioral health and primacy care, and to help address the current mental health and substance use disorder crisis. Letter of stakeholder support is attached.

What temporary flexibilities provided to CHCs during the COVID-19 pandemic merit permanent extension?

Congress should continue to provide CHCs with telehealth flexibilities extended during the COVID-19 public health emergency. These flexibilities, such as lifting geographic and site of service restrictions and allowing the use of audio-only appointments, allow continued and necessary access to mental health and substance use disorder services for individuals who are physically unable to reach a doctor and for those who lack the technology or bandwidth for

video communication. These flexibilities have been literal lifelines enabling patients to receive care during the pandemic. The APA encourages the Healthy Futures Task Force to support the permanent extension of these flexibilities to increase access to care for medically underserved populations and to promote health equity.

Mandatory funding for CHCs was most recently reauthorized in 2019 through FY2023 as part of the Consolidated Appropriations Act, 2021 at $4 billion annually. As Congress looks toward its next reauthorization, what programmatic changes should Congress consider, and what activities might CHCs be able to pursue with more robust funding?

Congress should consider increasing the reauthorization period for this program, or making the authorization permanent enabling CHCs to operate without fear of funding lapsing when the authorization is nearing its expiration. A longer reauthorization period for CHCs and CCBHCs would provide stability to continuum of care services and help retain and continue to build the health care workforce.

(Number 12) The COVID-19 pandemic highlighted how chronic medical conditions elevate an individual's risk of severe illness, hospitalization, and death. This elevated risk extends beyond COVID-19 and is tied to poor outcomes on numerous measures of health. Worryingly, 6 in 10 Americans have a chronic medical condition, and 4 in 10 have two or more. The Centers for Disease Control and Prevention (CDC) operates numerous programs and offices dedicated to chronic disease prevention and health promotion. Are there alternatives to current disease-specific programming that address multiple underlying conditions and promote healthy living? What flexibilities or authorities would be required to promote such cross-programmatic efforts?

In recent years a broad range of initiatives have been launched at the federal level, including within the CDC, to address social determinants of health and further health equity. These efforts reflect a systemic movement toward care integration and more holistic delivery models, which aim to address patients' physical, mental, and social needs, while shifting towards payments tied to quality and outcomes. Though there has been significant progress recognizing and addressing social determinants of health, siloed programs with separate funding streams continue to impede progress. Gaps and inconsistencies remain in the collection and sharing of data on social determinants of health, limiting the ability to aggregate information to better inform policy. Specifically, data collected over the past two years supports the finding that mental illness is a factor shown to increase COVID risk. However, unfortunately mental health and substance use disorder programs and data are often siloed in separate programs and data sets from physical health programs. As such, APA would thus encourage the Healthy Futures Task Force to pursue and support policies aimed at better coordination between existing disease-specific programs, with a specific emphasis on aligning and integrating mental and physical health which have been historically siloed. Better coordination of both research and treatment between such programs, will help to address existing health disparities and align CDC efforts with ongoing movement towards "whole-person" models of care.

(Number 14) Social determinants of health are another key driver of healthcare spending. Individual behavior and social and environmental factors are estimated to account for 60% of health care costs. To what extent do federal health programs already account for and address social determinants of health?

While there is more work to do in investing in programs that address social determinants of health (SDOH), the government does have existing programs that aim to address SDOH. Many of these programs are administered through the Health Resources and Services Administration (HRSA), particularly through programs that focus on increasing workforce capacity and care access in underserved and rural populations. Further, HRSA programs target multiple vulnerable patient populations, from addressing maternal mortality to staffing Health Professional Shortage Areas through programs like the National Health Service Corps. Indian Health Service (IHS) programs also play an instrumental part in addressing SDOH within reservations and the Native American community. Finally, CDC programs that target minority and vulnerable populations could also use additional support in addressing SDOHs. APA encourages the Healthy Futures Task Force to consider policies like the current telehealth flexibilities allowed during the COVID-19 public health emergency, such as lifting the geographic and site of service restrictions and allowing for the use of audio-only technology, as policies that directly address SDOHs like transportation and a lack of high-speed broadband. Artificial restrictions on access enacted in the 2020 Consolidated Appropriations Act allowing a telehealth visit only if there has been an in-person visit within six months should also be removed as it is inconsistent with how the law already treats SUD's and co-occurring SUD and mental health disorders. Continuing direct funding to agencies that have programs which provide access to medically underserved populations and making permanent telehealth flexibilities after the public health emergency are ways to utilize existing federal health programs to reduce the impact of SDOH, in addition to implementing new strategies.

How can Congress best address the factors that influence overall health outcomes in rural, Tribal, and other underserved areas to improve health outcomes in these communities?

To better address factors that influence the health of rural, Tribal, and other medically underserved communities**, the Task Force should consider policies that promote better integration of social service programs and streamlined eligibility, notification and enrollment systems.** Better integration of assistance systems and streamlined enrollment for programs like affordable housing, employment assistance, Medicaid and SNAP would allow beneficiaries to get the help they need, while simultaneously helping them stay healthy, support their families and get back into the workforce more quickly. Additionally, **Congress should pass the following telehealth legislation to address transportation and lack of high-speed broadband access as social determinants of health:**

- H.R. 3447 – Permanency for Audio-Only Telehealth Act
- H.R. 4058/S. 2061 – Telemental Health Care Access Act
- H.R. 4770 – Evaluating Disparities and Outcomes of Telehealth (EDOT) Act of 2021
- H.R. 5837 – A bill to expand telehealth services relating to substance use disorder

- H.R. 6202 – Telehealth Extension Act of 2021
- H.R. 912 – American Indian and Alaska Native Veterans Mental Health Act

In addition to telehealth legislation, APA supports the passage of **H.R. 5218, the Collaborate in an Orderly and Cohesive Manner Act, which would provide greater access to telepsychiatry in primary care settings.** Further, increasing funding for workforce development programs, such as the SAMHSA Minority Fellowship Program, and passing legislation like the Resident Physician Shortage Reduction Act, H.R. 2256 to improve patient access to care. Finally, APA encourages the Task Force to consider legislation that offers loan repayment to health care providers who work in underserved areas as a necessary step in addressing social determinants of health.

What flexibilities or authorities are needed to promote the adoption of policies and strategies in federal health programs to address these social determinants?

Congress should make the current COVID-19 telehealth flexibilities allowed under the pandemic public health emergency permanent. As mentioned above, lifting geographic and site of service restrictions and allowing for the use of audio-only, allow continued and necessary access to mental health and substance use disorder services for individuals who are unable to travel to a doctor and for those who lack the technology or bandwidth for video communication. These flexibilities have enabled large numbers of patients to receive care during the pandemic, and they should continue to be available to increase access to care for medically underserved populations and to promote health equity.

What innovative programs or practices, whether operated by non-governmental entities or local, State, or Tribal governments, might Congress examine for implementation on a national scale?

As mentioned above in our RFI response, APA supports H.R. 5218, the Collaborate in an Orderly and Cohesive Manner Act, which integrates behavioral health care within the primary care setting. Increased implementation of evidence- and measurement-based integrated behavioral and primary health care using population health strategies would help address the current mental health and substance use disorder crisis by providing early intervention and expanding access to essential MH/SUD services, bringing down patient and programmatic costs and increasing outcomes.

(Number 15) The COVID-19 pandemic has called attention to some populations' distrust of public health departments and officials, whether through historical wrongs or because of skepticism of more recent public health measures. How can Congress work to bolster Americans' confidence in public health institutions?

Promoting a culturally competent workforce - To address the endemic mistrust of public health institutions within historically marginalized communities, the Task Force should support legislation that aims to train a culturally and linguistically competent workforce. To that end, APA supports the House passed Pursuing Equity in Mental Health Act (H.R. 1475/S.1795),

comprehensive legislation that would take important steps to improve diversity in our behavioral health workforce by increasing funding for the SAMHSA Minority Fellowship Program, authorizing multiple grant programs to increase recruitment and training of diverse MH/SUD providers, and directs HHS to develop outreach campaigns and study mental and behavioral health disparities. Further, the APA supports the expansion of loan repayment and forgiveness programs that make medical school more affordable for socially and economically disadvantaged students, thus making the financial burden of paying for medical school less of a barrier to entry.

Community Outreach - It is equally important to meet underserved and minority populations that may harbor distrust in the health system where they are, in part, by partnering with the faith-based community. APA has found success in this area with the Mental Health and Faith Community Partnership, a collaboration between psychiatrists and clergy aimed at fostering a dialogue between two fields, reducing stigma, and accounting for medical and spiritual dimensions as people seek care. The partnership provides an opportunity for psychiatrists and the mental health community to learn from spiritual leaders to whom people often turn in times of mental distress. At the same time, it provides an opportunity to improve understanding of the best science and evidence-based treatment for psychiatric illnesses among faith leaders and those in the faith community. We similarly encourage the Task Force to pursue policies that promote partnerships between health information sources, faith-based institutions and local community organizations when launching health promotion messages and initiatives. Finally, we encourage the Task force to address general public distrust with public health messaging that has grown during the pandemic by focusing on policies that support public health messaging based on science (I.e., vaccines prevent severe COVID-19 illness and hospitalization). Further, the Task Force should focus on rebuilding and bolstering the public health infrastructure in order to increase the number of trusted health care providers who can serve as reliable messengers of public health information to the public.

(Number 18) The annual cost for all individuals with Alzheimer's or other dementias will total $355 billion for health care, long-term care, and hospice care in 2021, with Medicare and Medicaid covering $239 billion of these costs. Due to an aging population, the costs of Alzheimer's and other dementias will exceed $1.1 trillion (in 2021 dollars) by 2050. What challenges do the federal government and its partners face in increasing early detection and diagnosis of Alzheimer's and other dementias?

According to a 2021 report by the Alzheimer's Association, people of color experience more barriers when accessing dementia care, which posits a challenge to early detection and diagnosis within these communities. The report found that half or more non-white caregivers experienced discrimination when navigating health care settings for their care recipient, expressing that the health care professionals and staff do not listen to what they said because of their race, color, or ethnicity. Racism in healthcare is certainly a barrier to early detection and diagnosis of chronic illnesses, and **the Task Force should continue supporting programs that allow for a racially diverse health care workforce, such as the Minority Fellowship Program (MFP), in order to help provide culture competence in health care settings.** APA

supports increasing funding for workforce programs like the MFP and encourages the Task Force to continue to fund research into early detection of dementias so we can properly care for our aging populations and relive the burden on caregivers along with the long-term care and hospice systems. Further, funding early detection research will provide a better understanding of early diagnosis and mitigate misdiagnosis of Alzheimer's disease. Finally, individuals such as family, friends, or licensed caregivers who are taking care of loved ones with dementias are often unpaid. **The Task Force should prioritize legislation that provides training and monetary compensation to the caregiver workforce.**

How can the federal government better support prevention efforts and risk reduction activities through current, or new, efforts? With an expected doubling of the number of Americans living with Alzheimer's over the next three decades, how can Congress better prepare for this increased demand for care and caregiver support?

To better prepare for the increased number of Americans living with Alzheimer's disease, **Congress should provide support to caregivers by training and paying those who take care of individuals living with Alzheimer's and other dementias.** Further, Congress should continue to fund programs that create a more diverse network of health care providers, as well as programs that fund early detection research. Finally, lawmakers should support initiatives like the Alzheimer's campaign, which seeks to make currently incurable effects of Alzheimer's reversable. The Campaign focuses on funding research, creating more advocates for the disease, and providing information on local support.

(Number 21) How can Congress better utilize existing programs to address the maternal health crisis?

Increase Maternal Mental Health Services Funding - Maternal mental health (MMH) conditions are the most common complications of pregnancy and childbirth, affecting 1 in 5 women each year in the United States. Recent studies show that suicide and overdose combined are the leading cause of death for mothers in the postpartum period, contributing to the distressingly high maternal mortality rate in the United States. Further, the COVID-19 pandemic has exacerbated MMH conditions: recent studies show that pregnant women and new mothers are experiencing anxiety and depression during the pandemic at 3-4 times the rate prior to the pandemic. With thousands of young mothers suffering from MMH conditions, there is a critical need to provide support and treatment before these conditions create long-lasting adverse health outcomes for mother and baby. Last year, the House passed the Labor, Health and Human Services, and Education (LHHS) Appropriations bills for Fiscal Year (FY) 2022. This legislation included the following programs and funding levels:

- $5 million for the Maternal Mental Health Hotline, an increase of $2 million above the FY 2021 enacted level,
- $10 million for Screening and Treatment for Maternal Depression and Related Disorders state grants, which is double the FY 2021 enacted level and,

- $868.7 million for the Maternal and Child Health Block Grant, which is $156 million above the FY 2021 enacted level.

APA supports these funding increases and encourages the Task Force to support them as the negotiation process between the House and the Senate continues for FY 2022 Appropriations.

Support Maternal Health Legislation – In addition to supporting finding increases for maternal mental health services, APA urges the Task Force to support the passage of the following maternal health bills:

- **H.R. 3345, Helping MOMS Act,** - This bipartisan bill would permanently ensure that all pregnant women on Medicaid and the Children's Health Insurance Program retain their health coverage during the first year of postpartum.
- **H.R. 3407, MOMMAS Act** – This bill would address the maternal health crisis by improving maternal health care and ensuring that evidence-based mortality and morbidity practices are available to all expectant and new mothers.
- **H.R. 4770, Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency (EDOT) Act of 2021** – This bill would develop data-driven policies for telehealth after the COVID-19 pandemic to better understand the utilization and cost of telehealth services, as well as how to serve those who are experiencing the digital divide.

APA recommends that the Task Force support Congress directing the Centers for Medicare and Medicaid Services (CMS) to review early and periodic screening, diagnostic and treatment (EPSDT) requirements and whether they are being implemented successfully at the state level to support access to prevention, early intervention services, and developmentally appropriate services across the continuum of care.

Extending Medicaid Coverage to 12 months Postpartum - Untreated maternal mental health conditions can have long-term negative impacts on mother, child, and the entire family. Given Medicaid's role in covering nearly half of all births in the nation and 65 percent of births to Black mothers, stabilizing affordable health coverage for new mothers would help ensure access to vital mental health and substance use disorder treatment services and address health disparities during this vulnerable time in new mothers' lives. Currently, federal law requires pregnancy-related Medicaid coverage to last for 60 days postpartum. After this time has concluded, many women lose their Medicaid coverage if there are no other factors that qualify them for continued coverage. There are major risks to becoming uninsured shortly after experiencing pregnancy. For example, one in seven women experience symptoms of postpartum depression in the year after giving birth, and evidence suggests women with substance use disorder are more likely to experience relapse and overdose seven to 12 months postpartum. The Families First Coronavirus Response Act dictates that states must provide continuous coverage to Medicaid enrollees for the duration of the public health emergency to be eligible for enhanced federal matching funds. Further, the American Rescue Plan Act of 2021 gives states the option to extend Medicaid postpartum coverage to 12 months. This option

takes effect on April 1, 2022, and will be available to states for five years. However, this is only an option, and pregnant persons residing in states that do not choose to adopt this option will not receive the coverage that they need. Further, states that want to implement the extended coverage after the end of the public health emergency but before April 1 must submit a Section 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) or use their own state funds. **To help improve maternal health and provide coverage stability to women within all states, APA supports extending the Medicaid postpartum coverage period for individuals enrolled in Medicaid while pregnant for a full year after pregnancy and urges CMS to adopt the Section 1115 waiver to make this regulatory change at the federal level. Additionally, APA urges the Task Force to consider policy proposals that make the 12-month of postpartum coverage mandatory.**

(Number 22) What other policy considerations should Congress examine concerning improving public health and public health infrastructure?

Workforce Development - To address ongoing provider shortages that are especially acute amongst specialties like psychiatry, and to promote access to care in rural and underserved areas, Congress should further prioritize workforce-building programs administered by the Health Resources and Services Administration (HRSA) and should also expand psychiatry residency slots through Medicare's Graduate Medical Education (GME) program, and should also make similar expansions of GME slots for other specialties with severe workforce shortages. Specifically, APA supports the Mental and Substance Use Disorder Workforce Training Demonstration Program which awards grants to institutions to support training for medical residents and fellows in psychiatry and addiction medicine who are willing to provide substance use disorder treatment and services in underserved communities. Likewise, the National Health Service Corps (NHSC) Loan Repayment Program for Substance Use Disorder Treatment Workforce program provides loan repayment for mental health professionals working in high-need communities or federally designated mental health professional shortage areas. APA is supportive of further investment in both programs to encourage the recruitment, enrollment, and retention of students from disadvantaged backgrounds and shortage areas. In addition to NHSC, we recommend increasing funding for Medicare's GME program with an explicit focus on specialties that have severe shortages such as psychiatry.

Expanding Use of The Collaborative Care Model – As our healthcare system moves toward value-based integrated care, the most promising near-term strategy for providing prevention, early intervention and timely treatment of mental illness and substance use disorders is the implementation of evidence-based integrated care models using a population-based approach. As stated above, the CoCM is a proven, measurement-based approach to providing treatment in a primary care office that is evidenced-based and already reimbursed by Medicare, with established CPT codes. Involving a primary care physician working collaboratively with a psychiatric consultant and a care manager, CoCM is supported by over 90 randomized control studies demonstrating improved access, reduced cost, and improved clinical outcomes. CoCM is currently being implemented in many large health care systems and practices and is also reimbursed by several private insurers and about half of all state Medicaid programs, however,

one of the most significant impediments to adoption of CoCM is the start-up cost for primary care practices. As such, APA encourages the Task Force to support the passage of the Collaborate in an Orderly and Cohesive Manner (CoCM) Act (H.R. 5218), which would assist primary care practices in setting up CoCM arrangements by providing grants to implement the model.

Investment in Crisis Services – An effective and widely accessible mental health crisis system is essential to combat the national mental health pandemic, and the launch of the new 988 crisis hotline in July is an important step towards supporting the millions of Americans who face a mental health or substance use crisis annually. To ensure that those who call 988 can readily access appropriate and timely care, Congress should make significant and necessary investments to scale local crisis services via the Community Mental Health Block Grant (MHBG) and continue the evidence-based 10% crisis services set-aside. These funds directed towards core crisis services—crisis call centers, mobile crisis response, and short-term residential stabilization units —have proven effective in reducing costly emergency department boarding, freeing law enforcement officers from managing MH/SUD patients in crisis, and diverting patients with severe mental disorders away from emergency rooms and the criminal justice system and into appropriate treatment and care. As the new 988 hotline number is implemented in calendar year 2022 and beyond, resources for the full continuum of crisis response services will be vitally needed. Congress should also expand the resources available for crisis services through means other than only annual appropriations, including Medicaid.

(Number 23) Please share any brief additional comments or recommendations that were not properly addressed with the above prompted questions.

Mental Health Parity Compliance – Currently, the 2008 federal Mental Health Parity and Addiction Equity Act (MHPAEA), commonly referred to as the "parity law" does not apply to Medicare at all (except for the very rare examples of Medicare Advantage plans provided through an employer-sponsored plan). Under current law, Medicare beneficiaries are not protected by the vital MHPAEA anti-discrimination law that protects Americans with most other types of insurance coverage. Not only is this a major shortcoming that harms those 65 and older, but it is also a serious barrier for the nine million Americans who have Medicare coverage because of their disability status. That means that many of those with the most severe mental illnesses are not protected by the federal parity law and do not receive the mental health or substance use disorder care they need. Congress could address this by applying the federal MHPAEA law to Medicare Parts A through D and ensuring that Medicare covers specific mental health and SUD benefits that it now excludes.

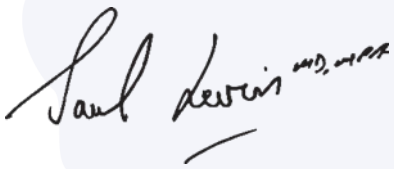
Achieving full compliance with the federal parity law's requirements is essential given the need to access and maintain coverage for MH/SUD services, especially with how COVID-19 has exacerbated the previously existing mental health and substance use crises. To advance that end, APA supports the Parity Implementation Assistance Act (H.R. 3753/S. 1962), a bipartisan proposal that authorizes grant funding to state insurance departments to use for parity implementation. Under the bill, to receive a grant a state must request and review the

comparative analyses insurers are now required to perform thanks to the parity provisions included in the December 2020 Consolidated Appropriations Act.

Telehealth - Bipartisan agreement during 2020 allowed Congress and the previous Administration to increase access to telehealth services to treat mental illness during the COVID-19 public health emergency. Prior to COVID-19, SUD and co-occurring MH services were exempt from geographic and site of service restrictions under Medicare, but mental health treatment services alone were not. At the end of 2020, Congress took the important step of permanently waiving these restrictions for mental health. Unfortunately, at the same time Congress also passed a new provision requiring patients receiving care via telehealth to have an in-person evaluation with their mental health provider within the six-month period prior to their first telehealth visit and at subsequent periods as required by the HHS Secretary. This arbitrary in-person requirement has not been applied to those with substance use disorders or co-occurring substance use disorders and mental health conditions who see their clinicians via telehealth. APA encourages the Task Force to support legislation (H.R. 4058/ S. 2061) that removes the six month in-person requirement for mental health treatment to ensure that mental health and substance use disorder services furnished via telehealth are treated equally and these decisions are made by those who should make them based on diagnosis and patient need—physicians and patients.

The APA thanks you for your leadership in compiling these thoughtful, thorough RFI questions on mental health / substance use disorder needs and appreciates the opportunity to submit these comments for consideration as the GOP Healthy Futures Task Force develops a legislative package. The APA is eager to aid your efforts to improve mental health across our nation. If you have any questions, please contact Daniel “Trip” Stanford at dstanford@psych.org or (315) 706-4582.

Sincerely,



Saul Levin, MD, MPA, FRCP-E, FRCPsych
CEO and Medical Director

January 5, 2022

The Honorable Lizzie Fletcher
1429 Longworth House Office Building
Washington, DC 20515

The Honorable Jaime Herrera Beutler
2352 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Fletcher and Herrera Beutler:

On behalf of the undersigned organizations, we would like to thank you for your leadership in introducing H.R.5218. Your legislation will improve access to evidence-based mental health and substance use disorder care that many Americans struggle to find. Our country is in the midst of a growing behavioral health crisis with suicide and overdose deaths at record levels. Many individuals first display symptoms of a mental health condition or substance use disorder in the primary care setting but frequently cannot access the necessary follow-up treatment. Often they have difficulty finding a mental health professional or avoid seeking treatment due to the stigma that still exists around mental health and substance use disorders. The Collaborative Care Model (CoCM) provides a strong building block to address these problems by ensuring that patients can receive expeditious behavioral health treatment within the office of their primary care physician.

The CoCM integrates behavioral health care within the primary care setting and features a primary care physician, a psychiatric consultant, and care manager working together in a coordinated fashion. Importantly, the team members use measurement-based care to ensure that patients are progressing and treatment is adjusted when they are not. The model has over 90 research studies demonstrating its efficacy and is covered by Medicare, most private insurers, and many state Medicaid programs. Additionally, the CoCM has tremendous cost savings potential. For example, cost/benefit analysis demonstrates that this model has a 12:1 benefit to cost ratio for the treatment of depression in adults.[1] Furthermore, the Model greatly increases the number of patients being treated for mental health and substance use disorders when compared to traditional 1:1 treatment. Lastly but no less important, the CoCM has been shown to increase physician and patient satisfaction and reduce stress among primary care physicians.

Despite its strong evidence base and availability of reimbursement, uptake of the Collaborative Care Model by primary care physicians and practices remains low due to the up-front costs associated with implementing the model. Additionally, many primary care physicians and practices may be interested in adopting the model but are unsure of next steps. H.R. 5218 addresses both potential roadblocks by providing grants to primary care practices to cover start-up costs and by establishing technical assistance centers to provide support as practices implement the model. Moreover, the bill promotes research to identify additional evidence-based models of integrated care.

We commend you for introducing this legislation that will expand needed access to high-quality behavioral health care that is proven to be effective. Your leadership is greatly appreciated and vitally

[1] Washington State Institute for Public Policy Benefit-Cost Results for Adult Mental Health. Retrieved from: https://www.wsipp.wa.gov/BenefitCost?topicId=8

necessary. We look forward to working with you to advance this important legislation and improve outcomes for our patients.

Sincerely,

2020 Mom
Academy of Consultation-Liaison Psychiatry
American Academy of Addiction Psychiatry
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Association for Geriatric Psychiatry
American Association for Psychoanalysis in Clinical Social Work
American Association on Health and Disability
American College of Obstetricians and Gynecologists
American College of Physicians
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Medical Association
American Osteopathic Association
American Psychiatric Association
American Society of Addiction Medicine
Anxiety and Depression Association of America
Association for Behavioral Health and Wellness
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Association
College of Psychiatric and Neurologic Pharmacists (CPNP)
Depression and Bipolar Support Alliance
Global Alliance for Behavioral Health and Social Justice
HR Policy Association and American Health Policy Institute
International OCD Foundation
The Kennedy Forum
Lakeshore Foundation
Massachusetts Association for Mental Health
Maternal Mental Health Leadership Alliance
Meadows Mental Health Policy Institute
National Alliance of Healthcare Purchaser Coalitions
NAMI, National Alliance on Mental Illness
The National Alliance to Advance Adolescent Health
National Association for Children's Behavioral Health
National Association of Social Workers
National Council for Mental Wellbeing
Shatterproof
SMART Recovery
The Trevor Project
Treatment Advocacy Center