AMERICAN PSYCHIATRIC ASSOCIATION

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The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chair Wyden and Ranking Member Crapo:

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 your stakeholder Request for Information (RFI) as the Finance Committee assembles a bipartisan mental health package for consideration. 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, bipartisan 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.

Strengthening Workforce

The increased need for MH/SUD services, especially since the COVID-19 pandemic, has highlighted significant mental health care workforce shortages, especially for patients of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. To expand patient access to MH/SUD treatment, Congress should address these workforce shortages across the continuum of care. APA encourages Congress to make increasing access to MH/SUD a priority by investing heavily in the MH/SUD workforce and in evidence-based care delivery models to use the current workforce more efficiently.

What policies would encourage greater behavioral health care provider participation in these federal programs?

Many psychiatrists work in private or small group practices, often with no administrative staff. The administrative burden associated with providing care is often cited as one reason why psychiatrists do not participate in public health care programs like Medicare and Medicaid or commercial insurance. In addition, reimbursement rates under these programs often do not cover the costs of

running a practice. To encourage behavioral health practitioners to participate in public programs, Congress and the Administration **should work to limit administrative burdens (prior authorizations, credentialing, limits on the number of visits) and increase payment for MH/SUD care.** In addition, Congress should create a new loan repayment program specifically for psychiatrists coming out of residency training who see at least 10% of patients in these federal programs.

What barriers, particularly with respect to the physician and non-physician workforce, prevent patients from accessing needed behavioral health care services?

More than half of people with mental illness don't receive help for their disorders. Often, people avoid or delay seeking treatment due to concerns about being treated differently or fears of losing their jobs and livelihood. Stigma, prejudice and discrimination against people with mental illness and SUDs are also still problematic barriers to care. In addition, there is a **significant shortage of ALL mental health professionals**, especially in rural areas. Further, this shortage is exacerbated by narrow and/or inadequate provider networks in addition to affordability issues. Finally, social determinants of health such as education, food insecurity, lack of access to broadband or reliable internet, childcare issues, transportation barriers and affordable housing also create major barriers that impede many patients from accessing MH/SUD services. **Solutions such as using telepsychiatry (video and audio) as well as evidence-based models of integrating mental health care into primary care practices can both reduce the stigma** associated with going for treatment to a behavioral health specialist office as well as improve access to services. In addition, addressing social determinants of health and improving access to better wraparound services could greatly improve health access and outcomes, particularly for underserved populations.

What policies would most effectively increase diversity in the behavioral health care workforce?

For almost 50 years, the Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship Program (MFP) has helped improve behavioral health care outcomes for racial and ethnic populations by growing the number of diverse behavioral healthcare providers in the nation's workforce. The program seeks to reduce health disparities and improve behavioral health care outcomes by providing experiential learning experiences and coursework for psychiatry trainees, thus enhancing their ability to provide culturally competent, quality mental health and substance use disorder services within medically underserved communities. Investing further in this important program will not only help to strengthen diversity in the mental health profession, but also help address current and projected behavioral health workforce shortages and promote needed training for providers to address health disparities. To that end, **APA supports the House passed *Pursuing Equity in Mental Health Act*, and would encourage Congress to consider the Senate companion, S. 1795**. This comprehensive legislation would take important steps to improve diversity in our behavioral health workforce by increasing funding for the MFP, authorizing multiple grant programs to increase recruitment and training of diverse MH/SUD providers, and directs the Department of Health and Human Services 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.

What federal policies would best incentivize behavioral health care providers to train and practice in rural and other underserved areas?

To build a more robust workforce and promote access to care in rural and underserved areas, the **APA strongly supports further prioritization of workforce-building programs administered by the Health Resources and Services Administration (HRSA)**. 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 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 in order 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 Graduate Medical Education program with an explicit focus on specialties that have severe shortages such as psychiatry.**

In addition, international medical graduates (IMGs) are also vital contributors to our workforce and play a critical role in helping to fill the behavioral health workforce gap, particularly in mental health professional shortage areas where nearly 120 million Americans live. IMGs make up almost a quarter of the total resident and practicing physician workforce. Currently, most resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country for two years after their residency has ended before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. **Reauthorization of the Conrad State 30 J-1 visa waiver program**, through legislation like the *Conrad State 30 and Physician Reauthorization Act*, S. 948, **serves the dual purposes of easing the administrative burdens for certain IMGs while boosting the workforce of physicians** available to treat mental illness and addiction in rural and other medically underserved areas. In addition, legislation like the *Healthcare Workforce Resilience Act*, S. 1024, recaptures up to 15,000 unused employment-based visas for use by international physicians and provides for expedited processing of visa applications. Though not within the jurisdiction of the Senate Finance Committee, given the severe workforce shortage, APA encourages the Committee to consider adding these pieces of legislation to any mental health/substance use disorder package.

Are there payment or other system deficiencies that contribute to a lack of access to care coordination or communication between behavioral health professionals and other providers in the health care system?

A growing body of research shows coordinated medical care can improve health outcomes,[1] but providers may be resistant to sharing mental health patient information due to confusion and stricter than necessary interpretations surrounding HIPAA laws. In addition, stricter requirements for the sharing of certain substance use disorder records make it difficult for patients with substance use disorders to benefit from high-quality, coordinated care models. Often, practitioners refuse to share information with other practitioners due to incorrect legal advice or for fear of being out of compliance with HIPAA. In December 2017, the Department of Health and Human Services' Office of Civil Rights released helpful clarifying guidance regarding situations in which mental health information can be shared between health care practitioners. In order to help alleviate some of these patient information sharing issues, **the Committee could include policies encouraging greater adoption of electronic health records and the use of secure information exchange among mental health, substance use, and community providers**, which would allow better information sharing in these care scenarios.

In addition to clarifying patient-information sharing rules and regulations, Congress should consider legislation that includes incentives (i.e. grant programs, increased reimbursement) for measurement-based care models that encourage behavioral health professionals to coordinate with other practitioners in the health care system.

Which characteristics of proven programs have most effectively encouraged individuals to pursue education and careers in behavioral health care?

As noted above, financial incentives such as the Health Resources and Services Administration (HRSA) loan repayment programs have proven effective in attracting psychiatrists and other behavioral health providers to practice in rural and underserved areas. APA thus:

- **Supports the expansion of existing loan repayment programs for psychiatric and subspecialty trainees** who treat mental health and substance use disorder patients covered by public insurance.
- Encourages the Committee to consider alternative avenues of financial support such as **scholarships for qualified students who pursue behavioral health professions and serve in underserved communities,** stipends, and scholarships to strengthen the size, distribution, and diversity of the behavioral health workforce.
- Supports proposed **pipeline programs such as the Rural and Underserved Pathway to Practice Training Program for Post-Baccalaureate and Medical Students** included in the House Budget Reconciliation Bill, which would utilize scholarships and other financial resources to encourage those from rural and underserved communities to pursue medical careers.
- Recommends **increasing Medicare and Medicaid reimbursement for behavioral health**. Low reimbursement for health professionals and facilities of all types is an important

factor that discourages physicians in training, and other future healthcare professionals, from pursuing careers in behavioral health. It is encouraging that the Department of Labor has made reimbursement its top parity enforcement priority, but while badly needed, that will only affect the private insurance market. The Committee should focus its attention on improving behavioral health provider and facility reimbursement within Medicare and Medicaid, which are also notoriously poor reimbursors compared to other healthcare professionals and facilities. In fact, this often fuels the low reimbursement in commercial insurance because commercial insurers base many of their reimbursement strategies on Medicare rates.

Should federal licensing and scope of practice requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?

The APA strongly supports access improvement strategies that alleviate very real workforce shortages across the mental health provider continuum including increasing recruitment, training and retention of psychiatrists and other mental health practitioners. Given movement towards value-based integrated care, the APA believes that it would be inappropriate to change federal licensing or modify scope of practice requirements. Though some non-physician practitioners may argue that scope of practice requirements keep them from "practicing to the top of their licensure," that is not how coordinated, integrated care works. **Allowing non-physician practitioners to practice without physician involvement and/or beyond the scope of their education and training only serves to further silo care and put patients at risk by lowering standards of care.** Patients with MH/SUD often have co-morbid medical conditions that complicate treatment planning. As such, these patients need to be treated by practitioners who have the requisite medical training and education in order to manage these complicated comorbidities. Rather than lowering standards of care and putting our most vulnerable patients at risk by modifying federal licensing or scope of practice requirements, the overall goal should be to instead enhance integrated care so that care team members work together to provide the best care possible to patients. Further, expanding access to telehealth will also enable more patients to access the care they need, and an in-depth examination of the impediments to recruiting and retaining practitioners across the entire workforce continuum can yield long-term solutions that to not diminish quality of care. Likewise, existing challenges associated with disparate insurance coverage, narrow networks, and a lack of mental health parity continue to serve as actual impediments to care and would thus merit further exploration by the Committee, rather than making changes to scope of practice requirements.

What public policies would most effectively reduce burnout among behavioral health practitioners?

Investing in our workforce by ensuring adequate recruitment and retention of behavioral health practitioners is the best way to reduce burnout. Behavioral health workforce shortages persisted prior to the COVID-19 pandemic due to a variety of factors. However, the pandemic has further exacerbated the workforce shortage and the need for services has heavily outpaced the supply of practitioners. Along with our other colleagues practicing in the health care system,

behavioral health clinicians and other practitioners have been working grueling hours during the pandemic in attempts to meet the needs of patients with mental health and substance use disorders. Congress should further invest in recruiting and training new mental health practitioners across the care continuum in the long term. **In the short term, investing in and encouraging integrated behavioral and primary care health practices can help reduce burnout amongst behavioral health and primary care practitioners.** Increasing our workforce numbers across the continuum of care reduces the number of extra shifts current workers must take on to meet demand, and overall alleviates the strain on the health care system when demand greatly outpaces supply. Further, health care employers need to invest in more robust and supportive employee assistance programs to help their healthcare staff get the help they need when they do experience burnout or other mental health or SUD conditions without fear of job loss or career repercussions when asking for help. For this reason, the **APA supports S. 610, the *Dr. Lorna Breen Health Care Provider Protection Act* and applauds the Senate for passage of this legislation earlier this year.** This legislation, which provides grants to health care practitioners and systems to improve mental and behavioral health among health care workers, is a good first step in tackling the issue of health care worker burnout.

Increasing Integration, Coordination, and Access to Care

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. **The Collaborative Care Model (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. CoCM involves a primary care physician working collaboratively with a psychiatric consultant and a care manager to manage the clinical care of behavioral health patient caseloads. This model allows patients to receive behavioral health care through their primary care doctor in the primary care setting, alleviating the need to seek behavioral health services elsewhere, unless the behavioral health needs are more serious. **Unlike other models of integrated behavioral health care, CoCM is supported by over 90 randomized control studies which indicate that implementing the model improves access to care and has been shown to reduce depression symptoms by fifty percent**. CoCM is currently being implemented in many large health care systems and practices, and is also reimbursed by several private insurers and Medicaid programs.

What are the best practices for integrating behavioral health with primary care? What federal payment policies would best support care integration?

As detailed above, widespread adoption of the CoCM by primary care practices across the country would best put into action the most highly evidence-backed, measurement-based, and best practice model of integrated primary and behavioral health care delivery. However, one of the most significant impediments to adoption of CoCM is the start-up cost for primary care practices. As such, **APA encourages Congress to pass H.R. 5218, the *Collaborate in an Orderly and Cohesive Manner (CoCM) Act*, which would assist primary care practices in setting up CoCM arrangements by providing grants to implement CoCM and establishing CoCM technical assistance centers to ensure that practices are correctly implementing the model**. Further, the

legislation also includes funding for more research studies into other promising behavioral and primary care integration models. Congress should promote proven, evidence-based models of care that have demonstrated improved patient outcomes. For example, other models like the Primary Care Behavioral Health model, include varied approaches that are not measurement–based or population-based, and as a result, continue to provide one-to-one care which does not address the access issue. **An intentional effort to produce evidence to support additional integrated care models would benefit patients, clinicians and health systems.** However, to date, no other model has demonstrated improved patient outcomes like the CoCM.

In addition to supporting implementation of the CoCM, **elimination of the patient cost-sharing requirement under Medicare would remove an additional barrier to care for Medicare beneficiaries.** Practices that have implemented CoCM have seen attrition related to cost-sharing requirements, despite patients reporting positive benefits. Concerns have also been expressed that this may lead patients to underreport mental health or substance use disorder concerns. Removal of any cost-sharing requirement for CoCM would encourage patients to engage and remain within CoCM care.

Consideration should also be given for **funding streams to implement Measurement-Based Care (MBC) techniques in both primary and specialty care.** MBC is a set of standard processes that use patient self-report questionnaires or standardized assessment tools to guide care. The implementation and use of MBC processes provides significant value to both patients and clinicians, helping to enhance communication and understanding of symptoms and guiding both parties in adjusting treatment options based on their outcomes for the patient.

What programs, policies, data, or technology are needed to improve access to care across the continuum of behavioral health services?

Providing psychiatric inpatient care to patients with acute psychiatric symptoms proves challenging given limited hospital beds and the unavailability of sufficient community services. Many communities across the United States lack a comprehensive continuum of care that includes treatment services shown to improve outcomes for diverse populations. As such, the APA recommends the following policy changes:

- Reduce regulatory burdens that drive up costs without commensurate benefit: Eliminate 42 CFR part 482 Subpart E COPs: e.g., Subpart E, 482.60, .61 (med record requirements: treatment plans), .62 (staff requirements).
- Develop a modified per diem rate based on actual audited costs by type of facility and geography with compensation for: complexity; severity; additional tests/ treatment clinically indicated to achieve a realistic operating margin of at least 10%.
- Increase funding for a continuum of care inclusive of community and residential options.
- Ensure that parity with general medical services is outcome-based, rather than merely equivalent “Length of Stay” based. This applies also to housing/ boarding in the emergency department.

- Eliminate the IMD exclusion on state, for-profit, and not-for-profit facilities while maintaining the maintenance of effort.
- Eliminate 190-day lifetime limit for psychiatric hospitals and apply the mental health parity law to Medicare (see parity section below).
- Enforce the Emergency Medical Treatment and Labor Act (EMTALA) to reduce inappropriate manipulation of the system.

Further, since the beginning of the original Meaningful Use Program to current efforts (e.g., the Office of the National Coordinator's Interoperability and Information Blocking Final Rule) to improve interoperability, there is a long history of using technology to get the right data, to the right patient, at the right time, through the right practitioner. Unfortunately, there remain several barriers to ensuring that such technological solutions are equitably deployed across the healthcare ecosystem. Many of these barriers are associated with the known "digital divide" across the United States, which can be conceptualized as the racial, socio-economic, or generational access to digital resources that increases access to care. Digital divide barriers include lack of reliable broadband internet, lack of access to updated technology, and/or the inability to use technology, among other things. The digital divide can increase healthcare disparities, with some patients being better able to use solutions like smart phones, tablets, and high-speed internet to access services like live video telehealth encounters, patient portals, online pharmacies, and more. **Future legislative efforts should be mindful of the growing digital divide and allocate resources that can address some of these issues.**

What programs, policies, data, or technology are needed to improve patient transitions between levels of care and providers?

Some current and emerging policies support improving patient transitions between levels of care and providers. For example, within the Promoting Interoperability Performance Measure of Medicare's Merit-Based Payment Incentive System (MIPS), Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) are required to report on the "Support Electronic Referral Loops by Sending Health Information" measure. This requirement supports creating a summary of care record using ONC-certified electronic record technology and then electronically exchanges this record.

Other policies, in line with the *21st Century Cures Act,* also support transitions of care. Notably, these include the Admission, Discharge, and Transfer Patient Event Notification Conditions of Participation (CoP) for Medicare; the Patient Access API within Medicare and the "Open API" plan by the ONC, all of which will empower patients to take their health records with them from practitioner-to-practitioner.

However, one solution that could greatly improve transitions of care would be the implementation of a Unique Patient Identifier (UPI) across all of healthcare. Presently, EHR systems and Health Information Exchanges use an assortment of patient data to identify patients as they travel within the healthcare system. These data include demographics, social security numbers, former addresses, birth dates, and more. Unfortunately, because each system is

unique, these multiple layers and types of data may misidentify patients, resulting in a lack of transition of care, or even patients and providers having to complete the same intake paperwork over and over. Related, in 2019, the Government Accountability Office submitted a report to Congress entitled "*Approaches and Challenges to Electronically Matching Patient Records*." APA urges Congress to revisit this report and work with the Office of the National Coordinator for Health Information Technology to develop a plan to adopt a UPI for patients within the U.S. healthcare system.

What policies could improve and ensure equitable access to and quality of care for minority populations and geographically underserved communities?

As noted above, supporting the implementation of the Collaborative Care Model (CoCM) increases equitable access to care by providing quality behavioral health care in the primary care setting. Enabling patients to receive MH/SUD care in the primary care setting reduces the stigma many minority populations experience when seeking behavioral health care. In addition, CoCM also builds on the patient-physician trust relationship, allowing patients to work with their trusted primary care provider to receive sometimes difficult-to-access or stigmatized MH/SUD services. Further, in allowing patients to receive this care in the primary care setting, the **CoCM also reduces the requirement that patients travel long distances to receive MH/SUD care. CoCM has also been shown to be particularly successful when implemented in minority communities.** In 2001, one study examined racial differences in response rates to an intervention involving CoCM and usual care among 360 veterans treated for depression at Department of Veterans Affairs community-based primary care clinics. The study showed that racial disparities in depression care may be ameliorated through collaborative care programs.

In addition to CoCM, continued coverage of care through a variety of modalities (in-person, telehealth, audio-only) is also critical to ensuring all persons can access behavioral health care regardless of their circumstance. Some research suggests that limiting access to audio-only care may increase disparities among certain populations. For example, a survey conducted by The California Healthcare Foundations[1] revealed that more than a third of respondents (38%) had received a phone visit, and 72% said they were just as, or more, satisfied with their phone visit compared to their last in-person visit. The study also found that high utilization of, and satisfaction with phone visits specifically among those with low incomes and among people of color, who already face significant barriers to traditional and telehealth care, was positive. Flexibility in the modality of care, coupled with improvements in such things as access to broadband, transportation, and childcare, reduce barriers to care and have the potential to positively impact care. Maintaining current telehealth flexibilities allowed under the COVID-19 Public Health Emergency, along with directing funding to study and better understand

[1] "The Doctor Will Call Me Maybe: The Uncertain Future Of Audio-Only Visits And Why We Need Them To Address Disparities, " Health Affairs Blog, March 3, 2021.DOI: 10.1377/hblog20210225.26462

the impact these modality changes have had on quality care, including in minority populations and underserved communities, is critical.

In addition, **policies supporting the implementation of Measurement-Based Care (MBC) in specialty care have been shown to improve patient outcomes and reduce disparities in care.** The routine use of validated rating scales enables psychiatrists and other clinicians to track patient progress and reduces the potential for clinical inertia that can occur and delay improvement. **Consideration should be given to creating funding streams to implement MBC techniques within mental health and substance use disorder treatment settings.** Implementation requires workflow and staffing changes, so ongoing funding for costs not currently covered by existing payment mechanisms would be important, as well as technical assistance to facilitate adoption. Adoption of quality measures supporting MBC would encourage clinicians to routinely use this in daily practice.

How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?

Evidence supporting the Crisis Now model shows that the three elements of a strong crisis response system are (1) crisis call centers, (2) mobile crisis response, and (3) medically staffed crisis stabilization units. Evidence also points to 24/7 coordination between these three elements as being vital to facilitating access to appropriate care during a crisis and improves outcomes through better opportunities for follow-up. As Congress does the important work of funding 988, crisis call centers and mobile crisis response, it is **essential to also provide sustainable resources for crisis receiving and stabilization facilities** that provide short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment. **Such facilities should be reimbursed by Medicaid and private insurance.** CAHOOTS and other models depend on the presence and 24-7 availability of such facilities, including their willingness and ability to take all patients. There should also be options available for patients who would benefit from short-term residential care. Resources, including outreach supports, should be available to ensure services are culturally competent and linguistically appropriate with support to help individuals and family members navigate accessing crisis services, especially for populations that may be underserved by our current mental health system due to lack of coverage, stigma, or difficulties navigating the system.

Crisis services models like CAHOOTS connect people to more coordinated and accessible care when they exist in tandem with all three Crisis Now elements. They do so in part by diverting patients to appropriate care and avoiding criminalizing those experiencing a mental health crisis, as well as by avoiding costly emergency department (ED) boarding. The most frequently cited **cause of ED boarding is the shortage of inpatient psychiatric beds. In addition, insufficient funding for lower levels of care, from community clinics to intensive outpatient programs, community crisis stabilization units, and respite services fuels the crisis and leads patients to seek care in emergency settings.** Average boarding times for psychiatric patients in EDs range from 6.8 hours to 34 hours, are very costly, and subject patients to a frequently chaotic environment that is far from ideal in addressing their care-related needs. A 2008 survey of 1,400 ED directors conducted by the American College of Emergency Physicians found that 79% of the

328 respondents reported having psychiatric patients boarding in their EDs; 55% of ED directors reported psychiatric boarders on a daily or at least multiple days per week basis; and 62% reported that there were no psychiatric services involved with the patient's care while they are being boarded prior to their admission or transfer. By supporting each element as part of the full continuum of crisis care, Congress can reduce ED boarding and facilitate higher quality care with better outcomes.

How can providers and health plans help connect people to key non-clinical services and supports that maintain or enhance behavioral health?

Health plans and practitioners should coordinate to ensure that patients receive appropriate information about non-clinical behavioral health services and supports available in their communities. Coordination and patient education on non-clinical services can include providing information to patients during appointments, at clinics, online, through community engagement, through public health workers, at schools and places of worship. The role of psychosocial stressors across the patient life cycle as both risk factors and modifiers of the course of mental illness has been well described. For example, adverse childhood experiences are strongly linked with adolescent depression (Felitti et al., 1998) and a variety of negative physical and mental health outcomes much later in life (Catalano et al., 2011). Therefore, it is **critical to fund and develop policies and programs that connect patients to non-clinical services, starting in infancy and supporting healthy attachment.** Deliberately focusing on wraparound services and addressing social determinants of health will enhance access to non-clinical behavioral health services and community supports such as transportation, housing and peer groups services.

Ensuring Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law on October 3, 2008. Unfortunately, MHPAEA has never been sufficiently enforced, which has allowed continuing insurance discrimination against those with mental health conditions and substance use disorders. In addition, **MHPAEA does not apply to Medicare** except for Medicare Advantage plans offered by an employer, which cover a very small proportion of Medicare enrollees. This means that millions of Americans are not afforded protection from the discrimination in coverage of MH/SUD treatment that MHPAEA prohibits. This is a critical gap not only for older Americans, but also for the more than nine million Americans under the age of 65 who are enrolled in Medicare because of disability status. Further, this population includes many individuals with serious mental illness, such as those with schizophrenia and bipolar disorder. **Additionally, the Medicare mental health and substance use disorder benefit design is narrow and excludes crucial services** such as: residential treatment; intensive outpatient treatment for substance use disorders; mental health crisis services; coordinated specialty care for first episode psychosis; assertive community treatment; nutritional counseling for eating disorders and other essential services. We ask that Congress expand the MHPAEA requirements to Medicare recipients to ensure that they receive these critical services, while also working to hold private plans, administrators, and issuers accountable to the law.

How can Congress improve oversight and enforcement of mental health parity laws that apply to private plans offering coverage under the federal health programs? How can we better understand and collect data on shortfalls in compliance with parity law?

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. Enacting legislation that gives the Department of Labor the ability to levy civil monetary penalties on plan issuers, sponsors and third-party administrators will encourage compliance with Mental Health Parity laws. **The *Parity Enforcement Act* (H.R. 1364) would give the Department of Labor the authority for plan sponsors and issuers, and could be further improved by expanding its applicability to third-party administrators to also hold them accountable**, seeing as though third party administrators often have complete control over employer-sponsored plans. This was proposed by the House Committee on Education and Labor in its recent 2021 Budget Reconciliation proposal.

In addition to expanding the application of existing federal parity law, **providing grants to states to enforce parity for the plans they regulate would also improve compliance and enforcement.** For example, *The Parity Implementation Assistance Act* (H.R. 3753/S. 1962) is a bipartisan proposal that authorizes grant funding to state insurance departments to use for parity implementation. Under the bill, a state must request and review the comparative analyses insurers are now required to perform thanks to the parity provisions included in last year's December 2020 *Consolidated Appropriations Act*, in order to receive a grant.

Finally, Congress can support parity compliance by ERISA plans by providing the Employee Benefits Security Administration with the funding it needs to carry out its legal enforcement obligations, as has been proposed in the House FY 2022 bills that have been released to date.

How can Congress ensure that plans comply with the standard set by Wit v. United Behavioral Health? Are there other payer practices that restrict access to care, and how can Congress address them?

Congress should look to states that have already taken legislative action to ensure that plans under their jurisdiction meet the standards set by *Wit*. **Most recently, the Oregon Legislature passed HB 3046, which requires insurers that sell health insurance policies in Oregon to adhere to the standards of *Wit* when making care determinations for behavioral health. Congress could do the same** thing for ERISA plans as well as for Medicare and Medicaid. While states such as Oregon, California, and Illinois have codified the Wit standards, the majority of Americans are covered by plans that operate beyond state jurisdiction. Only an act of Congress can ensure that all Americans have the standard of care as set by *Wit*.

Are there structural barriers, such as the size of the provider network, travel time to a provider, and time to an appointment, that impede access to the behavioral health care system?

Behavioral health provider networks are notoriously poor in terms of adequacy. This is a major reason why the Milliman report from 2019 found that patients seeking behavioral health care were five times more likely to do so on an out-of-network basis than patients seeking

medical/surgical care. MHPAEA requires that insurers respond to shortages in their behavioral health provider networks in a way that is comparable to what they do for shortages in their medical/surgical provider networks. When there are shortages of providers in their medical/surgical networks, insurers will quickly increase reimbursement rates and relax network admission standards to ensure that they have enough providers to meet demand. By contrast, when there are shortages of behavioral health providers in an insurer's network, insurers generally do not attempt to entice more behavioral health practitioners to join. Even though demand for behavioral health services is at an all-time high in rural, urban, and suburban communities as a result of COVID-19, insurers have not reacted to this spike in demand by adding more practitioners to their networks. This is a violation of MHPAEA and it should be a focus of enforcement efforts as well as Congressional efforts to expand access to behavioral health services.

To what extent do payment rates or other payment practices (e.g. timeliness of claims payment to providers) contribute to challenges in mental health care parity in practice?

Low reimbursement rates for the same unit of work, burdensome administrative requirements, delayed payments and post payment service reviews all contribute to clinicians' unwillingness to join health insurances panels.

As a result of these rates and payment practices, many people who need care are unable to find an in-network clinician and must either pay out of pocket or go without care. Additionally, a growing trend among payers of all types is post-service, pre-payment reviews under which the payer reviews care that was already delivered and withholds payment until it completes an audit. While this happens for all types of health care, it is happening with greater regularity for behavioral health care, particularly for inpatient care. Even when audits result in an affirmation that care was necessary, the delay from service delivery to payment can be months. Smaller behavioral health facilities often operate on very thin margins, and this delayed payment can lead to severe financial strain and even closure.

How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicaid fee-for-service programs impact access to care and patient health?

Congress could start by applying the federal parity law to Medicare Parts A through D. Currently, the federal 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 the current arrangement, Medicare beneficiaries are not protected by the vital 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.

In addition to applying the parity law to Parts A through D, **Congress should also authorize Medicare reimbursement for specific mental health and substance use disorder benefits that are excluded today including: residential treatment; intensive outpatient treatment for substance use disorders; mental health crisis services; coordinated specialty care for first**

episode psychosis; assertive community treatment; nutritional counseling for eating disorders and other essential services.

If an individual is enrolled in a Medicaid Managed care plan, or an alternative benefit plan (benchmark equivalent plan), the parity law covers that person. However, there is a subset of people who receive all of their Medicaid benefits through fee-for-service, and those individuals are not protected by the federal parity law. **Extending the parity law to Medicaid fee-for-service would ensure that every Medicaid beneficiary is covered by the parity law.**

Expanding 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, it also required 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 Secretary. This arbitrary 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 supports the removal of 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.

How do the quality and cost-effectiveness of telehealth for behavioral health care services compare to in-person care, including with respect to care continuity?

One way in which continued access to telehealth increases continuity of care is by decreasing patient no-show rates. Psychiatrists who responded to a survey of APA members in June 2020 indicated that, at that time, they had transitioned to exclusive use of telehealth for over 90% of their patients. The data further showed that patient no- show rates dropped significantly as telehealth became the primary way for patients to keep appointments with their psychiatrists. Allowing patients to be seen in the home via telehealth likely contributes to this trend, as 94% of respondents in a second APA survey indicated that patients were receiving telehealth in their home or another location of the patient's preference. Patient satisfaction with telepsychiatry also appeared high, with 90% of psychiatrist respondents reporting that patients who were seen for the first time via telehealth reported being somewhat or very satisfied with the care they received. **Fewer patient no-shows and increased satisfaction means that patients are better able to follow their recommended course of treatment, including psychotherapy and medication compliance, which reduces cost to the healthcare system overall.** Regardless of whether the behavioral health appointment is in person or via telehealth, in general, when patients keep their first appointment, they are more likely to keep subsequent appointments and when patients are satisfied with treatment, they are more likely to continue with their course of therapy. Research also suggests that this **results in better medication compliance, fewer visits**

to the emergency department, fewer patient admissions to inpatient units, and fewer subsequent readmissions.

How can Congress craft policies to expand telehealth without exacerbating disparities in access to behavioral health care?

Legislation that addresses access to **telehealth services should not require an in-person physical visit to a clinician's office in order to begin or continue being treated via telehealth**. Such a requirement is particularly **burdensome for patients who live in rural areas**, as well as for those in urban communities who lack adequate transportation options. Under the SUPPORT for Patients Act, there is currently no requirement for an in-person visit for patients with SUDs or more complex co-occurring SUD and mental health diagnoses. So, requiring the in-person appointment for patients diagnosed with a mental illness alone creates a disparity and access limitation within the healthcare system for these patients. A **determination about whether the patient could benefit from being seen in person by their psychiatrist should be at that psychiatrist's discretion, based on their clinical judgment about what is best for the patient, not dictated by an arbitrary limit on access**. Furthermore, the APA recommends funding policies and programs to address social determinants of health and health equity as it relates to telehealth, including for data collection, to better understand the impact of telehealth access on diverse communities. **APA supports H.R. 4770, the '*Evaluating Disparities and Outcomes of Telehealth (EDOT) Act*'**, which would study the impact of telehealth during the COVID-19 pandemic and authorize an analysis of utilization, access, and outcomes for race, ethnicity, geographic location, and income. Further, APA recommends that Congress examine ways to **improve reliable broadband** coverage for patients so that they can access telehealth services.

How has the expanded scope of Medicare coverage of telehealth for behavioral health services during the COVID-19 pandemic impacted access to care?

Numerous flexibilities for telehealth enacted by Health and Human Services' COVID-19 Public Health Emergency (PHE) declaration and facilitated by congressional action have increased access to psychiatric care in a variety of ways. This increases patient access to timely MH / SUD services and treatment may avoid downstream costs from hospitalization or emergency room services. The **option to treat a patient at home,** rather than being required to present at a Medicare Qualified Originating Site, **has increased access for those who may not be able to travel to an Originating Site** due to limitations imposed by their physical health, mental health diagnosis, or lack of proximity to services on-site. **The availability of audio-only services has also increased access for patients** who:

a) lack access to video-capable technology, such as a smart phone or tablet;

b) lack access to high-speed broadband Internet; or

c) are unwilling or unable to use videoconferencing software due to cognitive limitations or because of how the symptoms of their mental illness manifest.

The aforementioned telehealth flexibilities allowed during the pandemic have been a lifeline for many patients needing MH/SUD services. **Telehealth has also provided clinicians with**

additional means to expand patient access and treatment to MH/SUD services and to reach patients from diverse communities. We know that the need for MH/SUD services will continue after the pandemic ends, and **APA encourages Congress to retain these flexibilities in order to expand access to MH/SUD in addition to in-person evaluations and treatment.**

How should audio-only forms of telehealth for mental and behavioral health services be covered and paid for under Medicare, relative to audio-visual forms of telehealth for the same services?

According to our members, the work of the psychiatrist does not necessarily change in volume or in cognitive effort between seeing a patient over video versus over the telephone for audio-only encounters. Covered services between the two modalities are of equal value and should be reimbursed at the same rate.

Are there specific mental health and behavioral health services for which the visual component of a telehealth visit is particularly important, and for which an audio-only visit would not be appropriate? For which specific mental and behavioral health services is there no clinically meaningful difference between audio-visual and audio-only formats of telehealth? How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?

Some diagnostic assessments would necessitate the patient appearing on video. For example, psychiatrists who want to assess certain psychomotor symptoms associated with some diagnoses or as side effects of some medications would need to see these patients over video (e.g., to view hand tremors, gait/mobility). With respect to specific mental and behavioral health services, there is currently limited evidence comparing the clinical effectiveness of video and audio-only care for services such as psychotherapy or medication management. However, APA asserts that **such decisions should be left to the clinician's discretion based on their professional training** to determine the specific therapeutic modality through which the patient should be seen at the point of service.

How should Medicare pay for the practice expense portion of Medicare's telehealth payment for mental and behavioral health services? Should the practice expense resources needed for telehealth forms of these services be independently measured, or should Medicare rely on the practice expense values used for in-person forms of Medicare payment for the services?

Medicare should continue to **pay for all services at the same in-person rate regardless of the modality of care**. **Clinicians will continue to incur practice expenses regardless of the mode of care and in some cases may be incurring additional expenses** to ensure patients have access to the care through a variety of means. Patient presentation and clinical judgement drive the decision as to what modality of care is most appropriate. APA anticipates that during the post PHE, the typical clinician will provide care though a hybrid model that offers access to care through the full range of modalities including in-person, telehealth and audio-only.

Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care (in addition to flexibilities already provided on a permanent basis in the SUPPORT for Patients and Communities Act and the Consolidated Appropriations Act, 2021)? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?

Congress should extend the current telehealth flexibilities for at least two years after the public health emergency to ensure that the continuity of care for patients seeking MH/SUD services, and to further study the delivery of services via telehealth. Congress should **permanently eliminate the requirement under the Consolidated Appropriations Act (CAA) that requires an in-person visit with a provider within six months** of the first telehealth appointment, so mental illness is treated the same as SUDs and co-occurring MH disorders. As such, **APA supports enactment of the *Telemental Healthcare Access Act,* S.2061**, which eliminates the six-month in-person requirement and provides appropriate safeguards. In addition, Congress should **allow for the appropriate use of audio-only treatment via telehealth** for both MH/SUD services to ensure equitable access for those lacking broadband coverage or for those without the means to use audio-video capabilities when there is not a reasonable alternative, and the clinician believes it is medically appropriate. **APA recommends that Congress utilize similar protections and safeguards for telehealth that are currently in place for Medicare's in-person services**. For example, regular audits of CPT billing codes will reveal if Medicare providers are overbilling for telehealth services based on patient volume over various billing cycles.

What legislative strategies could be used to ensure that care provided via telehealth is high-quality and cost-effective?

Research indicates that telehealth encounters result in similar patient outcomes to in-person encounters. For a review of these standards, **APA recommends examining "*Best Practices in Videoconferencing Based Telemental Health*," written by the APA and the American Telemedicine Association.** This guide emphasizes that the standard of care should remain the same between in-person and telehealth services. When these best practices are adhered to, telehealth will be high quality. As mentioned above, telehealth also remains cost effective for a variety of reasons. Deference to a clinician's medical judgment should be underscored in legislation, including determinations about when audio-only telehealth services are appropriate and when patients should see their doctor in person.

Further, APA recommends legislative support for the implementation of Measurement-Based Care (MBC), which has been shown to improve outcomes across mental and substance use disorder diagnoses when done in conjunction with mental health encounters, including those provided via telehealth. As a set of standard processes, MBC can increase patient engagement, ensure initiation of evidence-based treatments, and facilitate essential follow-up assessment and continuous care planning. For example, implementation of MBC with regular outcome assessments has been linked to improvements in service delivery and lower readmission rates (Slade et al, 2006). Moreover, routine outcome measurement that was fed back to the clinician

and used to make joint treatment decisions with the patient led to better reported quality of life (Priebe et al., 2002). Legislation calling for funding to support training and implementation of MBC would increase adoption of this evidence-based activity.

What barriers exist to accessing telehealth services, especially with respect to availability and use of technology required to provide or receive such services?

As mentioned above, access to stable, high-speed internet is inconsistent across the country. This is a limiting factor for patients who wish to use live video telehealth services. Also as mentioned above, certain physical, cognitive, or mental health diagnoses might preclude using live video technology, which underscores the need for continued access to audio-only telehealth.

Improving Access for Children and Young People

Now more than ever, families and children, from infancy through adolescence need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services to appropriately address their mental and behavioral health needs. Mental and behavioral health concerns in children and teens have been on the rise for many years. Suicide is the second leading cause of death for youth ages 10-18 in the United States. The COVID-19 pandemic has worsened the ongoing children's mental health crisis and increased the fragility of the mental health safety net system for children and adolescents. The prevalence and severity of mental health conditions among children have sharply increased since March 2020. Risk factors associated with childhood mental health conditions have also grown precipitously, including family mental health and substance use issues, adverse childhood experiences, racial disparities, social isolation, trauma, food and housing insecurity, economic stress, and poverty. The human and economic toll of inadequately addressing childhood mental and behavioral health problems is significant. Untreated and undiagnosed mental and behavioral health disorders are associated with family dysfunction, school expulsion, poor school performance and disconnection from school, juvenile incarceration, substance use disorders, unemployment, and suicide.

How should shortages of providers specializing in children's behavioral health care be addressed?

In the long term, the focus should be on recruitment, training and retention of practitioners across the behavioral health care continuum who specialize in children's care, including psychiatrists, psychologists and social workers. In the short term, we must expand the use of coordinated primary and behavioral health care delivery models like the Collaborative Care Model (CoCM). **CoCM, with modifications for child and adolescent populations, allows children and adolescents to receive behavioral health care services within the primary care setting from their regular pediatrician or family doctor**. As with adult populations, CoCM removes the necessity of following up with a separate behavioral health referral, finding a practitioner who takes new patients and finding a practitioner who accepts the child's insurance. Further, CoCM in the pediatric setting does not put the extra burden on parents and caregivers having to take additional days off work to attend both seprate primary care and psychiatric care appointments and reduces transportation barriers to finding stand-alone MH/SUD practitioners in addition to already established primary care provider relationships. Finally, improving reimbursement rates

for CoCM and other behavioral health services would help recruit more behavioral health practitioners, as well as retain these practitioners throughout the care continuum.

How can peer support specialists, community health workers, and non-clinical professionals and paraprofessionals play a role in improving children's behavioral health?

Children's behavioral health treatment should always be developed and overseen by a medical practitioner with a clinical background. The clinical practitioner-developed treatment plan can include working with a peer support specialist, community health worker or non-clinical professional and/or paraprofessional. Support specialists, community health workers, and non-clinical professionals and paraprofessionals can serve as vital parts of the care team ensuring that pediatric and adolescent patients adhere to their treatment plans and have the support they and their families need during MH/SUD treatment. However, given the potential side effects and interactions of psychotropic medication, it is vital that a child's behavioral healthcare treatment plan be overseen by a physician.

Are there different considerations for care integration for children's health needs compared to adults' health needs?

When providing mental health care for children there should be additional considerations or adaptations to any program. Pediatric mental health conditions are frequently diagnostically ambiguous, commonly with comorbid conditions, and complicated by atypical and/or delayed development, impairment in family functioning, and/or learning issues. As a result, in the CoCM, within a pediatric practice the behavioral health care manager (BHCM) should be a fully qualified mental health clinician, skilled in a variety of evidence-based psychotherapy models, and able to work both individually with the child and with the family. The BHCM should engage with parents as full partners in the child's treatment, empower them to be agents of change for their children, and be prepared to help parents access their own mental health services when needed. The BHCM should understand and be able to interact with child-serving systems (i.e. schools, child protective services) and agencies to address social determinants of health. In addition, clinical measures should be selected that have been proven to be valid and developmentally appropriate for the specific age of the patient.

How can federal programs support access to behavioral health care for vulnerable youth populations, such as individuals involved in the child welfare system and the juvenile justice system?

First and foremost, children in child welfare systems and juvenile justice systems should have access to high quality mental health and substance use disorder care. This cannot be achieved without an adequate workforce of all pediatric specialists, especially child and adolescent psychiatrists. Children in these systems have often experienced trauma, abuse, and deal with significant social issues in their families and communities. Too often children in the child welfare system are treated with multiple medications, and not psychosocial interventions. **Ensuring that these pediatric patients are being evaluated by clinicians who understand both pediatric medical needs and mental health needs is essential to appropriate diagnosis and treatment**. Providing loan repayment for individuals treating patients within these systems would enhance the workforce and improve access to quality care.

What key factors should be considered with respect to implementing and expanding telehealth services for the pediatric population?

For many pediatric psychiatrists, the ability to prescribe controlled substances for certain diagnoses, such as Attention-Deficit Hyperactivity Disorder (ADHD), is a cornerstone of high-quality care. This same level of care is achievable through telehealth by way of electronic prescribing. Under the *Ryan Haight Online Pharmacy Consumer Protect Act*, clinicians who would dispense a controlled substance via an electronic prescription using telepsychiatry must first complete an in-person examination of the patient. During the Public Health Emergency, the Drug Enforcement Administration (DEA) used the Emergency Exception under the Ryan Haight law to allow for the electronic prescribing of controlled substances (EPCS) without an in-person examination. For child patients with barriers to accessing or traveling to a child psychiatrist's office, this exception allowed for children newly diagnosed with ADHD and certain other conditions to receive their medications without the in-person exam.

In 2018, under the SUPPORT for Patients Act, Congress mandated that the DEA finally release long-awaited regulations around the "special registration" process under Ryan Haight, which would allow for clinicians to apply for a special registration under their DEA license to EPCS without the in-person exam. Unfortunately, the DEA missed the October 2019 deadline imposed by Congress, leaving many child patients unable to get the care they need. **While the PHE Exception has offered temporary flexibility to this barrier to care, APA urges Congress to work with the DEA to release a proposed rule around a special registration process.**

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 Senate Finance Committee develops a mental health legislative package. The APA is eager to aid your efforts to improve mental health across our nation. If you have any questions, please contact Michelle Greenhalgh at mgreenhalgh@psych.org / 202.459.9708.

Sincerely,

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