AMERICAN PSYCHIATRIC ASSOCIATION

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Testimony of the

American Psychiatric Association

On

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Submitted for the record to the

U.S. House of Representatives Ways and Means Committee

FULL COMMITTEE HEARING:

America's Mental Health Crisis

Chairman Neal, Ranking Member Brady, and distinguished members of the House Ways and Means Committee, thank you for the opportunity to submit this testimony for the record on behalf of the over 37,400 psychiatrists of the American Psychiatric Association (APA) for your February 2, 2022 hearing entitled "*America's Mental Health Crisis."* The APA is dedicated to providing our physician members with education and training on the most modern evidence-based treatments to diagnose and treat patients with mental illness and substance use disorders (SUD). The APA and our members are focused on ensuring humane care and effective treatment for all persons with mental illness and SUD, and is actively engaged in pursuing policies that affect our patients' access to quality care. We appreciate the Committee's continued work on this critically important matter and hope that you will find our comments below helpful.

Collaborative 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 integrated care model. The model provides mental health and/or SUD treatment in a primary care office through consultation between a primary care practitioner working collaboratively with a psychiatric consultant and a care manager to manage the clinical care of behavioral health patient caseloads. The CoCM is population-based, which allows for more patients to be treated, versus usual one to one care. This is critical given the shortage of all mental health clinicians, and is a useful way to quickly extend the current workforce and enhance access to care. This model allows patients to receive behavioral health care through their primary care provider in the primary care setting, alleviating the need to seek behavioral health services elsewhere. The model is evidence-based and allows for the early diagnosis and intervention of mental health conditions in the primary care setting, which is important to prevent ER visits or hospitalization. Furthermore, the model uses measurement-based care, which means the patient's progress is tracked and treatment adjusted if indicated.

Unlike other models of integrated primary and behavioral health care, CoCM is supported by over 90 randomized control studies which indicate that implementing the model has been shown to reduce a patient's depression symptoms by fifty percent. In addition, studies show the CoCM, enhances access to care for patients in rural or underserved areas because the consultations between the team members are often done remotely, not face to face. CoCM is currently being implemented in many large health care systems and practices, and is also reimbursed by Medicare, several private insurers and numerous state Medicaid programs. Expanding the use of the CoCM will help improve access to MH/SUD treatment despite current workforce shortages; improve outcomes and health equity; and reduce health care costs. However, the requisite start-up costs have proven to be a barrier for to its adoption by many practices. As such, though not under the Committee's direct jurisdiction, APA **encourages Committee members to cosponsor H.R. 5218, bipartisan legislation that creates a grant program to assist with the implementation of Collaborative Care model in primary care offices.**

In addition to supporting H.R. 5218, APA encourages the Committee to examine policies that would eliminate patient cost-sharing requirements like copays under Medicare. This would remove an additional barrier to care for Medicare beneficiaries who must pay copays to receive care through CoCm. Practices that have implemented CoCM have reported that some patients drop out of the program because of the cost-sharing/co-pays associated with the care they receive on an on-going basis, despite reporting positive benefits. Concerns have also been expressed that this may lead patients to underreport mental health or substance use disorder symptoms and concerns. Removal of any cost-sharing requirement for patients enrolled in CoCM care would encourage patients to engage and remain within a CoCM program.

Workforce

We applaud Congress and the Committee for investing in physician training by adding 1,000 new Medicare-supported Graduate Medical Education (GME) positions via the 2021 Consolidated Appropriations Act. In addition, the APA thanks the Committee and Congress for including provisions that expand Medicare GME residency training positions by 4,000 new positions with fifteen percent allocated to psychiatry, in the Build Back Better Act. **We are hopeful that this GME expansion provision will be retained and passed before the end of the 117th Congress.**

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). 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.

Telehealth

Bipartisan agreement during 2020 allowed Congress and the previous and current Administration to increase access to telehealth services to treat mental illness during the COVID-19 public health emergency. Prior to COVID-19, substance use disorders and co-occurring mental health 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. However, Congress also passed requirements for 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, which does not apply to those with substance use disorders or co-occurring substance use disorders and mental health conditions who see their clinicians via telehealth, creates an unnecessary and difficult barrier to needed care for Medicare patients with a mental health diagnosis. Whether a patient needs to be seen in person is a clinical decision that should be made together at the appropriate time by a patient and their doctor. **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**.

Further, APA encourages the Committee to support policies that expand the telehealth flexibilities afforded to providers under the COVID-19 Public Health Emergency, including lifting of site of service and geographic restrictions as well as allowing for the use of audio-only when clinically appropriate, and no other alternative exists. Extending these flexibilities for at least two years post-Public Health Emergency is critical to ensuring that all persons, including minority populations and underserved communities, can access behavioral health care regardless of their circumstance, and will allow for Congress to study the impact of these current flexibilities.

Health Equity

APA thanks the Committee for its continued work on health equity and for its promotion of policies to address heath disparities. Specifically, we thank the Committee for its work last Congress on the *Something Must Change: Inequities in U.S. Policy and Society* and accompanying framework, *A Bold Vision for a Legislative Path Toward Health and Economic Equity* as well as the *Left Out: Barriers to Health Equity for Rural and Underserved Communities*. We also thank the committee for the opportunities to submit comments on both the: (1) Request for Information regarding misuse of race in clinical algorithms and exploring potential strategies to address inequities via clinical decision support tools in October of 2020 and (2) the Request for Information issued by the Rural and Underserved Communities Health Task Force in November of 2019. The APA is encouraged that the Committee has sought to address health disparities by prioritizing policies and funding programs to advance access to evidence based and culturally competent care.

We agree with the Committee that more work in these areas needs to be done. The disproportionate impact of the COVID-19 pandemic on racial and ethnic communities and vulnerable populations has highlighted the necessity of addressing health inequities. Social determinants of health are among the most significant contributors to negative health outcomes and overall health inequity. It is for these reasons that we encourage the Committee to focus on policies that **(1) increase the culturally competent workforce of mental health and substance use disorder practitioners, (2) increase the availability of culturally competent resources for practitioners and states to help them meet unmet mental health and substance use disorder screening and treatment needs in hard to reach populations, (3) work to reduce discrimination and bias in the screening and treatment of minority patients, (4) increase access to culturally competent and inclusive maternal prenatal, delivery and post-partum care to help reduce maternal mortality and severe maternal morbidity, (5) and increase**

resources for public health campaigns that use evidence-based practices to reduce mental health and substance use disorder stigma, encourage community support and dispel population distrust in the medical profession, specifically mental health practitioners.

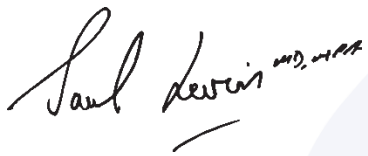
Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that insurance coverage for mental health and substance use disorder services be no more restrictive than coverage for other medical care. However, many health plans are not in compliance with the requirements of MHPAEA despite the law having passed over than ten years ago. Achieving full compliance with the parity law's requirements is essential given the need to access and maintain coverage for mental health and substance use services, especially with the increase in deaths from drug overdoses and suicides during the COVID-19 pandemic. As a follow-up to changes to the law which strengthened the MHPAEA and were included in the December 2020 Consolidated Appropriations Act (CAA), **APA supports provisions levying civil monetary penalties on health plans, issuers and third-party administrators found to be in violation of parity law requirements.** This is essential, especially given the recently issued report to Congress about health plans and insurers' compliance with amendments made to the federal parity law in the 2020 CAA. The 2020 CAA required all health plans and insurers in the country to perform comparative analyses demonstrating their compliance with the existing provisions of the MHPAEA law and to submit these analyses to federal and state regulators upon request. The 2020 CAA also required federal agencies to request a certain number of analyses from insurance plans and insurers each year. According to the report issued on January 25, 2022 by the Departments of Labor, Health and Human Services and Treasury, the federal agencies requested 171 comparative analyses, which far exceeded the minimum threshold established by the 2020 CAA. The agencies found that upon initial examination, not a single analysis contained sufficient information. Additionally, throughout the process of collecting supplemental information, the agencies found numerous parity violations potentially affecting millions of beneficiaries. The report validates APA's position that insurance plans and insurers were still not fully compliant with the federal parity law and more transparency and accountability was needed. **APA encourages the Committee and Congress to support policies that would bring insurers into compliance with MHPAEA immediately.**

Further, APA also encourages the Committee to examine policies that would **extend MHPAEA parity protections to the Medicare program.** 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 (except for the very rare examples of Medicare Advantage plans provided through an employer-sponsored plan). That means that many of those with the most severe mental illnesses are not protected by the MHPAEA and do not receive the mental health or substance use disorder care they need. 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. Congress and the Committee 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.

Thank you for the opportunity to submit this testimony for the record, and for your leadership and focus on the issue of our country's mental health. Please let us know how we can aid your efforts to address mental health and substance use disorders. If you have any questions, please contact Michelle Greenhalgh at mgreenhalgh@psych.org / 202.459.9708.

Sincerely,



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