I am writing on behalf of the American Psychological Association (APA) to share our organization’s written comments for the consideration of the House Ways & Means Committee for its hearing on “America’s Mental Health Crisis.” APA is the nation’s largest scientific and professional organization representing the discipline and profession of psychology, with more than 133,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in the field of psychology. Through the application of psychological science and practice, our association’s mission is to have a positive impact on critical societal issues.

The COVID-19 pandemic has placed an enormous strain on the nation’s mental health. During the pandemic, roughly four times as many adults reported symptoms of anxiety or depressive disorder and an APA survey of psychologists demonstrates an increased demand for treatment for these and other signs of severe mental distress. Data also shows a surge in emergency department visits attributable to a mental health crisis, suicide attempts, and drug. Rates of eating disorders, sleep disruptions, and alcohol consumption have also increased, and between June 2020 and June 2021 approximately 100,000 people in the U.S. died from a drug overdose, a substantial increase over the prior year’s tragic toll.

However, the need for greater investment in behavioral health care existed before COVID-19. Establishing a robust and effective mental health and substance use disorder treatment system

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4 University of Minnesota Medical School. (2021, April 12). COVID-19 pandemic has been linked with six unhealthy eating behaviors: Study shows a slight increase in eating disorders, one of the deadliest psychiatric health concerns. ScienceDaily. Retrieved from www.sciencedaily.com/releases/2021/04/210412114740.htm


will require action across multiple fronts, ranging from improving access to the full spectrum of high-quality treatment to addressing social determinants of health. We must use the current crisis as an opportunity to make major structural improvements and new, sustained investments.

While a holistic approach is needed, the recommendations we share today focus on policies and programs within the jurisdiction of the committee. Specifically, APA urges the committee to approve the following initiatives:

- Strengthen the psychological services workforce by establishing Medicare coverage of services provided by psychology trainees under the supervision of a licensed psychologist;
- Extend psychologists’ existing authority to see Medicare patients independently in office-based settings to also include facility-based settings, as is allowed under private-sector health plans, the Veterans Health Administration, and Tricare;
- Bring Medicare into compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), including by improving coverage of behavioral health services;
- Strengthen Medicare incentives for the delivery of integrated primary and behavioral healthcare services using evidence-based models;
- Improve Medicare patients’ access to behavioral health services in rural and underserved areas by making psychologists eligible for the same incentive payments currently provided only to physicians, and by securing the improvements in behavioral health services access achieved through telehealth;
- Remove barriers to the use of contingency management for treatment of stimulant use disorders;
- Eliminate unnecessary administrative burdens on behavioral health providers, such as those imposed by the new rules under the No Surprises Act.

Before expanding upon these recommendations, it should be noted that the pandemic is particularly affecting the mental health of two demographic groups: children and youth, and members of racial and ethnic minorities.

During the first three-quarters of 2021, children’s hospitals reported a 14% increase in mental health related emergencies and a 42% increase in cases of self-injury and suicide, compared to the same period in 2019. In recent months, children’s hospitals saw their highest number of children “boarding” in hospital emergency departments awaiting treatment. Surveys of households with young children found high levels of childhood hunger, emotional distress among parents, and frequent disruptions in child-care services. Nearly 10% of U.S. children

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lived with someone who was mentally ill or severely depressed, and since the start of the pandemic over 167,000 children have lost a parent or caregiver to the virus, further contributing to anxiety, depression, trauma, and stress-related conditions in children. Aggressive action is needed to address the long-term impacts of the pandemic on the mental health and well-being of children and adolescents.

The burdens of the pandemic have not been proportionately borne by different communities, and people of color remain at disproportionately higher risk of infection, hospitalization, and death from the virus. The pandemic has also exacerbated the impact of historic disparities in access to behavioral health care among communities of color, which has further harmed their mental well-being since the start of this crisis. Rates of suicide, which have traditionally been high predominantly among White and Native American children, have risen sharply among Black and African American youth. Black and Hispanic children lost a parent or a caregiver at more than two times the rate of White children, while American Indian, Alaska Native, Native Hawaiian and Pacific Islander children lost caregivers at nearly four times that rate. Additionally, young people within other marginalized populations, including those who identify as LGBTQ+ and children with developmental and physical disabilities, have been disproportionately impacted.

Medicare policies may not apply directly to many members of these populations. However, since Medicare covers almost one in five Americans, its policies and reimbursement rates set the standard for health insurance coverage in our nation. Given its considerable influence in our health care system, Medicare’s coverage policies for treatment of mental health and substance use disorders should set a strong example for other insurers.

**Strengthening the Behavioral Health Workforce**

A strong mental health workforce is critical to combating the long-term impact of the pandemic and remedying longstanding access gaps. Doctoral-level clinical psychologists play a critical role in providing behavioral health services to Medicare beneficiaries, and account for more than a third of all psychiatric diagnostic services, roughly 40% of all psychotherapy services, more than 90% of all health and behavior services, and three-quarters of all psychological and neuropsychological testing and assessment services received by beneficiaries. Even before COVID-19, the U.S. lacked an adequate supply of mental and behavioral health providers,
including psychologists, with shortages expected to worsen significantly by 2030.\textsuperscript{19, 20, 21} Rural communities in particular face major challenges in recruiting licensed mental and behavioral health care professionals.\textsuperscript{22}

Despite the substantially increased need for behavioral health services, there are multiple barriers to educating and training psychologists, including the cost of attending graduate school, which most students finance by taking on student debt. Doctoral psychologists graduate with an average student debt load of between $95,000 and $160,000 from their graduate degrees alone, and close to half of doctoral-level psychologists rely on loans to pay for graduate school, which takes on average 5-6 years to complete.\textsuperscript{23} Data shows that psychology graduate students struggle to afford health care, worry about the affordability of completing their training requirements, and experience difficulties focusing on their studies as a result of trying to make ends meet.\textsuperscript{24} At the same time, the imposition of higher interest rates and multiple loan origination fees, as well as the elimination of subsidized federal loans for graduate students, have further increased the cost of financing graduate education.\textsuperscript{25}

High levels of student loan debt impede workforce diversity in mental and behavioral health care fields, where demand for representative, culturally competent providers is high.\textsuperscript{26} Due to a variety of factors, including lack of generational wealth, many students—including first-generation students, those from communities of color, and those with a lower socioeconomic background—working toward doctoral psychology degrees disproportionately rely on student loans.\textsuperscript{27} The prospect of adding further debt often disincentivizes the pursuit of advanced degrees, and research shows that debt also impacts career choice by reducing the probability that qualified professionals will enter public service careers.\textsuperscript{28}

Establishing Medicare coverage of behavioral health services provided by clinical psychology interns and trainees under the supervision of a licensed psychologist would both reduce the cost of graduate training for psychologists by providing equitable reimbursement to thousands of highly trained doctoral trainees in treating the beneficiary population. Unlike physicians,


\textsuperscript{22} Rural Health Information Hub. (2021). Rural Mental Health: RHIhub. https://www.ruralhealthinfo.org/topics/mental-health


doctoral-level psychologists are not eligible for Medicare-funded residency programs through Graduate Medical Education (GME). In addition, although clinical psychology interns receive an average of 500-700 hours of direct patient experience while going through a training process similar to psychiatry residents, services provided by trainees under the supervision of a licensed psychologist are not reimbursable under Medicare. Several state Medicaid programs already identified this gap and opted to cover services provided by psychology trainees. Medicare coverage of trainee services would help close the substantial gap between our investment in training of our medical workforce and our behavioral health workforce.

**Extend psychologists’ authority to practice independently to all Medicare treatment settings**

Medicare recognized licensed clinical psychologists as independent practitioners in 1989, allowing patients to see clinical psychologists without prior authorization or orders from a physician in office-based settings. Unlike all other insurers, however, current law requires Medicare patients to get physician approval before receiving such care in other treatment settings including skilled nursing facilities, outpatient rehabilitation facilities, partial hospitalization programs, home health agency programs, and hospice programs. Psychologists working in these settings report frequent delays in providing services within their scope of licensure while waiting for physician approval; in many cases, physicians lack familiarity with the role behavioral health interventions should play in patient care, while in others, psychologists experience logistical difficulties in communicating with physicians.

This outdated and inconsistent prior approval requirement delays Medicare patients’ access to behavioral health services. All U.S. jurisdictions license clinical psychologists to practice independently, in all treatment settings, in providing the services established under their scope of practice. Private sector health plans, the Veterans Health Administration, and TRICARE all allow psychologists to practice independently in all treatment settings. Establishing independent practice authority for psychologists would not expand the scope of services they provide and would not change Medicare’s long-standing requirement that psychologists consult with beneficiaries’ other treating physicians as necessary for the health of the patient.

**Bring Medicare into compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and improve coverage of behavioral health services**

APA applauded the passage of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), a groundbreaking law with the promise of equal coverage and reimbursement for mental and behavioral health services. As demonstrated by the Department of Labor’s recent report to Congress, however, actual compliance with MHPAEA continues to fall far short of the Act’s goals. APA urges Congress to support more stringent parity enforcement measures, such as the authorization of a civil monetary penalty for parity violations contained in the Build Back Better legislation approved by the House of Representatives.

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Although MHPAEA’s provisions apply to most commercial plans, the law’s exemption of Medicare, traditional Medicaid, and TRICARE continues to hinder its effectiveness. Over 60 million older adults and individuals with disabilities who rely on Medicare have limited coverage for mental health and substance use disorder services. These individuals are no less deserving of fair and equal access to mental, behavioral, and substance use disorder services.

Congress should close discriminatory gaps in Medicare coverage of behavioral health services, including the 190-day lifetime limit on coverage for inpatient psychiatric hospital services; the lack of coverage for intensive outpatient and residential treatment services for individuals with behavioral health disorders; and the lack of coverage of the full range of services provided by substance use treatment centers for individuals, regardless of the substance involved. We also encourage the application of MHPAEA requirements to Medicare Advantage plans under Part C.

The COVID-19 pandemic continues to underscore the cost of continuing 20th century coverage policies, and of failing to provide the full range of treatments and services we know are needed to treat mental health and substance use disorders. Establishing such coverage will not be possible without updating the policies of our nation’s single largest health insurance program.

**Strengthen Medicare incentives for the delivery of integrated primary and behavioral healthcare services using evidence-based models**

As many as three-quarters of primary care visits involve mental or behavioral health components of patient well-being, including both mental health and substance use disorders or difficulties, and behavioral factors associated with physical conditions or chronic disease management.\(^{30}\) Investing in evidence-based integrated primary and behavioral health care across multiple models would help us meet the behavioral health crisis. More than a decade of research shows that programs implementing the primary care behavioral health (PCBH) model, the collaborative care model (CoCM), and blended models of integrated care can increase access to care and achieve the health care triple aim of improving patient outcomes, increasing satisfaction with care, and reducing overall treatment costs.

In the PCBH model of integrated care, primary care providers, behavioral health consultants (BHCs), and care managers work as a team to monitor and manage patient progress. PCBH is a population-based approach to integrated care, in which the goal is to improve both mental and physical health outcomes for the clinic’s patients—of every age and condition--by managing behavioral health problems and bio-psychosocially influenced health conditions.\(^{31}\) Generally, the behavioral health consultant strives to see patients on the same day the primary care provider (PCP) requests help—often through an immediate, face-to-face interaction—and works with the PCP to implement clinical pathways for treatment. Both patients and providers have reported high levels of satisfaction with PCBH model services.\(^{32} \) From the patient’s perspective,

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behavioral health services are seamlessly interwoven with medical care, mitigating the stigma often associated with seeking and receiving behavioral health services.

Unfortunately, implementation of evidence-based integrated care remains limited. CMS data show that although use of Medicare behavioral health integration services billing codes roughly doubled between 2018 and 2019, it appears that well under 1% of Medicare beneficiaries receive services provided by an integrated care team.\(^\text{34}\) Adoption of PCBH and other integrated care models is often challenging for primary care providers, as they face barriers related to physical office space, inadequate information technology systems, management procedures, clinical staffing and policies, health records and data tracking practices, and provider education and training.

Congress should provide stronger incentives and support for the adoption of evidence-based integrated primary care within Medicare, including improvements in reimbursement rates and coding options. Importantly, any such increases should be implemented under a waiver of the Medicare physician fee schedule budget neutrality requirements. Otherwise, increases in payments to primary care providers are likely to be achieved at the expense of reimbursements for behavioral health service providers. Congress should also provide significant new technical assistance and financial support to help primary care practices initiate integrated care programs. Such support should give providers the flexibility to choose the model of integrated care that works best for their community and patient population.

**Improve Medicare patients’ access to behavioral health specialist services in rural and underserved areas, including through telehealth and audio-only coverage extension**

As reported recently by the Government Accountability Office, more than one-third of Americans live in mental health provider shortage areas as designated by the Health Resources and Services Administration (HRSA).\(^\text{35}\) Research indicates that compared to their urban counterparts, Medicare beneficiaries living in rural areas are more likely to suffer from mood and/or anxiety disorders, are less likely to receive services, are half as likely to receive care from a behavioral health specialist, and travel roughly twice as far to receive care.\(^\text{36}\)

To help address this shortage of specialty providers, we urge Congress to extend Medicare incentive payments for services provided in mental health professional shortage areas to clinical psychologists. Under current law, psychiatrists are the only mental health specialist provider eligible for such bonus payments. Similar incentives for clinical psychologists should be established.

The decisions by Congress and CMS to expand access to tele-mental health services in Medicare represented a rare positive outcome of the COVID-19 pandemic, as it extended evidence-based

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mental health care to many individuals in areas and communities that traditionally lacked access to these services and made access to care easier and/or safer for many others. There is ample evidence demonstrating that mental and behavioral health services delivered via telehealth can be at least equally effective as services delivered in person. Audio-only telehealth is an especially important treatment modality for those residing in areas that lack accessible or affordable broadband Internet services, as well as individuals who lack the technological familiarity with video conferencing platforms. Telehealth will remain in use long after the pandemic ends; according to a recent survey of practicing psychologists, 93% of respondents said that they intend to continue offering telehealth as an option in their practice after the pandemic.

APA has endorsed several bills before Congress to cement the gains in access achieved under recent improvements in telehealth and audio-only services coverage, including the Telemental Health Care Access Act (H.R. 4058), which would remove certain Medicare coverage restrictions for behavioral health services delivered via telehealth, as well as eliminate a new requirement that unnecessarily requires patients to be periodically seen in person.

To incentivize providers to continue offering telehealth services, coverage of and reimbursement for telehealth services should be equivalent to their in-person counterparts. Reimbursing at a lower rate and requiring coverage on more stringent terms would drive providers to offer more in-person services, making it more difficult for the many patients who rely on services delivered via telehealth to access care.

Remove barriers to the use of contingency management for treating stimulant use disorders

To help address the rising number of drug overdose deaths, Congress should work with the Administration to make contingency management services widely accessible to individuals with substance use disorders. Many communities are experiencing increases in overdose deaths associated with the use of the stimulants methamphetamine and cocaine. Contingency management is an effective form of treatment for substance use disorders, and is the leading form of treatment stimulant use disorders.

Contingency management (CM) is a behavioral treatment that provides tangible incentives to patients in return for meeting clinical goals such as providing negative drug tests. Decades of research have demonstrated the effectiveness of CM, and programs incorporating CM achieve abstinence rates roughly double those that do not include CM. Despite its effectiveness, federal prohibitions against kickbacks to patients from healthcare providers are preventing widespread use of CM. Congress should work with the Administration to establish policies, procedures, and guidance for delivering CM services as part of substance use disorder treatment programs without violating federal civil monetary penalty and anti-kickback statute policies.

No Surprises Act

APA urges the Committee to investigate the disproportionate impact of the Interim Final Rules issued last year under the No Surprises Act on mental and behavioral health providers. APA and ten

of the top mental and behavioral health organizations sent a letter to U.S. Department of Health and Human Services Secretary Xavier Becerra on January 25, 2022. Collectively, we expressed concerns with the impact the IFRs will have on access to mental and behavioral services, particularly in communities that have long lacked access to these services. Our practitioners must be transparent about fees with their patients, as is required under professional ethics codes.

While we are concerned about the heavy administrative burdens imposed by these rules, we have broader concerns that when CMS develops the rules for Good Faith Estimates (GFEs) for insured patients, insurers will use the information contained in the required Good Faith Estimates (GFEs) as a mechanism or justification to limit treatment. We also urge that those rules do not carry over the flawed Part I dispute resolution provisions identified in the American Medical Association (AMA) and American Hospital Association (AHA) lawsuit. We, and other mental and behavioral organizations, welcome the opportunity to work with the Committee to ensure unnecessary administrative burdens do not take away from the ability of mental and behavioral health providers to provide their patients access to quality treatment.

APA is heartened by the focus on mental health in Congress, and eager to work with this Committee and its members to develop legislation and enact the initiatives cited above. We urge Congress to see the COVID-19 pandemic as an opportunity to address the longstanding shortcomings of our behavioral health treatment system.

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