



**AMERICAN
PSYCHOLOGICAL
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March 4, 2022

The Honorable Mariannette Miller-Meeks
1716 Longworth House Office Building
Washington, DC 20515

The Honorable Mike Kelly
1707 Longworth House Office Building
Washington, DC 20515

The Honorable H. Morgan Griffith
2202 Rayburn House Office Building
Washington, DC 20515

Dear Representative Miller-Meeks, Representative Kelly, and Representative Griffith,

The American Psychological Association (APA)¹ respectfully submits the following response to your [letter](#) on behalf of the Modernization Subcommittee of the Healthy Future Task Force requesting input from stakeholders on efforts to modernize the national healthcare system. Amidst the COVID-19 pandemic, data shows an unmistakable surge in emergency department (ED) visits attributable to mental health crises, suicide attempts, and overdoses during the COVID pandemic.² As the nation continues to cope with the pandemic's long-term mental health impact, we believe that greater attention expanding access to evidence-based mental health treatment while reducing unnecessary administrative burdens on providers should be necessary and inextricable components of the Subcommittee's efforts. Given that the pandemic's mental health impact will be with us for generations to come, we ask the Subcommittee to begin planning for a post-pandemic future by supporting the policies and legislation referenced in this letter.

Expanding Access to Telehealth and Digital Therapeutics

The decisions by Congress and CMS to expand access to tele-mental health services in Medicare represented a rare cause for optimism amidst COVID-19 pandemic, as it extended access to evidence-based mental health treatment to underserved geographic areas and communities 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.³ 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;

¹ APA is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 122,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

² Holland KM, Jones C, Vivolo-Kantor AM, et al. Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic. *JAMA Psychiatry*. 2021;78(4):372–379. doi:10.1001/jamapsychiatry.2020.4402

³ See, e.g., Turgoose, D., et al., (2018) *Journal of Telemedicine and Telecare*, Vol. 24, No. 9, <https://doi.org/10.1177/1357633X17730443>; Varker, T., et al., (2019), *Psychological Services*, Vol. 16, No. 4, <https://doi.org/10.1037/ser0000239>; Slone, N.C., et al., (2012) *Psychological Services*, Vol. 9, No. 3, <https://doi.org/10.1037/a0027607>.



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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.⁴

APA appreciates the Administration's recognition of the need for telehealth access, including audio-only services, beyond the COVID-19 public health emergency (PHE) in the recent physician fee schedule.⁵ APA also appreciates its recent investments in expanding access to telehealth services⁶ and broadband Internet⁷ in rural and underserved areas, all of which are necessary to sustain this unprecedented expansion of services. However, APA is concerned that certain unnecessary administrative barriers may hamper this expansion at the conclusion of the PHE. The six-month in-person visit requirement established under Section 123 of the Consolidated Appropriations Act of 2021 serves no clinical function in the assessment or treatment of mental health needs, and only serves to reduce service utilization. Accordingly, APA asks for members of the Caucus to support the bipartisan **Telemental Health Care Access Act (H.R. 4058)**, which repeals this provision.

Contrary to widespread belief, it is not less expensive for mental health providers to offer telehealth as a new modality of treatment. Providers choosing to offer telehealth to their patients must bear certain up-front costs—such as investment in staff training, purchase of new equipment, and subscription to HIPAA-compliant and interoperable software—in adopting telehealth, while also keeping their physical offices open and accessible to patients who prefer receiving treatment in person or who may be required by their insurance plan to receive periodic in-person visits. APA is concerned about reports of insurance plans reverting their telehealth coverage and reimbursement policies back to their pre-pandemic versions. 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 would drive providers to offer more in-person services, making it more difficult for the many patients who require services delivered via telehealth to access care. In addition to supporting maintenance of in-person reimbursement rates for mental health services in public programs such as Medicare, APA also asks members of the Caucus to support the bipartisan **Telehealth Coverage and Payment Parity Act (H.R. 4480)**, which requires private insurance plans to cover tele-mental health services on equal terms and reimburse at equal rates as their in-person counterparts.

Like telehealth, digital therapeutics platforms also serve as an innovative vehicle to expand the reach of mental health providers. Mental health digital therapeutics involve the use of software programs to deliver evidence-based and validated interventions to treat or manage mental and behavioral health disorders,

⁴ American Psychological Association (Oct. 19, 2021), Worsening Mental Health Crisis Pressures Psychologist Workforce: 2021 COVID-19 Practitioner Survey, <https://www.apa.org/pubs/reports/practitioner/covid-19-2021>.

⁵ CMS Newsroom (November 2, 2021), Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Rule, <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule>.

⁶ HHS Press Office (August 18, 2021), Biden-Harris Administration Invests over \$19 Million to Expand Telehealth Nationwide and Improve Health in Rural, Other Underserved Communities, <https://www.hhs.gov/about/news/2021/08/18/biden-harris-administration-invests-over-19-million-expand-telehealth-nationwide-improve-health-rural.html>.

⁷ USDA Press Office (Oct. 22, 2021), USDA to Make Up to \$1.15 Billion Available to Help People in Rural Communities Access High-Speed Internet, <https://www.usda.gov/media/press-releases/2021/10/22/usda-make-115-billion-available-help-people-living-rural>.



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such as chronic insomnia and substance use disorders. They can be used independently or in conjunction with medications or other therapies to improve patient care and health outcomes. However, digital therapeutics are not typically direct-to-consumer mental health apps obtained by the patient alone and require the approval of a qualified mental health professional. Rather than limiting access to these innovations only to those authorized by a physician's prescription, APA asks the Caucus to support access to and reimbursement for evidence-based digital therapeutics obtained on the order of all providers acting within the scope of their professional practice.

Supporting All Evidence-Based Forms of Integrated Care

Despite the recent expansion in tele-mental health services, many individuals have consistent access to a primary care provider but never obtain mental or behavioral health treatment when they experience symptoms of a mental health crisis. This is attributable to any one of many factors—lack of local providers, cost, social stigma, and burdensome barriers to coverage, to name a few. However, there are several innovative and evidence-based models of integrating primary and mental health care, such as the Primary Care Behavioral Health (PCBH) model, that have the potential to expand access to care, improve patient outcomes and satisfaction with care, and reduce overall treatment costs. While PCBH and other integrated care models promote these goals, there are challenges to the adoption of these models by health care practices. These include significant changes to providers' physical offices, information technology systems, management procedures, clinical staffing and policies, health records and data tracking practices, and provider education and training.⁸

Given these challenges, as well as differences in patient populations and the goals of the integration effort, there is no “one-size-fits-all” approach to effective integrated primary care; instead, approaches to integration should be responsive to the specific needs and environment of the community. We ask the Caucus to support practices with adoption of all evidence-based forms of integrated care, rather than focusing on a single model. Primary care clinics with the capacity to offer behavioral health services through one of these models should do so with the goals of expanding access to care and responsiveness to the needs of their patients, rather than being dogmatic about any one approach. A flexible approach to integrated behavioral health care will better serve all patients and address the health of the broader community.

Encouraging Interstate Cooperation

The recent expansion in telehealth occasioned by the pandemic also highlighted the need for interstate licensure cooperation. APA supports state adoption of the Psychology Interjurisdictional Compact, or PSYPACT. Developed in partnership with the Association of State and Provincial Psychology Boards and recognized by CMS since 2020, PSYPACT enables eligible doctoral-level psychologists from states that have adopted the Compact to practice in other states that have adopted it—either permanently for services provided via telehealth or for up to 30 days per year for services provided in-person. Psychologists must meet certain standards of practice, and both the psychologist's home state and the state where services are provided retain disciplinary oversight of the psychologist's services. Twenty-eight states including the

⁸ Zerden, L. D. S., Lombardi, B. M., Richman, E. L., Fraher, E. P., & Shoenbill, K. A. (2021). Harnessing the electronic health record to advance integrated care. *Families, Systems, & Health*, 39(1), 77.



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District of Columbia have already joined PSYPACT, with PSYPACT enabling legislation introduced in 10 state legislatures for their 2022 session.

For psychologists, PSYPACT averts the costs and administrative burden of obtaining licensure in multiple states and territories. For patients, PSYPACT has the dual benefit of expanding the mental health workforce in rural and underserved areas, as well as ensuring continuity of care for families who frequently move across state lines. The latter benefit is especially helpful for military families and college students, who are often called to move amongst different states but have the same need for reliable access to mental and behavioral health services regardless of where they are living. While Congress need not approve PSYPACT for it to be fully operational, federal grant funding would aid states and territories in its adoption and implementation.

Eliminating Unnecessary Administrative Burdens

Finally, APA urges members of the Caucus to examine the disproportionate impact of the Interim Final Rules (IFRs) issued last year under the No Surprises Act on independent mental and behavioral health practitioners. APA led a coalition of eleven mental and behavioral health provider associations in a letter⁹ to the leadership of the Department of Health and Human Services (HHS) requesting an exemption from certain requirements affecting routine mental and behavioral health services. Collectively, we expressed concerns that these IFRs will hinder access to mental and behavioral services in communities that have long lacked access to these services by diverting attention towards unnecessarily burdensome paperwork requirements and away from patient care.

While psychologists are already bound by ethical codes to be transparent about fees with their patients, these rules nonetheless impose a gratuitous regulatory burden of providing and updating detailed Good Faith Estimates (GFEs) of costs to patients, even when such disclosures have no relationship to a patient's out-of-pocket costs. We have broader concerns that when rules concerning the transmission of GFEs to insurers are developed, insurers will then use the information contained in the GFE as a mechanism or justification to limit treatment beyond its scope or duration. We echo the concerns articulated in the lawsuit filed by the American Medical Association and American Hospital Association concerning the inequitable design and implementation of the independent billing dispute resolution process outlined in the rules.

Thank you for your consideration of our proposals. APA stands ready to assist the Caucus in its efforts to guide the future of mental and behavioral health treatment. If you have any questions or require any further resources, please contact Andrew Strickland, J.D. at astrickland@apa.org.

Sincerely,

Katherine B. McGuire
Chief Advocacy Officer

⁹ Letter to HHS Secretary Xavier Becerra, et. al. (January 25, 2022), available at <https://www.apaservices.org/advocacy/no-surprises-act-letter.pdf>.