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November 1, 2021

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo,

The American Psychological Association (APA)¹ respectfully submits the following response to your [letter](#) requesting input from stakeholders on a future package of mental health legislation from the Committee. We appreciate the Committee's focus on mental and behavioral health, as the nation confronts the long-term mental health impact of this pandemic. Many families have lost loved ones, experienced loss of jobs and income, or otherwise experienced a traumatic event because of this pandemic. The data shows an unmistakable surge in emergency department (ED) visits attributable to mental health crises, suicide attempts, and overdoses during the COVID pandemic.² Given that the pandemic's mental health impact will likely be with us for generations to come, we ask the Committee to begin planning for a post-pandemic future and include in its legislation the recommendations described in this letter.

As you know, many underserved communities—including but not limited to rural communities, communities of color, children and adolescents, and people with disabilities—lacked access to treatment pre-pandemic and remain at heightened risk of contracting COVID-19 or experiencing severe illness, which multiplies the burden of the disease itself and its mental health ramifications on these already vulnerable populations. As a critical first step in remedying these ongoing inequities, APA recommends that members of the Committee support efforts to enhance research on health disparities, improve the pipeline of culturally competent providers, build outreach programs to reduce stigma, and develop a training curriculum for providers to effectively manage disparities.

Strengthening the Workforce

A robust mental health workforce capable of evaluating, disseminating, and delivering evidence-based interventions is a critical factor in combatting the long-term impact of the pandemic and remedying these longstanding access gaps. Nationwide, the U.S. faces a serious shortage of mental and behavioral health providers, including psychologists, which has been further exacerbated by the pandemic. According to

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



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results from SAMHSA’s 2020 National Survey on Drug Use and Health, over 30% percent of U.S. adults with any mental illness perceived unmet mental health needs during the previous year, and nearly half of those with serious mental illness report having unmet mental health needs.³

Considering these treatment gaps, which existed long before the pandemic, the insufficient supply of psychologists is projected to worsen by 2030.⁴ Despite the need for their services, however, multiple barriers remain to the training of psychologists who, unlike physicians, cannot rely on Medicare-funded residency programs, nor can they claim reimbursement for services provided under the supervision of a licensed psychologist. Instead, the future of the psychology workforce largely depends on whether psychologists obtain an adequate share of funding through programs like the Minority Fellowship Program (MFP), the Graduate Psychology Education (GPE) program, and the Behavioral Health Workforce Education and Training (BHWET) program.

With subpar reimbursement rates for psychologists’ services in public programs such as Medicare⁵ and Medicaid⁶, many providers accept a few patients enrolled in these programs as a form of public service but often cannot serve a large volume of patients covered by these programs because the rates are insufficient to maintain a sustainable clinical practice. This disproportionately affects communities and geographic areas relying on these programs as a consistent source of accessing mental health treatment. Other federal incentives—including but not limited to student loan repayment assistance and forgiveness programs—are essential to attract providers to these communities. Unfortunately, doctoral-level psychologists are exempted from incentive programs like the Health Professional Shortage Area bonus program due to their designation as “non-physicians” within the Medicare system.

Increased diversity within the scientific research enterprise is also necessary to increase the cultural competence of mental health professionals to expand their reach to underserved communities. Substantive representation by those in these communities is critical to clinical trials, research, and the workforce. In recent years, NIH responded with new initiatives focused on increasing diversity among its workforce. Accordingly, APA applauds ongoing federal efforts to achieve this goal, such as the UNITE initiative from the National Institutes of Health (NIH) and further recommends Congress receive an update from the NIH on the agency’s ongoing efforts to improve diversity in clinical trials.

³ Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health, <https://www.samhsa.gov/data/sites/default/files/reports/rpt35319/2020NSDUHFFR1PDFW102121.pdf>.

⁴ Health Resources and Services Administration, Behavioral Health Workforce Projections, 2016-2030: Clinical, Counseling, and School Psychologists, <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/psychologists-2018.pdf>.

⁵ Lopez, E., Neuman, T., et. al. (April 15, 2020). How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature, <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>.

⁶ Zuckerman, S., Skopec, L., et. al. (February 2021). Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare in 2019, Health Affairs, 40(2), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00611>.



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Increasing Integration, Coordination, and Access to Care

The Medicare program contains several coverage limitations and exclusions that uniquely apply to mental and behavioral health services. For example, Medicare imposes a 190-day lifetime limit on inpatient psychiatric hospital services, an arbitrary restriction in coverage that applies to no other form of treatment and abruptly cuts off necessary treatment for individuals with serious mental illness. Medicare also does not cover residential or intensive outpatient levels of care for mental health treatment, nor does it cover evidence-based, multidisciplinary team interventions such as Coordinated Specialty Care for early psychosis or Assertive Community Treatment (ACT) teams. Additionally, despite their training as doctoral-level mental health practitioners, psychologists remain subject to unnecessary supervision requirements by those deemed “physicians” within Medicare, adding to both delays in mental health treatment and administrative burdens for physicians.

There are many individuals who, despite having consistent access to a primary care provider, never obtain mental or behavioral health treatment when they experience systems of a mental health crisis. This is attributable 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.⁷

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 that the Senate Finance Committee adopt a flexible approach to assisting practices that use an array of evidence-based forms of integrated care with transition costs. 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 population.

Medicaid and CHIP programs remain the largest payer of mental and behavioral health services⁸, and yet many patients cannot access quality affordable care in their communities, instead seeking care in emergency rooms or facing interminable waitlists for services. Despite their status as “essential health benefits” that many private plans must cover under the Affordable Care Act, mental, behavioral, and substance use services are not mandatory benefits under state Medicaid programs. Accordingly, APA

⁷ 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.

⁸ Centers for Medicare and Medicaid Services (May 14, 2021), Press Release: CMS Data Shows Vulnerable Americans Forgoing Mental Health Care During COVID-19 Pandemic, <https://www.cms.gov/newsroom/press-releases/cms-data-shows-vulnerable-americans-forgoing-mental-health-care-during-covid-19-pandemic>.



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recommends including Senator Smith's **Medicaid Bump Act (S. 1727)**, which incentivizes state Medicaid programs to increase their coverage of mental and behavioral health services. Additionally, because telehealth is such a critical means of extending access to low-income families and people with disabilities in rural and underserved areas, APA also recommends inclusion of the bipartisan **Telehealth Improvement for Kids' Essential Services (TIKES) Act (S. 1798)** co-sponsored by Sen. Carper and Sen. Cornyn, which calls for guidance to states on increasing coverage of telehealth services through state Medicaid and CHIP programs.

Despite Congress' commendable efforts to curb the opioid epidemic through landmark legislation such as the SUPPORT Act (Pub. L. No. 115-271), the nation is experiencing a rising substance use and overdose crisis. Over 93,000 Americans died of a drug overdose in 2020, an increase of nearly 30% above 2019 deaths.⁹ While opioids, especially fentanyl, continue to account for the bulk of overdose deaths, many others are associated with the use of psychostimulants such as methamphetamine.¹⁰ We must respond aggressively to address this mounting crisis by expanding access to the full range of treatment options, including evidence-based non-pharmaceutical approaches to treatment. APA also urges the Committee to include in its bill the **Medicaid Reentry Act (S. 285)**, which allows inmates to enroll in Medicaid within 30 days of their release to curb the high rates of mental health crises and overdoses that often occur shortly after their release.

Finally, the effectiveness of a mental health system depends on access to a complete range of mental health and substance use disorder services, and a strong public health response requires providers to meet individuals wherever they are in the community. Without access to crisis services, patients often find themselves languishing in emergency rooms or seeking treatment in other inappropriate settings. We strongly support the inclusion of Chairman Wyden's **CAHOOTS Act (S. 764)** to incentivize state programs to cover services provided by round-the-clock mobile crisis teams. The increased funding for these services provided under this bill will, in addition to improving outcomes, increase the efficiency of states' mental health care systems and help enable national initiatives around mental health—such as the 988 National Suicide Prevention Lifeline—to reach their full potential.

Ensuring Parity

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. Over a decade later, however, psychologists and their patients continue to see inequitable barriers—such as lower reimbursements, more restrictive prior authorization protocols, more aggressive audits and inadequate provider networks—that health plans/insurers (Plans) impose on their services. APA applauded Congress' efforts to strengthen enforcement and oversight of insurers' compliance with the law in the 2020 year-end spending package and further supports any effort by the Committee to aid states with fulfilling their obligations under the new law. APA also supports the inclusion of language currently

⁹ Ahmad FB, Rossen LM, Sutton P. (2021). Provisional drug overdose death counts, National Center for Health Statistics, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

¹⁰ Han B, Cotto J, Etz K, Einstein EB, Compton WM, Volkow ND (2021). Methamphetamine Overdose Deaths in the US by Sex and Race and Ethnicity. *JAMA Psychiatry*, 78(5):564–567, doi:10.1001/jamapsychiatry.2020.4321.



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contained in Section 21005 of President Biden’s “Build Back Better Act” that authorizes the imposition of civil monetary penalties for a Plan’s failure to comply with federal parity requirements.

While the Northern District of California’s ruling in *Wit v. United Behavioral Health* offers some hope of accountability for parity compliance, the Committee need not wait for the litigation to resolve itself before acting. A good starting point would be federal legislation governing ERISA plans that resemble California’s recently enacted S.B. 855. This new law is designed to ensure *Wit* compliance by requiring Plans’ coverage determinations to be based on “nationally recognized standards of care”, instead of using guidelines that are only meant to cut costs. We believe that such legislation would promote a key tenet of the *Wit* decision: that health plans and insurance companies that administer those plans cannot always be relied upon to use medical necessity standards based on objective research and science. As found in the *Wit* case, and in the experience of APA’s membership, company profit may be prioritized over ensuring that patients receive the mental health care they need.

Although MHPAEA’s provisions apply to most commercial Plans, the exemption of Medicare, traditional Medicaid, and TRICARE continues to hinder the law’s 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, as do 20 million enrollees in traditional Medicaid and 10 million enrollees in TRICARE. These individuals are no less deserving of fair and equal access to mental, behavioral, and substance use disorder services than enrollees in MHPAEA-covered plans, and we urge the Committee to extend MHPAEA’s rights and benefits to Medicare, all Medicaid programs, and TRICARE.

Despite Congress’ continued attention to parity, critical enforcement issues remain. Primarily, there is a lack of clear federal enforcement authority for the tens of millions of individuals who rely on fully insured employer-sponsored Plans. In many states, particularly where state insurance commissioners lack the resources or expertise to address complex issues like network adequacy, there is no clear federal mandate to step in and make sure that critical parity provisions are enforced. Another key enforcement gap in MHPAEA is a provision permitting self-funded non-federal government employee plans to opt out of the law. Many enrollees in these plans are first responders and educators who are facing a particularly heavy mental health impact from the COVID-19 pandemic due to the nature of the services they provide to people in need. APA urges the Committee to close this loophole.

Expanding Telehealth

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 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.¹¹ Audio-only telehealth is an especially important treatment modality for those

¹¹ 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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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.¹²

While we appreciate the Administration's recent investments geared towards expanding access to telehealth services¹³ and broadband Internet¹⁴ in rural and underserved areas, we remain concerned that the current flexibilities in coverage will abruptly end with the current public health emergency, creating an unprecedented "access cliff" for those many patients and communities who have relied on telehealth to access mental health treatment during the pandemic, particularly those with limited or no access to in-person services. We urge the Committee to include provisions that permanently extend these coverage flexibilities for mental and behavioral health and substance use services delivered via telehealth, including coverage for audio-only services, and expand them beyond the diagnosis, management, and treatment of mental health disorders to include health behavior assessment and intervention services.

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. We are also concerned about the imposition of unnecessary administrative barriers to coverage of telehealth services, such as the six-month in-person visit requirement established under Section 123 of the Consolidated Appropriations Act of 2021. These requirements serve no clinical function in the assessment or treatment of mental health needs and only serve to reduce service utilization.

Ensuring adequate access to behavioral health services via telehealth requires a multilayered approach that permanently removes unnecessary barriers to coverage, incentivizes providers to offer services via telehealth, and expands tele-behavioral health access to more settings, including to the patient's own home. Accordingly, APA asks that the Committee include **all** the following provisions in its legislation:

¹² 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>.

¹³ 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>.

¹⁴ 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>.



- **The CONNECT for Health Act (S. 1512)**, which permanently removes certain restrictions on Medicare coverage of telehealth services, allowing patients to receive telehealth services from their own homes,
- **The Telemental Health Care Access Act (S. 2061)**, which removes a requirement that Medicare beneficiaries receiving services via telehealth have at least one in-person visit every six months,
- A Senate counterpart to the **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,
- A Senate counterpart to the **Telemental Health Care Access Act (H.R. 4058)**, which would remove certain Medicare coverage restrictions for behavioral health services delivered via telehealth, and
- A Senate counterpart to the **Permanency for Audio-Only Telehealth Act (H.R. 3447)**, which would continue to allow Medicare to cover mental and behavioral health services furnished via audio-only telehealth.

Another gap in coverage of telehealth relates to self-insured ERISA plans that are not subject to state telehealth mandates. These plans constitute at least half of the nation’s employer-sponsored health insurance coverage. Some of these plans voluntarily continue to cover services furnished via telehealth and recognize the value of telehealth to employee mental health and well-being, but others have already ended their pandemic-related flexibilities in telehealth coverage.

An additional problem is that enrollees often cannot tell whether their employer-sponsored coverage is a self-funded plan immune to state telehealth mandates because their insurance card only discloses the name of the insurance company administering the ERISA plan, without basic information about the type of plan they have, what telehealth requirements apply, and where to direct complaints about coverage. To address these problems, we urge the simple fix of a transparency mandate: all ERISA plans should be identified as such on the employee’s insurance card. In addition, the card should identify a website on which beneficiaries and providers can find current, accurate information about the plan’s telehealth policies.

Improving Access for Children and Young People

As APA’s CEO recently testified before a House subcommittee, “children and adolescents have been especially affected by the COVID-19 pandemic, experiencing higher rates of stress, anxiety, and fear.”¹⁵ There are many reasons for this phenomenon, many of which—including lack of services in the community and social stigma—existed long before the COVID-19 pandemic.¹⁶ We also know from

¹⁵ Putting Kids First: Addressing COVID-19’s Impacts on Children (Sept. 22, 2021). Hearing before the House Energy & Commerce Oversight & Investigations Subcommittee, Opening Statement of Arthur C. Evans, Jr., Ph.D., <https://energycommerce.house.gov/committee-activity/hearings/hearing-on-putting-kids-first-addressing-covid-19s-impacts-on-children>.

¹⁶ Agency for Healthcare Research and Quality. (2017). 2017 National Healthcare Quality and Disparities Report. Retrieved from: <https://www.ahrq.gov/research/findings/nhqdr/nhqdr17/index.html>; Irwin, C. E., Jr, Adams, S. H., Park, M. J., & Newacheck, P. W. (2009). Preventive care for adolescents: Few get visits and fewer get services. *Pediatrics*, 123(4), e565-72. doi:10.1542/peds.2008-2601.



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psychological science that the mental health of children is frequently tied to the health of their surroundings, including their communities, schools, and homes, such that if traumatic events are occurring in these settings, they almost always have a downstream impact on children's wellbeing.

The stakes of untreated mental and behavioral health symptoms are especially high for children and adolescents, as the consequences of failing to detect and address a child's early symptoms of a mental or behavioral health disorder can have a profound impact on the overall trajectory of their lives. This includes a greater likelihood of difficulties with learning, addiction to substances, lower employment prospects, and involvement with the criminal justice system later in life.¹⁷ Building a comprehensive system for early screening and intervention, as well as addressing the social determinants of health, requires a coordinated response from multiple governmental entities, agencies, and departments. APA recommends that the Committee, through its oversight capacity, encourage stronger collaboration and partnerships—including coordination of ongoing data collection efforts on the impact of COVID-19 on the behavioral health of children—between the Department of Education, the Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration.

In many communities, schools are an essential—and often the only—source of meeting the physical and mental health needs of students and families. As the third-largest stream of federal funding for school-based health care services, Medicaid remains a critical mechanism for meeting many of these needs among our most vulnerable students by broadening access to physical and mental health care available through school-based health centers. School districts can use Medicaid reimbursement to fund health professionals and specialized instructional support personnel (e.g., school psychologists),¹⁸ purchase and update specialized equipment and connect eligible students with providers outside of school settings.¹⁹ It covers a broad range of medically necessary services for children, including certain screening, diagnosis, and treatment services.²⁰ Medicaid can also be used to pay for services described in a Medicaid-enrolled student's individual education plan (IEP) under the Individuals with Disabilities in Education Act.

¹⁷ Sacks, V., & Murphey, D. (2018). The prevalence of adverse childhood experiences, nationally, by state, and by race/ethnicity. Bethesda, MD: Child Trends; National Collaborative on Education and Health. (2015). Brief on chronic absenteeism and school health. Chicago, IL: Healthy Schools Campaign.

¹⁸ Pudelski, S. (2017). Cutting Medicaid: A Prescription to Hurt the Neediest Kids. AASA, The School Superintendent's Association, https://www.aasa.org/uploadedFiles/Policy_and_Advocacy/Resources/CuttingMedicaid2018Addendum.pdf.

¹⁹ Centers for Medicare and Medicaid Services. (2003). "Medicaid school-based administrative claiming guide." Retrieved from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf>.

²⁰ MACPAC: Medicaid and CHIP Payment and Access Commission. (April 2018). Medicaid in Schools Issue Brief. Retrieved from: <https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf>.



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To meet the growing need for child and adolescent behavioral health services, including in schools, APA calls on the Committee to direct CMS to update its guidelines on Medicaid in schools to ensure that

Medicaid reimbursement can be utilized for school-based physical and behavioral health care. In addition, we oppose restrictions on Medicaid payments to schools for necessary services, as well as the implementation of per-capita caps or block grant funding for Medicaid programs. Finally, we urge the Committee to support a permanent extension of the Children's Health Insurance Program (CHIP) as a stable source of coverage for low-income children.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Katherine B. McGuire". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Katherine B. McGuire
Chief Advocacy Officer