April 18, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue S.W.
Washington, D.C., 20201

Dear Administrator Brooks-LaSure,

The American Psychological Association (APA)\(^1\) respectfully submits the following response to your Request for Information dated February 17, 2022 concerning access to coverage and care through Medicaid and CHIP programs. APA appreciates this opportunity to weigh in, as Medicaid represents the largest source of coverage for individuals in need of mental health, behavioral health, or substance use disorder services.\(^2\) During the COVID-19 pandemic, data shows an unmistakable surge in minor symptoms of mental distress\(^3\) as well as emergency department (ED) visits attributable to mental and behavioral health crises.\(^4\) As the nation continues to cope with the pandemic’s long-term mental health impact, we believe that greater attention to expanding access to evidence-based mental health treatment while reducing unnecessary administrative burdens on providers should be necessary and inextricable components of the Administration’s efforts.

Given that the pandemic’s mental health impact will be with us for generations to come, we ask the Administration to begin planning for a post-pandemic future by taking the following actions:

- Set the Medicare reimbursement rates for mental and behavioral health services as the “floor” for these services furnished through Medicaid and CHIP programs;
- Updating federal guidance on Medicaid coverage of services furnished in schools;
- Set rigorous network adequacy standards for mental health and substance use services in Medicaid, with sufficient attention and resources to conduct regular oversight and enforcement;
- Establish a set of uniform standards for mental health services covered by Medicaid programs;
- Issue guidance on how states can preserve or expand coverage of mental and behavioral health services furnished via telehealth and encourage equal coverage and reimbursement for these services;
- Encourage Medicaid programs’ adoption of all evidence-based forms of integrated care;

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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.


• Encourage coverage of all evidence-based digital therapeutics obtained on the order of all providers acting within the scope of their professional license;
• Engage with other federal agencies to set minimum data collection standards on social determinants of health;
• Support reimbursement of measurement-based care to allow for assessment and documentation of early signs of mental health distress in children and adolescents;
• Support APA’s HCPCS proposal requesting the creation of a new code to report assessment of social determinants of health in conjunction with mental health and health behavior services;
• Issue guidance to states on how to provide coverage of services furnished by advanced psychology trainees;
• Support federal funding to aid states and territories in the adoption and implementation of interstate licensure compacts such as PSYPACT; and
• Lessen unnecessary administrative burdens on providers by reconsidering the current approach to implementing the No Surprises Act.

Objective 1: Reaching Individuals and Communities Eligible for Coverage
Reimbursement rates for psychologists’ services in public programs such as Medicaid have long been insufficient for practitioners to maintain a sustainable clinical practice serving significant numbers of beneficiaries. This disproportionately affects communities and geographic areas relying on these programs as a consistent source of accessing mental health treatment because it lowers the ability of providers in underserved areas to participate in the program. To increase availability of these services, APA asks that CMS set the Medicare reimbursement rates for mental and behavioral health services as the minimum standard for these services furnished through state Medicaid programs.

Children and adolescents across the nation in particular have been affected by events over the past two years, as they have been grappling with the dual fallout of a global pandemic and a national reckoning on race. Parents report higher-than-normal levels of behavioral issues in their young children, and teens are experiencing elevated stress, anxiety, and symptoms of depression. Many school-age children continue to cope with social isolation, loneliness, and struggles with family financial insecurity. Others face

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unthinkable loss and severe trauma. The impact of the pandemic on children and youth from traditionally underserved populations, including communities of color, appears to be more severe. Even before the pandemic, these children were at a higher risk of depression and substance misuse, while also less likely to have access to behavioral health services.

In many communities, schools are an essential—and often the only—source of meeting the physical and mental health needs of students and families. Many school districts leverage Medicaid funds to stretch scarce resources and create school-based mental health programs. However, shortages of school-based behavioral health professionals continue to persist. While the recommended ratio of school psychologists is 1 for every 500 students, the national ratio before the pandemic was approximately 1 school psychologist for every 1,400 students. Given the increased demand for mental health services during the pandemic, we expect that ratio to worsen over time. Other school-based mental health professionals, such as school counselors and social workers, face similar shortages. Schools—especially those that are under-resourced and serve high numbers of low-income students and students of color—must receive more support to address these needs by increasing and retaining an adequate workforce of diverse, culturally competent school-based mental health professionals to provide accessible services.

As the third-largest stream of federal funding for school-based health care services, Medicaid is a critical mechanism for meeting many of these needs among our most vulnerable students. It broadens 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), purchase and update specialized equipment and connect eligible students with providers outside of school settings. It covers a broad range of medically necessary services for children, including certain screening, diagnosis, and treatment services. Medicaid can also be used to pay for services described in a Medicaid-enrolled student’s individual education plan (IEP) under the Individuals

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with Disabilities in Education Act. To help meet the growing need for behavioral health services for the nation’s youth, including in schools, APA recommends updating CMS’ guides on Medicaid in schools to ensure that Medicaid reimbursement can be utilized for school-based physical and behavioral health care.

**Objective 2: Ensuring Beneficiaries Experience Consistent Coverage**
Medicaid managed care plans are not immune to the phenomenon of shrinking provider networks experienced by patients covered by private plans. Many individuals proactively seeking treatment face exceedingly narrow provider networks or “phantom networks” that are often filled with providers who are no longer taking new patients or who have retired or relocated. Unfortunately, network adequacy standards in state Medicaid managed care plans are inconsistent across different states, creating confusion for providers and patients alike. APA applauds CMS’ efforts to establish uniform standards for behavioral health provider networks in 2016 and hopes that it will update and reissue these standards in short order.

APA adopts and incorporates the recommendations developed by mental health stakeholders calling on CMS to (1) set rigorous network adequacy standards for mental health and substance use care in regulated public and private health insurance programs that effectuate current law; (2) oversee network adequacy using data-driven approaches and enforce those standards; and (3) build federal and state capacity for oversight to ensure all children receive equitable access to mental health and substance use care. As CMS works to revise its prior standards, APA welcomes an opportunity to lend the experiences of its members to inform these efforts. Additionally, because many Medicaid programs fail to cover the full range of services provided by psychologists, often excluding critical services such as Health Behavior Assessment and Intervention services, APA recommends that CMS establish a set of uniform standards for the provision of mental health services through state Medicaid programs and welcomes an opportunity to work with CMS to inform these standards.

**Objective 3: Ensuring Beneficiaries’ Access to Timely, High-Quality, and Appropriate Care**
**Preserving Gains in Telehealth Coverage**
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, and throughout the pandemic, beneficiaries “used telehealth for a larger share of their behavioral health

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services compared to their use of telehealth for other services.” 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 physical hardware or technological familiarity to use 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. Telehealth has become a preferred modality of treatment by many patients, as evidenced by reduced rates of appointment “no-shows,” which increases the efficiency of service provision and removes a major obstacle to providing services within the Medicaid system.

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. APA also appreciates its recent investments in expanding access to telehealth services and broadband Internet in rural and underserved areas, all of which are necessary to sustain this unprecedented expansion of services. However, despite Congress’ recent actions to preserve the current telehealth coverage flexibilities in Medicare, APA is concerned that state Medicaid plans and their associated managed care entities may quickly seek to revert their telehealth coverage policies to their pre-pandemic versions shortly after the formal end of the PHE. Guidance from the Administration would be instrumental on how states can preserve or expand coverage of mental and behavioral health services furnished via telehealth.

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 that state Medicaid programs may provide inequitable coverage of telemental health services under this false assumption. To incentivize providers to continue offering telehealth services, CMS should encourage equal coverage of and reimbursement for tele-mental health services compared to their in-person counterparts. Enabling readily available telemental health services allows patients to receive treatment long before their condition

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escalates into a crisis, sparing states the additional costs of more intensive forms of mental health treatment.

**Integrating Primary Care and Behavioral Health Services**

The long-unmet need for mental and behavioral health services has not gone unnoticed by the medical community. Many are seeking to meet the whole health needs of their patients through integration of mental health services in their own clinical practices. Many evidence-based forms of integrated care, such as the Primary Care Behavioral Health (PCBH) model, expand access to care, seek to improve patient outcomes and satisfaction with care, and reduce overall treatment costs by incorporating a behavioral health clinician into a treatment team led by the primary care provider. However, there are challenges to the adoption of these models. These include a lack of reimbursement for codes that would allow psychologists to provide consultations to primary care teams and other mental health professionals. These include the codes for Interprofessional Telephone/Internet/Electronic Health Record Consultations (99446, 99447, 99448, 99449, 99451) to report interprofessional health record consultations through various forms of communication. Increasing psychologists' access and utilization of these codes for services that are not provided face-to-face would aid in sustainability for integrated behavioral health models and expand access to care. APA asks CMS to allow reimbursement for these codes to aid in the transition towards adoption of a fully functioning integrated care practice.

Given the 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 Administration to encourage state Medicaid programs’ 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.

**Ensuring Full Coverage of Digital Therapeutics**

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, 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 hopes the Administration will encourage state Medicaid programs’ coverage of evidence-based digital therapeutics obtained on the order of all providers acting within the scope of their professional license.

**Objective 4: Collecting Adequate Data to Measure, Monitor, and Support Improvement Efforts Related to Access to Services**
Treatment of a patient’s mental and behavioral health—particularly for children and adolescents—is in many ways reflective of their surrounding environment. While an understanding of the social determinants of health (SDOH) is essential to fully assess and treat patients in need of mental and behavioral health services, collection of SDOH data is not done on a consistent basis across federal programs. APA recommends that CMS engage with other federal agencies to set minimum data collection standards to ensure that such information is gathered and reported on a consistent basis. APA also asks CMS to support reimbursement of measurement-based care billed through codes such as 96127 that provide a vehicle for assessment and documentation of early signs of mental health distress in children and adolescents.

One of the first steps towards improving alignment among federal programs such as Medicaid to effectively address SDOH in a holistic way is measurement and documentation. Measuring SDOH has numerous barriers, including philosophical beliefs about the propriety of asking such questions, training gaps as to how or what to ask patients, and practical obstacles to identifying community-based interventions to address SDOH and ensuring patients receive services once they are identified. Establishing reimbursement mechanisms and creating other incentives will encourage more of the provider community to shift their focus to SDOH.

One method for implementing a standardized approach to measuring SDOH is collection of data via a health risk assessment or screening tool, documentation of it in the patient’s electronic health record, and mapping SDOH data onto existing ICD-10-CM Z-codes for documenting conditions in the environments where people are born, live, learn, work, play and age. Current Z-code categories capture issues related to education and literacy, employment status, housing and economic circumstances, social environment, primary support group including family circumstances, psychosocial circumstances, and occupational exposure to risk factors. This data could then be used to identify individuals’ social risk factors and unmet needs and trigger referrals to social services to address those needs. These steps, along with greater interoperability across electronic health data systems, would contribute greatly toward alignment of health services with community-based services to address the totality of patients’ health and social needs. To that end, APA asks for CMS’ support of its HCPCS proposal submitted in January of this year, requesting the creation of a new code to report assessment of social determinants of health in conjunction with mental and health behavior services, as well as other services.

Objective 5: Supporting the Workforce of Mental and Behavioral Health Providers

Doctoral-level clinical psychologists play a crucial role in providing behavioral health services to beneficiaries of public insurance programs; in the Medicare system alone, their practices 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 75% of all psychological and neuropsychological testing and assessment services. As part of a strategy to both attract and retain a sustainable psychology workforce, twenty-four state Medicaid programs provide some degree of reimbursement for services furnished by psychology interns and/or residents under the supervision of a licensed psychologist. APA asks that CMS issue guidance to states on how other states can do the same to help build a reliable pipeline of providers.

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 provide tele-mental health services or temporary, in-person services for up to 30 days a year in other states that have adopted it. 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 or access health care 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 need to continue receiving services from their current provider, with whom they have already established trust and rapport. While federal authorities need not approve PSYPACT for it to become effective, federal grant funding would aid states and territories in its adoption and implementation.

Finally, APA urges CMS to reconsider its approach to implementing the No Surprises Act. Although many provisions of the Act do not apply directly to Medicaid beneficiaries, these rules impose a heavy and disproportionate overall burden on independent mental and behavioral health practices serving an array of patients, including those who pay for services themselves and those covered by different public and private insurance plans. As we expressed to you in a letter24 alongside eleven other mental and behavioral health provider associations, 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 would not provide patients with significantly different information about their expected out-of-pocket costs. We continue to hear from our members’ clinical experiences demonstrating how these rules hinder access to mental and behavioral services in communities that have long lacked access to these services by diverting providers’ attention towards unnecessarily burdensome paperwork requirements and away from patient care.

Thank you for your consideration of our proposals. APA would welcome an opportunity to assist CMS in its efforts to expand access to mental and behavioral health services through Medicaid and CHIP programs. 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

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