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August 30, 2021

Senator Ronald Wyden
Chairman
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC, 20510

Dear Senator Wyden:

On behalf of the American Psychological Association (APA)¹, I would like to offer the following policy recommendations for your consideration in response to the Committee’s [letter](#) requesting input on a future package of bipartisan mental health legislation. As a legislative champion for mental and behavioral health, you know that this discussion comes at a timely moment in history amidst the ongoing spread of a virus that is both fueled by and worsening pre-existing socioeconomic inequalities. As you know, many communities—including but not limited to rural communities, communities of color, children and adolescents, and people with disabilities—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. Many families have lost loved ones, experienced loss of jobs and income, or otherwise experienced a traumatic event because of this pandemic. Given that the pandemic’s mental health impact will likely be with us for generations to come, we ask members of the Committee to advance—in tandem with their colleagues in other committees where necessary—the proposals referenced in this letter.

Health Equity

Despite some progress in the development and distribution of vaccines, challenges lay ahead in slowing the spread of the disease and preventing its mutation into more dangerous variants. Psychological science can inform strategies to combat the phenomenon of “vaccine hesitancy” which continues to persist in many communities. Furthermore, a population health approach is urgently needed to address the long-term mental health impact of the current pandemic and prepare the nation for future crises of this nature. We have a duty as a nation to unify and ensure that the most vulnerable among us get the help they need, and to build the social capital that will help us better endure the long-term effects of this crisis.

A population health approach offers a more proactive way to address the mental health of individuals and communities because it recognizes that our mental health exists on a continuum and emphasizes the importance of meeting people wherever they are on that continuum, rather than passively waiting for minor symptoms to escalate into a crisis to be treated under the current acute care system. The pandemic highlighted the need for this kind of early intervention approach, as there were not enough treatment

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.



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resources before the pandemic and the significant increase in need occasioned by this crisis quickly overwhelmed our mental health and substance use treatment systems.

As the nation digs in to combat the mental health impact of this pandemic, a sustained and community-focused public health emergency response is needed. APA continues to ask for increased federal leadership and investment in state, local, territorial, and tribal emergency response readiness supports that include guidance to state and local authorities on how to reach the most at-risk communities. We also encourage you to address research needs in the context of future pandemics, including effective and culturally competent risk communication and messaging. Such work could lead to more effective strategies for message framing that would be especially useful when pursued in collaboration with media sources and channels that are more heavily utilized by underserved communities.

The COVID-19 pandemic has been especially impactful on the mental health of children and adolescents. Social isolation, financial uncertainty and disrupted routines have placed considerable stress on children and their families, significantly impacting their mental health and well-being, as demonstrated by disproportionate increases in the rates of suicide attempts and other forms of self-harm amongst children and youth—particularly amongst those from communities of color.² People with disabilities represent another group facing unique stressors and challenges during the COVID-19 pandemic that have disproportionately exacerbated their mental health.³ Historically, individuals with disabilities have often found it difficult to access critical medical supplies as resources become scarce⁴, and policies around rationing medical care can intensify discriminatory attitudes towards people with disabilities during times of crisis, which in turn increases their anxiety about getting sick and requiring medical care.

As a critical first step in remedying these ongoing inequities, APA recommends that the Senate take up and pass the **Pursuing Equity in Mental Health Act (S. 1795)**. This bipartisan legislation aims to address disparities in mental health care among underserved and high-poverty communities through an array of strategies. These include authorizing grants and other funding to support research, improving the pipeline of culturally competent providers, building outreach programs to reduce stigma, and developing a training program for providers to effectively manage disparities.

Workforce

A robust mental health workforce—including clinicians, educators, and scientists alike—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

² Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. *MMWR Morb Mortal Wkly Rep* 2021; 70:888–894. DOI: <http://dx.doi.org/10.15585/mmwr.mm7024e1>[external icon](#); Science Friday (August 20, 2021), *Pandemic Unveils Growing Suicide Crisis For Communities Of Color*, <https://www.sciencefriday.com/segments/suicide-crisis-communities-of-color/>.

³ Czeisler M, Board A, Thierry JM, et al. Mental Health and Substance Use Among Adults with Disabilities During the COVID-19 Pandemic — United States, February–March 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:1142–1149. DOI: <http://dx.doi.org/10.15585/mmwr.mm7034a3>[external icon](#).

⁴ Mark Priestley PhD & Laura Hemingway MA (2007) Disability and Disaster Recovery, *Journal of Social Work in Disability & Rehabilitation*, 5:3-4, 23-42, DOI: [10.1300/J198v05n03_02](https://doi.org/10.1300/J198v05n03_02).



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U.S. faces a serious shortage of mental and behavioral health providers, including psychologists, which has been further exacerbated by the pandemic. According to results from SAMHSA's 2019 National Survey on Drug Use and Health, 26% percent of U.S. adults with any mental illness had unmet mental health needs during the previous year, and over 47% of those with serious mental illness report having unmet needs.⁵ Considering these existing unmet needs, the insufficient supply of psychologists is projected to significantly worsen by 2030.⁶ Despite the need for their services, however, multiple barriers remain to the training of psychologists who, unlike physicians, cannot rely on Medicare reimbursement for services provided by psychology trainees under the supervision of a licensed psychologist.

With subpar reimbursement rates for psychologists' services in public programs such as Medicare⁷ and Medicaid⁸, many providers accept only 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 impacts communities and geographic areas relying on these programs as a consistent source of accessing mental health treatment. Other federal incentives are essential to attract providers to these areas and communities. Accordingly, APA encourages you to include the bipartisan **Mental Health Professionals Workforce Shortage Loan Repayment Act (S. 1578)**, which authorizes a new student loan repayment program for mental and behavioral health care professionals who commit to working in an area lacking accessible care.

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. APA applauds ongoing federal efforts to achieve this goal, such as the UNITE initiative from the National Institutes of Health and further recommends that Congress direct the National Institutes of Health (NIH) to prepare a report on its efforts to improve diversity in clinical trials. Psychological science can be leveraged to identify biases in the review process as well as determine the effectiveness of interventions in the peer review process, such as blinding of applications and standardizing review processes.

As previously mentioned, the COVID-19 pandemic has been an especially heavy burden on school-age children. Many lost a key source of social interaction or access to mental health services, while others experienced some form of trauma from the loss of a loved one or other socioeconomic hardships within the family. Schools are critical settings for identifying students who may require mental health services

⁵ Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm>.

⁶ Health Resources and Services Administration, Behavioral Health Workforce Projections, 2016-2030: Clinical, Counseling, and School Psychologists, <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/psychologists-2018.pdf>.

⁷ Lopez, E., Neuman, T., et. al. (April 15, 2020). How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature. Retrieved July 19, 2021, from <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>.

⁸ Zuckerman, S., Skopec, L., et. al. (February 2021). Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019, Health Affairs, 40(2). Retrieved July 19, 2021, from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00611>.



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and providing them with necessary care and support. They can serve as environments for prevention, intervention, positive development, and regular communication with families. However, there are severe shortages of school-based mental and behavioral health professionals; in 2018, there were nearly 37,000 school psychologists who were each responsible for 1,200 students, nearly double the recommended caseload.⁹ For these reasons, APA recommends inclusion of the following legislation to increase access to school-based mental health services: the **Mental Health Services for Students Act (S. 1841)**, the **Increasing Access to Mental Health in Schools Act (S. 1811)**, and the **Comprehensive Mental Health in Schools Pilot Program Act (H.R. 3549)**. In addition, we encourage Congress to **fund an additional \$1 billion for school-based mental health providers**, as included in the House-passed FY 2022 Labor-HHS-Education Appropriations bill.

Integration, Coordination, and Access

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.¹⁰ 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 towards assisting with transition costs under an array of evidence-based forms of integrated care and reject efforts to fund one model of integrated care over all others.

Medicaid and CHIP programs remain the largest payer of mental and behavioral health services¹¹, and yet many patients cannot access quality affordable care in their communities, instead seeking care in emergency rooms or facing interminable waitlists for services. This discrepancy has an especially dire impact on people with disabilities and children who may rely on these programs to remain in their communities of choice or to receive a quality education. Accordingly, APA recommends including Senator Smith's **Medicaid Bump Act (S. 1727)**, which incentivizes state Medicaid programs to increase

⁹ National Association of School Psychologists (April 15, 2021). Student to school psychologist ratio 2019–2020 [infographic]. <https://www.nasponline.org/research-and-policy/policy-priorities/critical-policyissues/shortage-of-school-psychologists>.

¹⁰ 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.

¹¹ 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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their spending on 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.

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.

Parity

APA applauded the passage of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), a breakthrough law with the promise of equal coverage and reimbursement for mental and behavioral health services. Over a decade later, however, psychologists continue to see inequitable barriers—such as lower reimbursement and narrower provider networks—that health 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 urges the passage of Sen. Cassidy and Sen. Murphy's **Parity Implementation Assistance Act (S. 1962)** to aid states with fulfilling their obligations under the new law.

Despite Congress' commendable enactment of MHPAEA and continued attention to parity issues, multiple oversight and enforcement issues remain. Primarily, there is a major gap in MHPAEA enforcement – the near-total absence of a significant federal presence enforcing federal parity law for the tens of millions of individuals who rely on employer-sponsored insurance coverage. For most employer-sponsored health insurance plans, state insurance commissioners have primary enforcement authority and HHS has secondary enforcement authority. However, HHS interprets its secondary enforcement authority to mean that it only enforces the law in a handful of states. As a result, HHS engages in no parity enforcement efforts in the overwhelming majority of states, which are then left to enforce critical but very complex issues like network adequacy, often without the resources or expertise to address them.

One remedy for this enormous gap in enforcement would be to include language granting the Department of Labor (DOL) secondary enforcement authority over parity violations by employer-sponsored insurance plans whenever the relevant state agency cannot or will not act on a credible parity complaint or concern. DOL has demonstrated its expertise and ability with parity enforcement regarding self-insured plans, as it resolves many more parity complaints than HHS. An alternate solution could be language clarifying that HHS must step in and act in certain circumstances. Additionally, federal law permits states to exempt their



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own employee health insurance plans from parity requirements. 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 services they provide to people in need. APA urges you to close this loophole as part of the Senate Finance Committee’s legislation.

Telehealth

The decisions by Congress and CMS to expand access to these services via telehealth 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. 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.¹² Audio-only telehealth is an especially important treatment modality for individuals residing in areas that lack accessible or affordable broadband Internet services, or who lack the technological familiarity with video conferencing platforms.

While we appreciate the Administration’s recent investments¹³ geared towards expanding access to telehealth services 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. We urge the Senate Finance Committee to include provisions that permanently extend and expand these coverage flexibilities for mental and behavioral health and substance use services delivered via telehealth, including coverage for audio-only services, and eliminate unnecessary barriers to treatment. 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 many patients who require services delivered via telehealth to access care.

Accordingly, APA asks that you include the following provisions in the Senate Finance Committee’s legislation:

- **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;

¹² 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>.

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>.



- **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;
- **The Telemental Health Care Access Act (H.R. 4058)**, which would remove certain Medicare coverage restrictions for behavioral health services delivered via telehealth; and
- **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. However, enrollees often cannot tell whether their employer-sponsored coverage is a self-funded plan that is 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.

Substance Use

Finally, 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 resurgent substance use and overdose crisis amidst the COVID-19 pandemic. Over 93,000 Americans died of a drug overdose in 2020, an increase of nearly 30% above 2019 deaths.¹⁴ 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.¹⁵ CDC data also shows that overdose deaths attributable to the use of methamphetamine and other psychostimulants have been occurring in the American Indian/Alaska Native population at more than twice the rate of any other communities of color.¹⁶

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. Accordingly, we ask the Committee to include the following legislation in its bill:

- **The Drug Free Communities Pandemic Relief Act (S. 26)**, which incentivizes and supports communities in establishing their own programs to reduce substance use among youths;

¹⁴ 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>.

¹⁵ 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.

¹⁶ Volkow, N. National Institute on Drug Abuse, 2021. “U.S. Overdose Deaths Involving Psychostimulants (Mostly Amphetamine), by Race” [Powerpoint presentation], <https://www.apa.org/members/content/methamphetamine-addiction>.



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- **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 relapses and overdoses occurring shortly after their release;
- **The Mainstreaming Addiction Treatment Act (S. 445)**, which removes a requirement that prescribing providers obtain a waiver from the Drug Enforcement Agency (DEA) before prescribing buprenorphine for the treatment of substance use;
- **The Methamphetamine Response Act (S. 854)**, which directs the Office of National Drug Control Policy to establish an Emerging Threat Response Plan in response to rising rates of methamphetamine use; and
- **The STOP Fentanyl Act of 2021 (S. 1457)**, which among other provisions calls for the development and implementation of contingency management (CM) programs. CM is an innovative form of behavioral treatment providing reinforcement for targeted behaviors like abstinence from substance use, which is supported by decades of research¹⁷ but is limited in utilization often due to federal restrictions on the use of financial incentives related to treatment.¹⁸

Thank you for your consideration of our proposals. APA stands ready to assist your office in its efforts to ensure the broadest possible access to mental and behavioral health services. Please contact Andrew Strickland, J.D. at astrickland@apa.org or Scott Barstow at sbarstow@apa.org as resources in your efforts.

Sincerely,

Katherine B. McGuire
Chief Advocacy Officer

¹⁷ Roll, J. M., Higgins, S. T., & Badger, G. J. (1996). An experimental comparison of three different schedules of reinforcement of drug abstinence using cigarette smoking as an exemplar. *Journal of Applied Behavior Analysis*, 29(4), 495-505.

¹⁸ Office of the Inspector General. (December 12, 2011). Federal Anti-kickback Statute. U.S. Department of Health and Human Services, <https://oig.hhs.gov/newsroom/oig-podcasts/federal-anti-kickback-statute/>