AMERICAN PSYCHIATRIC ASSOCIATION

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Trump-Vance Administration
Department of Health and Human Services Transition Team
Washington, DC

Dear President Trump,

The American Psychiatric Association (APA), the national medical specialty society representing nearly 39,000 psychiatric physicians who treat mental health and substance use disorders, congratulates you on becoming the 47th President of the United States. We appreciated your leadership during your first administration in declaring the opioid crisis a public health emergency in 2017, as well as enacting the telehealth flexibilities during the COVID pandemic. As a result of these actions, the overall number of opioid deaths decreased, and many Americans received mental health and substance use treatment during the pandemic.

However, an unprecedented number of Americans continue to struggle with mental health and substance use disorders today. In the next four years, we strongly urge you to prioritize strengthening the ability to respond to an increasing demand for psychiatric services. Untreated mental illness and substance use have a resounding impact on society resulting in poor housing, unemployment, poverty, and trauma. Early intervention and treatment of mental illness and substance use disorder can lead to cost savings for individuals, health insurers, employers, and society. Suicide continues to be a leading cause of death and affects people of all ages, with rates increasing by approximately 36% between 2000–2022. Our health care system must be responsive to psychiatric needs by ensuring a continuum of levels of care and the reduction of stigma for people with mental illness or substance use disorders. People must feel as comfortable seeking and discussing their psychiatric needs as they do for diabetes, cardiovascular disease, and cancer.

APA looks forward to working again in partnership with your administration to improve the mental health system in America and to get our citizens the care they need to live healthy, productive lives; we offer the following policy solutions:

**Access to Inpatient Psychiatric Beds**

A lack of access to inpatient beds and community-based services, and failure to implement evidence-based models of care signify widespread systemic failure and cost our nation billions of dollars each year – costs that are faced by governments,

businesses, communities, and families. Lack of access to quality care and appropriate services is reflected in emergency department overcrowding and waiting lists for acute care. Policies that eliminate disparities in coverage between mental health and physical health, improve funding of psychiatric services and reduce regulatory burdens, would have a positive impact on access to care.

The Institutions for Mental Diseases (IMD) exclusion is a long-standing policy that prohibits the federal government from providing federal Medicaid funds to states for services rendered to certain Medicaid-eligible individuals who are patients in IMDs. This is the only part of federal Medicaid law that prohibits payment for the cost of providing medically necessary care because of the type of illness being treated. This discriminatory exclusion has resulted in unequal coverage of mental health care. People with mental health conditions — just like people with any medical condition — need a range of care options from outpatient services to inpatient care. Updating the IMD exclusion to allow for short-term stays in psychiatric hospitals would help strengthen the mental health system and provides those who rely on Medicaid with more treatment options. Allowing states to receive a federal exemption from the IMD Exclusion for state hospitals and all nonprofit treatment facilities with more than 16 beds that serve patients with mental health disorders (including substance use disorders), would improve access for the most vulnerable patients.

APA recommends:

- that states should be allowed to receive a federal exemption from the IMD exclusion for state hospitals and all nonprofit treatment facilities with more than 16 beds, without the express limitation of 15 days in a month of the payment; and
- increased funding for long-term inpatient beds for the severely persistently mentally ill and a continuum of community-based services.

**Medicare Physician Reimbursement and Administrative Burdens**

Many APA members report they want to continue to participate in Medicare and other networks, but are unable to due to decreasing reimbursement, increasing costs, and uncompensated time lost to overly burdensome administrative requirements (e.g., prior authorization). Psychiatrists can no longer absorb even the most minor cuts, and hard decisions are being made to keep practices open. Medicare beneficiaries' access to care is under threat because of continued structural challenges that have led to yearly cuts to payments. This includes both the arbitrary across-the-board cut to the Medicare physician fee schedule conversion factor to comply with budget neutrality requirements, which is scheduled to be a 2.8 percent cut in 2025, along with payment rates not being updated for inflation. Medicare payment rates have fallen 29 percent over the last two decades when accounting for the costs of running a practice, and 2025 would be the fifth straight year that the final MPFS rule includes an across-the-board cut to payment rates for physicians and other clinicians while the cost of providing care continues to increase. On a recent listening session, APA members suggested policymakers could facilitate increased participation in Medicare by allowing clinicians the flexibility to accept Medicare assignment on a case-by-case basis, rather than having to opt-out of Medicare entirely.

The prior authorization process currently serves as a barrier to care, impeding access to appropriate services and potentially increasing the cost of care. It should not be used routinely but rather selectively when needed to ensure quality care. The American Journal of Managed Care found that the share of Medicare Advantage enrollees in a plan requiring prior authorization for at least one category of healthcare services was 72.6 percent in 2019, which was similar to the rate it had been in 2009. By 2023, the Kaiser Family Foundation reported that nearly all enrollees (99 percent) in Medicare Advantage are required to obtain prior authorization for some services – most commonly, higher cost services, such as inpatient hospital stays, skilled nursing facility stays, and chemotherapy. According to the Kaiser study, "of the 46.2 million prior authorization determinations in 2022, more than 90 percent (42.7 million) were fully favorable, meaning the requested item or service was approved in full. The remaining 3.4 million (7.4 percent) were denied in full or in part. In comparison, between 2019 and 2021, less than 6 percent of prior authorization requests were denied." In 2022, only 9 percent of denied prior authorizations were appealed. It appears that prior authorizations are being used to impede access to necessary care given the high rates of successful authorizations. Costs and administrative burdens to psychiatrists and plans would be cut by eliminating or restricting the use of prior authorization requests to manage care. Currently an increasing number of our members are reporting that they are leaving Medicare Advantage networks because of the increasing numbers of prior authorizations, however reducing the use of prior authorization would encourage our members to remain in the network.

APA recommends:

- allowance for Medicare participation on a case-by base basis; and
- a reduction of the use of prior authorization and prior authorization reform, particularly in Medicare Advantage.

**Increased Investment in the Psychiatric Workforce**

Unfortunately, with nearly 150 million people living in Mental Health Professional Shortage Areas as defined by the Health Resources and Services Administration, more needs to be done to ensure access to quality mental health services. Unless the number of residency training positions expands at the nation's teaching hospitals, the U.S. will face a declining number of physicians per capita just as the baby boomers swell the Medicare rolls. For example, the proportion of the population over age 65 will increase from 12.4 percent of the U.S. population in 2000 to 20 percent by the year 2030. During the same period, the number of older adults with mental illness is expected to double to 15 million. This demographic shift will widen the current shortfall of not only health care providers with geriatric expertise, but specifically health care providers with expertise in geriatric mental health.

In addition, approximately one-fifth of the U.S. population resides in a rural area, and about one-fifth of those living in rural areas, or about 6.5 million individuals, have a mental health disorder. Though the prevalence of most psychiatric disorders is similar between U.S. adults living in rural and urban areas, those residing in rural geographic locations receive mental health treatment less frequently when compared to those residing in metropolitan locations due to a lack of access. One of the primary indicators of where a physician will ultimately practice is the location of their residency. Unfortunately, rural

hospitals are frequently at a disadvantage as they often cannot afford to take on new residents, regardless of need. We can address the significant psychiatric workforce shortage by allocating additional GME funding for underserved medical specialties as well as lifting the current cap on Medicare reimbursement payments to rural hospitals to cover the cost of taking on additional residents.

Critical shortages and uneven distribution of psychiatrists in rural and low-income urban communities have significantly limited accessibility and quality of care across the nation. In addition, highly skilled health professionals from other countries, many in roles that otherwise could not be filled, represent a significant portion of providers who care for American patients within our borders, meeting an important need in our nation's health care system. Current entry and renewal pathways for foreign nationals, including student, temporary visitor, extraordinary ability, and employment visas, provide a balanced approach that attracts the best and brightest from around the world and advances U.S. interests through educational and cultural exchange. Impeding these pathways jeopardizes critical access to health care for our nation's most vulnerable populations, including those in rural and urban underserved communities across the country.

The shortage and maldistribution of psychiatrists limits a patient's access to cost effective, preventive care, and it will become even more acute in the coming years if no action is taken. APA urges you to address the significant psychiatric workforce challenges we have in our country by:

- expanding Medicare-supported graduate medical education slots for psychiatry and psychiatry subspecialties, to increase access to high-quality care and strengthen our long-term health care infrastructure;
- promoting a mental health workforce that supports improvements in health care, access to providers, and equitable health for all patients regardless of their living in a rural or urban area; and
- ensuring continued entry and renewal pathways for physicians holding J-1 or H-B1 visas.

**Maintain and Enforce Mental Health Parity Coverage**

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires health plans to provide people with mental health and substance use disorders with insurance coverage that is comparable to coverage for medical and surgical claims. Mental health and substance use coverage cannot be more expensive or have more limits than other health care coverage, and insurance plans cannot engage in conduct that limits the scope or duration of mental health treatment. Yet, mental health parity remains a challenge. Insurers continue to violate parity requirements, especially in the areas of prior authorizations, medical necessity denials, and failing to provide a network of providers sufficient to meet the needs of the mental health and substance use disorder population.

Last year, the Department of Labor released additional rule-making that finally closed the loopholes in MHPAEA that insurance companies routinely use to deny care for mental health conditions and substance use disorders. The rule clarifies and strengthens requirements related to the analysis of non-quantitative

treatment limits, an area where parity violations continue to persist. The rule will also ensure parity protections for people who have health coverage from state and local governments. However, more needs to be done to ensure plans are abiding by the intent of the law. There must be robust enforcement of all existing and new provisions regulating MHPAEA, including the use of monetary penalties.

APA recommends:

- CMS improves its oversight of States' compliance with Medicaid managed care mental health and substance use disorder parity requirements;
- mental health parity protections be expanded to Medicare and TriCare benefits;
- third party administrators be held accountable for parity compliance; and
- the Department of Labor be funded to continue parity enforcement efforts.

**Permanent Removal of Telehealth Restrictions**

We again thank you for enacting the telehealth flexibilities under your previous Administration during the COVID pandemic. This action was critical as it provided access to care for many who may have not been able to during a time when depression and anxiety were on the rise. Since the end of the public health emergency, the telehealth flexibilities have been temporarily extended, however, now physicians and patients are worried about what will happen if the flexibilities are permanently lifted. At its peak in 2020, telehealth represented 40 percent of mental health and substance use outpatient visits then leveled out at 36 percent in 2022. Survey data from our physicians show they and their patients are generally satisfied or happy with options for virtual delivery systems, and that appointment no-show rates are reduced.

From before to after their state declared a public health emergency, the percentage of psychiatrists who reported that all their patients kept their appointments increased from 9 percent to 32 percent. In conjunction, about 85 percent of respondents said that patients who were seen for the first time via telehealth were either somewhat satisfied or satisfied with their care. This is consistent with nearly a decade of research on telepsychiatry that correlates patient satisfaction with using telehealth for treatment. Without assurance of permanency, many solo providers and small practices, including those who serve rural and underserved communities, will stop investment into the compliant technology tools and infrastructure to offer telehealth services.

To continue the use of virtual care, we recommend:

- finalizing the Drug Enforcement Agency (DEA) regulations for the Ryan Haight Act to balance common-sense safeguards for DEA enforcement of legitimate prescription of controlled substances without creating unnecessary administrative burdens to access treatment; permanently removing the frequency limitations for existing telehealth services in inpatient settings and nursing facilities; making permanent the allowance for teaching physicians to provide direct supervision of medical residents remotely through telehealth; and permanently removing the 6-month in-person exam requirement for telemental health services.

**Address the Stimulant Medication Shortages**

The nation has been grappling with a stimulant medication shortage since October 2022. Patients and their prescribers have been struggling to access first-line treatment for attention-deficit/hyperactivity disorder (ADHD), which affects more than 22 million children and adults in the United States. Many child and adolescent psychiatrists, general psychiatrists, and other physicians have been forced to switch their patients' medications, transitioning them to other medications that do not work as well to curb symptoms of ADHD and commonly occurring comorbid mental disorders. This leaves few options for families who are affected by this crisis. For psychiatrists, this leads to significant time spent tracking down appropriate stimulant medications and completing prior authorizations linked to switching a patient's medication is taking time away for actual patient care. The disruption to the daily lives of affected children, adolescents, and their families, cannot be overstated. Untreated ADHD can lead to other mental and behavioral disorders, including mood and substance use disorders, unintended injuries resulting from ADHD-related impulsivity, and long-term impacts on relationship-building, educational achievement, and professional success. Parents and families are also negatively impacted by the disruption untreated ADHD can cause in the home, school, and work environments.

The few agency actions taken to fix the issue have been prevented from amounting to a lasting solution due to multi-factorial regulatory and corporate systems. APA asks your Administration to organize a private-public sector approach incorporating systems that improve coordination and transparency between the agencies in order to have a firm understanding of supply and demand, to set regulatory measures to meet those needs and further, to work with manufacturers to gain more insights into practices, not only fix the current shortage but prevent future shortages of stimulants.

**Widespread Adoption of the Collaborative Care Model**

During this challenging time for all Americans, we are seeing increased rates of anxiety, depression, substance use, and trauma. We must meet the increasing demand for early identification and treatment of mental health and substance use disorders. If we do not address these illnesses early, they can lead to long-term chronic issues, greater use of emergency care, and the need for higher levels of care.

The Collaborative Care Model (CoCM) offers a proven evidenced-based model for providing mental health and substance use disorder services to patients within the primary care setting. This model, already implemented in many large health systems and individual practices, can detect and prevent suicide and overdoses in the primary care setting. CoCM is the only integrated care model covered by Medicare, as well as most commercial and many Medicaid payers. With more than 100 randomized control trials, it is the only model with strong evidence of cost-savings driven by the ability to detect illness and begin treatment sooner. The potential cost-savings from widespread implementation are considerable. The 2013 Center for Health Care Strategies study found savings in Medicare and Medicaid settings of up to 6 to 1 in total medical costs and an estimated $15 billion in Medicaid savings even if only 20 percent of beneficiaries with depression receive such care.

APA recommends:

- grants to primary care practices for implementation of the model; and
- increases to the CoCM billing codes to ensure sustainability.

Thank you for your consideration. If we do not invest in mental health and substance use disorder treatment, our systems will continue to get overwhelmed, costs will continue to rise, and many Americans will lack access to vital services. We look forward to working with you to improve coverage and access to effective psychiatric services for patients across the country.

If you have any questions, please contact me at mwills@psych.org and Kristin Kroeger, Chief of Advocacy, Policy, and Practice Advancement at kkroeger@psych.org.

Sincerely,


Marketa M. Wills, MD, MBA, FAPA
CEO & Medical Director