AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

March 6, 2022

The Honorable Morgan Griffith
2202 Rayburn House Office Building
House of Representatives
Washington, DC 20515

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

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

Dear Representatives Griffith, Kelly and Miller-Meeks:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing over 37,400 psychiatric physicians who treat mental health and substance use disorders, I write to respond to the Healthy Futures Taskforce Modernization Subcommittee's Request for Information (RFI). The APA applauds the steps you and your colleagues in Congress have taken over the past few years to invest in and expand mental health services and substance use disorder (MH/SUD) care, including the provision of additional resources during the COVID-19 Public Health Emergency. We appreciate your timely focus on identifying additional legislative steps Congress should take to improve access to effective, evidence-based MH/SUD care and services. Your focus on this area is a necessary and logical next step toward a sustained effort to address the MH/SUD crises that have been exacerbated by the pandemic. Our answers focus specifically on questions pertaining to MH/SUD care in the Employers, Payers, Providers, States, and Stakeholders section of the RFI.

Which flexibilities created under the COVID-19 public health emergency should be made permanent?

Numerous telehealth flexibilities enabled by Health and Human Services' COVID-19 Public Health Emergency (PHE) declaration and facilitated by Congressional action have increased access to psychiatric care, allowing for timely access to vital MH / SUD services that may likewise alleviate downstream costs from hospitalization or emergency room services. Lifting geographic and site of service restrictions and allowing for the use of audio-only services where appropriate have proven to be especially impactful. These flexibilities have enabled large numbers of patients to receive care during the pandemic, and they should continue to be available to increase access to care for medically underserved populations and to promote health equity.

The option to treat a patient at home via telepsychiatry, rather than being required to present at a Medicare Qualified Originating Site, has increased access for those who may not be able to travel to an Originating Site due to limitations imposed by their physical health, mental health diagnosis, or lack of proximity to services on-site. The availability of audio-only services has also increased access for patients who lack access to video-capable technology such as a smart phone or tablet, lack access to high-speed broadband internet, or are unwilling or unable to use videoconferencing software due to cognitive limitations.

The telehealth flexibilities allowed during the pandemic have been a lifeline for many patients needing MH/SUD services. Telehealth has also provided clinicians with additional means to expand patient access and treatment to MH/SUD services and to reach patients from diverse communities. We know that the need for MH/SUD services will continue after the pandemic ends, and APA encourages the Healthy Futures Taskforce to support efforts that would retain these flexibilities in order to expand access to MH/SUD in addition to in-person evaluations and treatment.

How does telehealth affect healthcare costs in the short-term, medium-term and long-term? Would you be willing to share aggregate cost data?

While the near term and intermediate costs associated with current telehealth flexibilities are difficult to quantify during the unique circumstances of the current public health emergency, for the treatment of MH/SUD, clinically appropriate use could produce significant cost savings in the long-term. We know, telehealth has increased access and continuity of care for many patients. Early intervention and prevention of more severe illnesses is key to saving costs in the long run. Psychiatrists who responded to a survey of APA members in June 2020 indicated that, at that time, they had transitioned to exclusive use of telehealth for over 90% of their patients. The data further showed that patient no- show rates dropped significantly as telehealth became the primary way for patients to keep appointments with their psychiatrists. Allowing patients to be seen virtually via telehealth likely contributes to this trend, as 94% of respondents in a second APA survey indicated that patients were receiving telehealth in their home or another location of the patient's preference. Patient satisfaction with telepsychiatry likewise appeared high, with 90% of psychiatrist respondents reporting that patients who were seen for the first time via telehealth reported being somewhat or very satisfied with the care they received.

Fewer patient no-shows and increased satisfaction mean that patients are better able to follow their recommended course of treatment, including psychotherapy and medication compliance. Regardless of whether the behavioral health appointment is in person or via telehealth, in general, when patients keep their first appointment, they are more likely to keep subsequent appointments and when patients are satisfied with treatment, they are more likely to continue with their treatment plan. Research also suggests that this results in better medication compliance, fewer visits to the emergency department, fewer patient admissions to inpatient units, fewer subsequent readmissions, and subsequently, reduced costs to our health care system. Even further, efficacy to MH/SUD treatment plans result in better management of

MH/SUD conditions. More effective management of MH/SUD conditions reduces the prevalence of crisis situations and saves overall costs to the economy in terms of poor productivity and absenteeism as a result of untreated or poorly managed MH/SUD conditions. APA continues to monitor potential cost savings produced by the proliferation of telehealth services but early indications are that broader utilization has the capacity to produce significant savings in the long-term.

Employers and plans are often faced with provider shortages in certain geographic areas. Increased use of telemedicine may help alleviate these shortages, but barriers still exist that keep providers from practicing across state lines. Should Congress allow for healthcare providers who hold a valid license in good standing in at least one state to practice via telemedicine in all or other states? Why or why not?

The APA supports access improvement strategies that alleviate very real workforce shortages across the mental health provider continuum including increasing recruitment, training and retention of psychiatrists and other mental health practitioners. Expanding access to telehealth would help to leverage the skills of our existing workforce but the adoption of interstate licensure may have a limited impact unless existing structural impediments are first addressed. Rather than seeking to codify disparate state licensure requirements, APA encourages the Taskforce to first address disparate insurance coverage, narrow and phantom networks, and a lack of mental health parity, all of which function to limit patient access to the existing behavioral health workforce. Likewise, the Taskforce should consider permanently eliminating the Medicare provision under the 2020 Consolidated Appropriations Act (CAA) that requires an in-person visit with a provider within six months of the first telehealth appointment. This barrier will inhibit access even if a national telehealth licensure agreement was reached and is inconsistent with how the law already treats SUD's and co-occurring SUD and mental health disorders.

Keeping in mind the Taskforce objective of maximizing our existing workforce, APA would encourage support for further implementation of the Collaborative Care Model (CoCM). CoCM is a population-based model that has shown to greatly increase the number of patients being treated for mental health and substance use disorders when compared to traditional 1:1 treatment. The model integrates behavioral health care within the primary care setting and features a primary care physician, a psychiatric consultant, and care manager working together in a coordinated fashion. Importantly, the care team members use measurement-based care to ensure that patients are progressing and treatment is adjusted when they are not. The model has over 90 research studies demonstrating its efficacy and is covered by Medicare, most private insurers, and many state Medicaid programs. Additionally, the CoCM has tremendous cost savings potential. For example, cost/benefit analysis demonstrates that this model has a 12:1 benefit to cost ratio for the treatment of depression in adults. Despite its strong evidence base and availability of reimbursement, uptake of the CoCM by primary care physicians and practices remains low due to the up-front costs associated with implementing the model. APA thus encourages the Taskforce to consider policies that would help to offset start-up costs associated with CoCM as well as establish technical assistance centers to provide support to practices implementing the model.

Thanks you for your leadership in compiling these thoughtful, thorough RFI questions and appreciates the opportunity to submit these comments for consideration as the GOP Healthy Futures Task Force develops a legislative package. The APA is eager to aid your efforts to improve mental health across our nation. If you have any questions, please contact Daniel "Trip" Stanford at dstanford@psych.org or (315) 706-4582.

Sincerely,

Saul Levin, MD, MPA, FRCP-E, FRCPsych
CEO and Medical Director