AMERICAN PSYCHOLOGICAL ASSOCIATION

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June 8, 2016

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Upton and Ranking Member Pallone:

On behalf of the American Psychological Association ("APA") and the American Psychological Association Practice Organization ("APAPO"), I am writing to express our appreciation of your work on the ***Helping Families in Mental Health Crisis Act of 2016*** ("H.R. 2646") and our support of the planned June 15 markup of the bill by the full Energy and Commerce Committee. In addition, as requested in the June 3 email from Committee staff, I am pleased to provide our recommendations for certain revisions to the current draft of H.R. 2646 designed to strengthen the bill and increase the clarity of the text.

The APA is the largest scientific and professional organization representing psychology in the United States. APA's membership includes more than 117,500 researchers, educators, clinicians, consultants and students. Through its divisions in 54 subfields of psychology and affiliations with 60 state, territorial, and Canadian provincial associations, APA works to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives. The APAPO is a companion organization to the APA, and is dedicated to advancing the practice of psychology and promoting the interests of psychologists who practice in diverse settings.

H.R. 2646 provides for comprehensive, major reforms and improvements of our nation's fragmented mental health system. These reforms are long overdue, and this important legislation will bring much needed help and assistance to individuals with serious mental illness ("SMI"), children suffering from mental health problems, and their families, as well as the mental and behavioral health professionals who provide their care.

We support many of the provisions contained in the June 3 draft of H.R. 2646, including those that provide for the creation of a National Mental Health Policy Laboratory (sec. 107), eliminate the Medicaid "same day" billing restriction (sec. 201), generate opportunities to improve the care of individuals with SMI in the Medicaid program by designing innovative service delivery systems (sec. 204), establish a new Interdepartmental Serious Mental Illness Coordinating Committee (sec. 301), provide for grants to establish and maintain assertive community treatment programs (sec. 501), improve community-based crisis response systems and inpatient bed registries (sec. 502), and provide for a study and report on the status of the mental health and substance use disorder workforce (sec. 710).

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We applaud the reauthorization of the National Child Traumatic Stress Initiative (sec. 623) and the Garrett Lee Smith Memorial Act (sec. 707), as well as the explicit authorization of the National Suicide Prevention Lifeline program (sec. 706).

We also greatly appreciate the inclusion of programs that support an adequate, effective, and efficient mental health workforce, and we encourage the Committee to consider authorization levels that reflect the growing demands on this workforce. These programs include the Minority Fellowship Program (sec. 711), which funds provider training and development across mental health disciplines to meet the treatment needs of our increasingly ethnically and racially diverse population.

We believe, however, that the bill would be even stronger and more effective if the following changes were made:

1. Reauthorization of Mental and Behavioral Health Education Training Grants. To fully meet the needs of individuals and families impacted by SMI, the current shortage of highly trained mental health providers, especially for children and older adults, must be addressed. We recommend including in H.R. 2646 the workforce provisions found in section 407 of the Mental Health Reform Act of 2016 (S. 2680), which reauthorizes the Mental and Behavioral Health Education Training Grants Program, including programs that support health service psychology education and training initiatives. Section 407 would amend the Public Health Service Act (42 U.S.C. 294e-1) to provide support for training of behavioral health service providers to work in integrated primary care settings. These critical programs, including the Graduate Psychology Education Program, prepare doctoral psychology students and other health professions students to work in integrated primary care settings in rural and urban communities and expand access to mental health services for underserved populations, including those with SMI. Given the demand for mental health providers trained to deliver evidence-based interventions to these underserved communities, we encourage the Committee to authorize these programs at levels commensurate with our growing national needs and not below the current authorization levels.

2. HIPAA. We applaud the goal of providing guidance and clarity regarding disclosures of the protected health information ("PHI") of individuals with SMI. We have concerns with sections 404(a)(5)(C) and (D) of the bill, however, which direct the HHS Secretary to issue regulations clarifying the situations under which certain such disclosures may be made. We recommend that these sections be revised as follows:

(a) The word "capacity" is used in both sections 404(a)(5)(B) and 5(C), but with reference to two different abilities, which makes it difficult to determine the distinct scenario that each of the two subparagraphs is intended to address. Section 404(a)(5)(B) refers to the "capacity to agree or object." Section 404(a)(5)(C) then refers to the "capacity … to make rational health care decisions." Section 404(a)(5)(C) also contains the term "incapacitated," which increases the confusion. The multiple uses of these identical or similar terms creates a lack of clarity within

and between sections 404(a)(5)(B) and 5(C). To address the problem, we suggest revising section 404(a)(5)(C) as follows:

- page 39, line 19: replace “capacity” with “ability”.

(b) We recommend that section 404(a)(5)(D) be stricken. When a patient does not consent to disclosure of PHI, allowing a provider or covered entity to disclose that information based simply on a belief that failure to do so “will lead to a worsening prognosis or an acute or chronic medical condition of the patient” would be inconsistent with current HIPAA statute and regulations. If adopted and issued as regulation, this approach would permit disclosure of PHI based solely on an assessment of the possible future state of a patient, whether mental or physical, not on the patient’s current situation and circumstances. The phrase “worsening prognosis or an acute or chronic medical condition” is overly broad.

If, however, section 404(a)(5)(D) is to be retained, we suggest striking the existing language (page 39, line 23, through page 40, line 2) and replacing it with the following text:

> “(D) the patient does not consent, but such communication and sharing of information is necessary to prevent impending and serious deterioration of the patient’s mental or physical health.”

This language would make the important clarification that subparagraph 5(D) is referring to situations in which the patient does not consent to a disclosure of PHI. In doing so, the alternate wording would also better align the subparagraph with the language of sections 404(a)(5)(A), (B), and (C). The alternate text would also avoid the overly broad language in current subparagraph 5(D) regarding a “worsening prognosis or an acute or chronic medical condition” and would replace it with a more focused standard -- the impending, serious deterioration of the patient’s mental or physical condition. The suggested language would also make it clear that the circumstances to be clarified by the HHS Secretary, for purposes of subparagraph 5(D), are those in which a provider or covered entity believes that the sharing of information is necessary in order to prevent such a deterioration.

(c) We recommend that section 405(b) of the November 2015 draft of H.R. 2646, entitled “Development and Dissemination of Model Training Programs,” be included in the current draft. That section would direct the HHS Secretary to develop and disseminate a model training program for health care providers, patients and their families, and other stakeholders regarding the circumstances under which the PHI of patients with a mental illness may be disclosed with and without patient consent. This type of training is directly on point with the goals of H.R. 2646 to clarify and provide guidance on the requirements of HIPAA in the context of serious mental illness, and we believe the current draft of H.R. 2646 would be strengthened by providing for through the inclusion of prior section 405(b).

3. Section 621 - Telehealth child psychiatry access grants. We believe the telehealth child psychiatry access grants established in section 621 of the bill should be broadened to include all clinical mental health professionals, given the widespread shortage of providers for this population. To accomplish this, we suggest the following changes:

- page 63:
  - line 4: replace “PSYCHIATRY” with “MENTAL HEALTH”
  - lines 18, 20, and 23: replace “psychiatry” with “mental health”
- page 64:
  - line 9: insert “and licensed mental health professionals” after “psychiatrists”.
- page 65:
  - line 6: insert “and psychology” after “psychiatry”.
  - line 14: insert “and mental health” after “psychiatric”.
  - line 22: strike “a”.
  - line 23: replace “professional” with “professionals” and “psychologists” with “psychologists”
  - line 24: replace “worker” with “workers” and “counselor” with “counselors”.

4. Section 704 - Peer Review. This section states that no fewer than half the members of a peer group reviewing a grant related to mental illness treatment must have a doctoral degree in psychology, an advanced degree in nursing or social work, or a medical degree, and must be “licensed and experienced professionals” in mental or substance use disorders. Many academic, scientific psychologists -- who are leaders in research on how to prevent and treat mental health and substance use disorders -- are not licensed practitioners. A requirement that no fewer than half the members of a peer review panel must be “licensed” restricts the opportunities for those non-practicing scientific experts to participate and to offer their knowledge and expertise as part of the grant review process. We suggest modifying the language of section 704, as follows, in order to remove this restriction:

- page 86, line 14: insert “, and/or scientific experts,” after “professionals”.

5. Include the provisions of the Integrating Behavioral Health

Through Technology Act of 2016 (S. 2691). The inability of mental health care providers to communicate with medical/surgical providers through interoperable electronic health record systems is a serious obstacle to the integration of mental health care into primary care. The Integrating Behavioral Health Through Technology Act authorizes a five state pilot program offering health information technology incentives for psychologists, Community Mental Health Centers, psychiatric hospitals, clinical social workers, and outpatient/inpatient addiction providers. These entities were excluded from full eligibility for health information technology incentive funds in the HITECH Act. Clinical care coordination for patients with health conditions is hampered without electronic health record systems that permit behavioral health providers to communicate and share clinical data with primary care physicians, medical specialty personnel, and hospitals. The Integrating Behavioral Health Through Technology Act recognizes the importance of enabling behavioral health providers to access the network of electronic health records to promote the integration of behavioral health in primary care settings, help reduce adverse drug interactions and duplicative tests, and provide necessary information to emergency departments to triage patients more effectively. Furthermore, without health information technology, mental health and substance use treatment providers will have serious

difficulties integrating with Medicare Accountable Care Organizations, Medicaid Health Homes, and other emerging value-based payment models.

6. Include the provisions of The Behavioral Health Coverage Transparency Act of 2015 (H.R. 4276). We support the inclusion in H.R. 2646 of the Behavioral Health Coverage Transparency Act, which will strengthen parity enforcement in several respects, including requiring issuers to disclose the analysis they perform in making parity determinations; requiring federal regulators to conduct random audits; and requiring the federal parity agencies to review denial rates for mental health versus medical claims. Additionally, the legislation would create a central online portal allowing consumers to access all information as a "one-stop shop," and to submit complaints and violations. These provisions will help ensure health care coverage is in compliance with parity, that applicable law is implemented effectively, and that treatment ultimately becomes available to people in need.

We appreciate your consideration of these recommendations. Thank you again for your work on this important and much-needed legislation, and we look forward to the full Committee markup of H.R. 2646 on June 15. If you have any questions or need further information, please call or email Doug Walter, J.D., Associate Executive Director, APAPO Government Relations, at (202) 336-5889 or dwalter@apa.org.

Sincerely,

Cynthia D. Belar, PhD, ABPP
Interim Chief Executive Officer