AMERICAN ACADEMY OF FAMILY PHYSICIANS

November 15, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Chair Wyden and Ranking Member Crapo:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 133,500 family physicians and medical students across the country, I am writing to share the family physician's perspective in response to the recent request for information on improving access to mental health care.

Mental health concerns are highly prevalent in the United States and are associated with an increased risk of morbidity and mortality. The COVID-19 pandemic has exacerbated existing issues with anxiety, depression, and post-traumatic stress disorder amid a growing shortage of mental health and behavioral health providers. Family physicians are critically important to addressing the mental health crisis because nearly 40% of all visits for depression, anxiety, or cases defined as "any mental illness" were with primary care physicians.[i] Primary care physicians are also more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with co-morbidities.[ii]

The AAFP supports integration of behavioral health services within a patient's medical home. This can include consistent coordination of referrals and exchange of information, colocation of services in the primary care setting, or full integration of treatment plans shared between primary care and behavioral health clinicians. Behavioral integration has shown significant cost-savings for payers and physicians, as well as more equitable access to mental health services for traditionally underserved populations.[iii, iv] Despite interest from family physicians, implementing behavioral health integration in primary care practices faces several barriers including a limited workforce, payment and reporting requirements, and burdensome start-up costs.

Strengthening Workforce

There are significant gaps in the provision of mental health care services in the U.S., especially related to vulnerable populations. Psychiatric and other mental health professionals are necessary for high-quality mental health care services, but primary care physicians are the main providers for most patients. Primary care physicians serve as the first point of contact for patients navigating the healthcare system, and most people with poor mental health will be diagnosed and treated in the primary care setting. Mental illness also complicates other medical conditions, making them more challenging and more expensive to manage. Together, this makes mental health an important issue

1133 CONNECTICUT AVE., N.W., STE. 1100 | WASHINGTON, DC 20036-4305 | (800) 794-7481 | (202) 232-9033

for primary care physicians. Preserving scope of practice requirements would benefit primary care physicians by allowing them to practice at the top of their license. However, when primary care physicians need to refer patients to other mental health providers, approximately two-thirds reported they were unable to find the appropriate outpatient mental health services for their patient.[v] This is largely attributed to a shortage of mental health providers and lack of insurance coverage. Strengthening the mental health workforce is critically important to achieve greater uptake of behavioral health integration into primary care practices.

Similarly, to equitably increase access to behavioral health services through primary care settings, availability of primary care physicians must also be prioritized. The AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. It is projected that the U.S. will face a shortage of up to 48,000 primary care physicians by 2034.[vi]

The lack of a diverse physician workforce also has significant implications for public health. Studies show that racial, ethnic and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[vii] [viii] While primary care specialties fares better than other specialties in representation of racial and ethnic minorities in the workforce, the entire physician workforce lags significantly behind the racial and ethnic diversity of the U.S. population. Today, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11 percent of physicians.[ix] [x]

Correcting the shortage and maldistribution of physicians, to ultimately improve equitable access to high-quality care, requires immediate action to expand the federal Graduate Medical Education (GME) program in a way that meets the needs of our nation.

Telehealth serves as an interim solution to workforce shortages but is restricted by arbitrary regulations. The AAFP has consistently advocated to waive the in-person requirement for mental health services provided via audio/visual technology to Medicare beneficiaries. We urge Congress to reject arbitrary restrictions that would require an in-person visit prior to a telehealth visit. Not only is there no clinical evidence to support these requirements, but they also exacerbate clinician shortages and worsen health inequities by restricting access for those individuals with barriers preventing them from traveling to in-person care.[xi]

Increasing Integration, Coordination, and Access to Care

Payment Barriers

The AAFP has applauded the inclusion of collaborative care management codes for family physicians and appreciates this necessary step to ensuring primary care physicians have payment options available when patients present with mental health concerns. Additionally, the AAFP recently endorsed the COCM Act to expand the Collaborative Care model (CoCM). However, the AAFP remains concerned about payment mechanisms that limit expansion of behavioral health integration models. Uptake of collaborative care management codes by family medicine physicians has remained low due to the complexity of the billing and coding requirements, a shortage of behavioral health practitioners, and the need for improved training for staff and physicians alike.

Additionally, these codes rely on a fee-for-service (FFS) structure. Although the ability to bill these codes aids a practice in building capacity for integration, behavioral health integration is best supported through alternative payment mechanisms (APMs) and value-based payment. Many alternative payment models (APMs) for primary care have generally not included collaborative care management codes in their calculations for care management fees or other prospective payments, which has limited use of the codes. To correct this, APMs need to be designed to provide sufficient resources to primary care practices for the integration of behavioral health. The flexibility provided by value-based payment, either through prospective payments or a capitated system, is best suited to allow physicians to develop innovative ways to meet their patients' behavioral health needs. APMs designed to support integration should also be risk-adjusted, promote quality care, and be paid within a patient's medical home to avoid care fragmentation, such as from third-party direct to consumer telehealth providers. Not only is this payment infrastructure beneficial to practices intent on delivering holistic, person-centered care, it is essential to ensuring access to high quality, continuous primary care and behavioral health care for patients. When primary care practices are supported by a predictable, prospective revenue stream for the full range of care needs presented by their patients, primary care practices thrive, and patients have better outcomes.

Finally, it is imperative that private health insurance coverage offer adequate and equitable coverage of mental and behavioral health services. The AAFP has long supported mental health parity. Because of the ACA, health plans are required to cover certain preventative services, and since 2019 IRS guidance expanding that definition, HSA-eligible high deductible health plans (HDHPs) now have the flexibility to cover certain chronic care management services and medications. Specifically, the HDHPs can cover medication for depression, but the screening and additional office visits are not considered by the IRS as preventative services, meaning they are still subject to the deductible. Cost barriers like those associated with screenings and counseling discourages patients, especially those of lower socioeconomic status, from seeking necessary care. This is problematic for many primary care services as well, which is why the AAFP has endorsed the *Primary and Virtual Care Affordability Act (H.R. 5541)* to waive cost sharing for necessary primary care services, including initial screenings for depression.

Interoperability Barriers

Integrating behavioral health in primary care practices, either through telehealth or colocation, requires significant workflow and technological updates. Appropriate medical information must be readily available to share between primary care physicians and mental health providers when approved by the patient when transitioning between clinicians. This requires functional and (Health Insurance Portability and Accountability (HIPAA)- compliant electronic medical record platforms in colocation models and additional technology updates if administered primarily through audio/visual platforms. Despite the tremendous cost savings potential of CoCM, many practices, especially small and solo physician practices, do not have the resources or technology to immediately integrate behavioral health. Upfront funding for these adjustments, like those provided by the COCM Act, are critical to ensuring physicians have the processes in place to successfully integrate behavioral health care services.

Barriers for Underserved Populations

Rural areas often suffer from a shortage of health care professionals, making access to and coordination with sub-specialists difficult, particularly for behavioral and mental health services. Additionally, there are limited opportunities for physicians and care teams to train in rural health settings, which coupled with a lack of incentives to draw primary care physicians and clinicians to rural areas, further exacerbate limited access and coordination opportunities for patients.

Once a primary care physician is practicing in a rural area, they face additional barriers to optimizing their care delivery. Many rural practices do not have access to reliable broadband services that enable effective use of telehealth, which limits their ability to provide important care coordination services. The Medicare physician fee schedule (MPFS) also typically pays less for services provided in rural payment localities, meaning Medicare funds care coordination less in those areas than it does in urban and suburban localities. Accordingly, the AAFP supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal, such as encouraging physicians to practice in underserved areas.

Additionally, many APMs have been focused on the Medicare population, with limited attention provided to Medicaid and safety net providers. The AAFP acknowledges underserved populations should be more intentionally engaged in value-based care and calls for increased collaboration between the Centers for Medicare & Medicaid Innovation (CMMI), Medicare, Medicaid, as well as private payers. Embedding equity as a shared aim regardless of the patient population and across all models will resource providers more efficiently to ensure all patients receive high quality, affordable, patient-centered care.

Additional opportunities to increase equitable access exist, including expansion of geographic testing of models and incentivizing patient participation. Current primary care models have been geographically limited in scope and repeatedly tested in the same regions. Since primary care is uniquely qualified to care for patients of all ages in diverse settings nationwide, efforts should be made to expand where models are tested to increase equitable access and avoid further exacerbation of disparities. Additionally, models should be designed with incentives that remove patient barriers to access, such as waiving co-pays or co-insurance for primary care. Waived co-pays should be covered by the payer rather than being waived by the practice to avoid financially penalizing practices.

Finally, telehealth expansion during the Public Health Emergency has expanded care for everyone, including minority populations and geographically underserved communities. Continuing to allow access to these services and compensation for these services will ensure more and better access to behavioral health. Additional recommendations are detailed in the “Telehealth” section below.

Crisis Intervention Models

The AAFP supports reforms to policing practices that mitigate disparities caused by biased and discriminatory policing, reduce health disparities caused by traumatic stress and over-policing in communities of color, and reduce the risk of exposure to direct and indirect police-related violence to members of the public – with particular attention to the impact on BIPOC and other marginalized populations. Successful interventions should encompass system-wide, anti-racist strategies at the community and policy levels. Additional research and funding are needed to identify and evaluate scalable, evidence-based reforms to current policing practices. This includes routing calls from the police department to a community response department (staffed by medical, social work, and mental and behavioral health professionals) for situations involving medical, mental health, disability-related, or other behavioral or social needs, using sobering centers as an alternative to incarceration for individuals publicly intoxicated, and using mental health courts and other community diversion alternatives to incarceration, including critical connections to vocational and housing assistance services.

Connecting Patients to Resources

The AAFP's policy on social determinants of health outlines how family physicians are uniquely qualified to identify social needs and connect patients with third-party services and public programs in their community to address those needs. To best address health equity and social determinants of health, we first need a robust and healthy public health infrastructure. While physicians and other clinicians, inclusive of all specialties, can potentially assist in identifying and facilitating addressing social needs, they cannot and should not be held responsible for resolving them. Existing FFS structures typically do not pay for or support robust care coordination activities for social needs within a patient's community, which can disadvantage patients who require more support and the physicians who care for them. As such, APMs need to be designed to support the needs of patients, inclusive of health-related social needs, without inappropriately holding primary care physicians responsible for outcomes outside their control.

Additionally, although health plans offer a variety of services and many offer care coordination and/or management directly to patients, it may not be effectively coordinated with the patient's existing primary care physician. When primary care plays a central role in care coordination, it is much more encompassing than care coordination outside of primary care, which is often episodic in nature or limited to a single organ system or disease state. Primary care provides patient advocacy in the health care system to accomplish cost-effective and equitable care by coordination of health care services.

Ensuring Parity

The Mental Health Parity and Addiction Equity Act and the Affordable Care Act require parity for the payment of mental health and substance use disorder treatment at the same level as physical health treatments. However, enforcement by the U.S. Department of Labor is limited to investigations and non-monetary actions. The AAFP supports giving the Department of Labor the authority to issue civil monetary penalties for insurers not offering parity for mental health services.

Additionally, access to mental and behavioral health care services is often impeded by burdensome regulations like prior authorization or step therapy. These barriers exist in primary care as well, but more stringent requirements for mental and behavioral health services would violate parity laws.

Prior authorization requires approval from a health plan before the delivery of a procedure, device, supply, or medication for insurance to cover the cost. According to a 2020 survey conducted by the American Medical Association (AMA), 85 percent of physicians report that the burden associated with prior authorization is "high" or "extremely high" and 30 percent of physicians report that prior authorization has led to a serious adverse event for a patient in their care. The AMA survey reports that physicians and their staff spend almost two business days each week completing an average of 40 prior authorizations per physician, per week. Studies show providers suffer costs of $11 per manual prior authorization and $4 per electronic prior authorization, which amounted to a total of $528 million in prior authorization costs for providers in 2019.[xii] Further, prior authorization interactions with insurers cost practices $82,975 per physician annually.[xiii] **The AAFP urges Congress to pass the *Improving Seniors' Timely Access to Care Act (H.R. 3173/S. 3018)* and permanently reduce the volume of prior authorization requirements across Medicare and Medicaid payers.**

Step therapy is an insurance protocol that requires patients to try one or more insurer-preferred medications prior to a physician recommendation. This practice is also known as "fail first" and can take weeks or months. Once a patient finds a medication that does work for them, they may have to repeat the step therapy process if they switch insurance plans. When implemented improperly, step

therapy can result in patients not being able to access the treatments they need in a timely manner. Physicians can request exceptions to step therapy requirements, but insurers may not respond promptly to such requests, resulting in a further delay of treatment. **The AAFP urges Congress to pass the Safe Step Act (S. 464 / H.R. 2163) to implement transparency guidelines to prevent inappropriate use of step therapy in employer-sponsored health plans and create a clear process for patients and physicians to seek reasonable exceptions to step therapy.**

Expanding Telehealth

Quality and Cost-Effectiveness

As outlined in our Joint Principles for Telehealth Policy, the AAFP strongly believes that the permanent expansion of telehealth services should be done in a way that advances care continuity and the patient-physician relationship. Expanding telehealth services in isolation, without regard for previous physician-patient relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the basic principles of the medical home, increase fragmentation of care, and lead to the patient receiving suboptimal care. In fact, a recent nationwide survey found that **most patients prefer to see their usual physician through a telehealth visit, feel it is important to have an established relationship with the clinician providing telehealth services, and believe it is important for the clinician to have access to their full medical record**. Telehealth can enable timely, first-contact access to care and supports physicians in maintaining long-term, trusting relationships with their patients, both of which are central to continuity of care and high-quality services.

As previously referenced, the AAFP has consistently advocated to waive the in-person requirement for mental health services provided via audio/visual technology to Medicare beneficiaries. Requiring in-person visit prior to a telehealth visit for mental health care does not improve the quality or cost-effectiveness of telehealth services.[xiv]

Additionally, **permanently remove geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth care at home can help patients access timely care and prevent more costly services**. Transitional care management (TCM) services illustrate how permanently eliminating geographic and originating site requirements could improve utilization of high-value care and ultimately improve care coordination and patient outcomes. TCM services are provided after a patient is discharged from a hospital stay, with the goal of ensuring care continuity once they return home. Facilitating TCM via telehealth allows patients to easily access their care and primary care physicians to make appropriate changes to their care to prevent hospital readmissions. To bring clarity and provide certainty to patients and providers, we strongly urge Congress to address these restrictions in statute by striking the geographic limitation on originating sites and allow beneficiaries across the country to receive virtual care in their homes, or the location of their choosing, where clinically appropriate and with appropriate beneficiary protections and guardrails in place.

Equitable Expansion

Coverage of audio-only E/M services is vital for ensuring equitable access to telehealth services for patients who may lack broadband access or be uncomfortable with video visits. Furthermore, seniors and those with limited English-proficiencies would benefit most from audio-only services. According to the Pew Research Center, only about 53% of patients over the age of 65 own smartphones, while 91% own any type of cell phone. Recent studies of telehealth utilization by patients with limited

English proficiency show that non-English speakers have used telehealth far less than English-speakers. Many physicians routinely use telephone translation services to provide linguistically appropriate care, and these services can be more seamlessly integrated into telephone visits, whereas integrating translation services into audio-video platforms can be costly and complex. **Requiring Medicare to cover audio-only evaluation and management services beyond the public health emergency will ensure equitable access to care.**

Finally, additional studies are needed to inform the direction of permanent telehealth policies and should include collection and reporting of data stratified by race, ethnicity, gender, language, and other key factors. The AAFP has called on Congress to pass the Evaluating Disparities and Outcomes in Telehealth (EDOT) Act. The EDOT Act requests data on telehealth utilization broken down by service modality (i.e. audio-video and audio-only). This data, in conjunction with data on patient outcomes, will be invaluable as the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies weigh whether and how to continue covering telephone services beyond the PHE. In addition to these and other factors specified by the EDOT Act, the AAFP also strongly recommends that any studies of telehealth utilization analyze volume, patterns and patient outcomes for visits provided by a patient's usual source of care versus one-off visits provided by a clinician with whom the patient has no relationship. There is ample evidence that greater care continuity leads to higher quality of care and lower health care utilization and costs.[xv, xvi, xvii] Telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes by enabling timely care interventions, and decrease costs when utilized as a component of, and coordinated with, longitudinal care as well as an existing physician-patient relationship.

Improving Access for Children and Young People

Caring for children's behavioral health needs can be more complicated. Clinicians working with children and adolescents will need to be aware of privacy concerns and will need to consider workflow/ways to integrate confidential or one-on-one time with patients to address some behavioral health issues. Ninety percent of adolescents and young adults received care from their family physician in the past two years. Of these patients, 50 percent of adolescents and 33 percent of young adults said they felt their parents' presence might affect their comfort level or change the outcome. Additionally, access to subspecialty care is challenged, particularly in under resourced areas. The AAFP has published a number of resources for family physicians who see children and teens that include special considerations for social and behavioral health needs.

Medicaid is a critical component of the response to the children's mental health crisis because it provides health insurance to 1 in 5 Americans and covers some of our most vulnerable populations, including low-income children, pregnant women, and families, children with special health care needs, non-elderly adults with disabilities, and other adults, many of whom are uniquely susceptible to COVID-19 and a host of other adverse health outcomes. When Congress raised Medicaid primary care payment rates to Medicare levels in 2013 and 2014, patient access improved.[xviii] Improving access to primary care through improved payment will in turn improve screening, diagnosis, and treatment of mental health and behavioral health needs. The *Ensuring Access to Primary Care for Women and Children Act* would return Medicaid payments for primary care services to Medicare payment levels for two years and expand the number of clinicians eligible for this increase to ensure that all Medicaid enrollees have access to the primary and preventive care they need. The legislation also raises Medicaid payment rates to those of Medicare for the duration of any future public health emergency and six months thereafter. During this time of crisis and once things return to normal, it is critical that the Medicaid program be able to respond to take on any qualified new individuals and ensure physicians have the means to serve these new patients.

AAFP's joint recommendations on improving mental health care for children outlines the importance of telehealth flexibilities and Medicaid expansion. It also includes detailed recommendations on improving investments in pediatric mental health infrastructure and supporting a robust, diverse mental health workforce. There are currently not enough inpatient beds to support children in crisis situations, which increases the number of children boarding in emergency departments. Congress should provide resources to support efforts to scale-up inpatient care capacity, including costs associated with reallocation of existing resources, such as the conversion of general beds to accommodate mental health patients or to update psychiatric facilities to meet current safety standards and the unique needs of children and adolescents. There is also a vital need to increase access to alternatives to inpatient and emergency department care. Congress should provide funding specifically for the creation of additional pediatric care capacity for new sites of care to improve access to mental health services including step-down, partial hospitalization and day programs. Moreover, shortages in the mental health workforce are persistent, more severe within pediatric specialties and projected to increase over time. To address barriers to entry into these critical professions and to recruit a more diverse workforce, Congress should invest additional funding in both new and existing pediatric mental health workforce training and loan repayment programs

Thank you for the opportunity to respond to the committee's request for information. The AAFP is eager to support the committee in finding solutions to address the growing mental health crisis. For additional questions, please reach out to Erica Cischke, Director, Legislative and Regulatory Affairs at ecischke@aafp.org.

Sincerely,

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

[i] Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). Assessing Primary Care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey: *Https://Doi.Org/10.1177/21501327211023871*, *12*. https://doi.org/10.1177/21501327211023871
[ii] Ibid.
[iii] Serafini, M., McDonough, D., Hoagland, G. W., Newell, B., & O'Gara, B. (2021, March). *Behavioral Health Integration 2021 | Bipartisan Policy Center*. https://bipartisanpolicy.org/report/behavioral-health-2021/
[iv] SY, L.-T., J, E., D, C., & PY, C. (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. *Psychiatric Services (Washington, D.C.)*, *69*(6), 628–647. https://doi.org/10.1176/APPI.PS.201700382
[v] Cunningham, P. J. (2009). Beyond Parity: Primary Care Physicians' Perspectives On Access To Mental Health Care. *Https://Doi.Org/10.1377/Hlthaff.28.3.W490*, *28*(3). https://doi.org/10.1377/HLTHAFF.28.3.W490
[vi] The Complexities of Physician Supply and Demand: Projections from 2019 to 2034. Association of American Medical Colleges. June 2021. Available at: The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)
[vii] Cooper LA, Powe NR.Disparities in patient experiences, health care processes, and outcomes: the role of patient-provider racial, ethnic, and language concordance. The Commonwealth Fund. Accessed October 8, 2021.
[viii] Poma PA. Race/ethnicity concordance between patients and physicians. J Natl Med Assoc. 2017;109(1):6-8.
[ix] https://www.census.gov/quickfacts/fact/table/US/PST0452197
[x] https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018
[xi] https://www.americantelemed.org/wp-content/uploads/2021/06/ATA-Overview-of-In-Person-Requirements-1.pdf
[xii] Council for Affordable Quality Health Care. (2020). "2019 CAQH Index: Conducting Electronic Business Transactions: Why Greater Harmonization Across the Industry is Needed." Web.
[xiii] Morra D, Nicholson S, Levinson W. Gans D, Hammons T, Casalino L. (2011). "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers." Health Affairs. Web.
[xiv] https://www.americantelemed.org/wp-content/uploads/2021/06/ATA-Overview-of-In-Person-Requirements-1.pdf
[xv] Bentler, S. E., Morgan, R. O., Virnig, B. A., & Wolinsky, F. D. (2014, December 22). The Association of Longitudinal and Interpersonal Continuity of Care With Emergency Department Use, Hospitalization, and Mortality Among Medicare Beneficiaries. PLoS One, 9(12), e115088. https://pubmed.ncbi.nlm.nih.gov/25531108/?dopt=Abstract
[xvi] Bazemore, A., Petterson, S., Peterson, L. E., Bruno, R., Chung, Y., & Phillips, R. L. (2018, November). Higher Primary Care Physician Continuity is Associated with Lower Costs and Hospitalizations. Annals of Family Medicine, 16(6), 492-497. https://www.annfammed.org/content/16/6/492.full
[xvii] Saultz, J. W. & Lochner, J. (2005, March 1). Interpersonal Continuity of Care and Care Outcomes: A Critical Review. Annals of Family Medicine, 3(2), 159-166.
[xviii] Polsky, Daniel; Richards, Michael; Basseyn, Simon; Wissoker, Douglas; Kenney, Genevieve; Zukerman, Stephen; Rhodes Karin: "Appointment Availability After Increases in Medicaid Payments for Primary Care" https://pubmed.ncbi.nlm.nih.gov/25607243/