AMERICAN ACADEMY OF FAMILY PHYSICIANS

February 11, 2022

The Honorable Richard Neal
Chairman
Ways and Means Committee
United States House of Representatives
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
Ways and Means Committee
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

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 write to share testimony in response to the Committee's hearing on America's Mental Health Crisis on February 2, 2022.

Mental health concerns are highly prevalent in the United States and are one of the most pervasive causes of disease and disability worldwide. 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.[i] Today, 139 million Americans live in mental health professional shortage area.[ii] Roughly two-thirds of primary care physicians are unable to connect their patients to outpatient mental health services.[iii] This results in the need for primary care physicians to assume a leading role in the management of mental health care services.[iv] Primary care physicians see nearly 40 percent of all visits for depression, anxiety, or cases defined as "any mental illness" and are more likely to be the main source of physical and mental health care for patients with lower socioeconomic status and for those with co-morbidities.[v]

**Behavioral Health Integration & Care Coordination**

To begin, Medicare is a key component of affordable and accessible health care for older adults and people with disabilities. The AAFP has applauded the inclusion of collaborative care management codes under Medicare and appreciates this necessary step to ensuring primary care physicians have payment options available when patients present with mental health concerns. Despite interest from family physicians, uptake of collaborative care management codes in primary care 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. To address this, the AAFP recently endorsed the Collaborate in an Orderly and Cohesive Manner (COCM) Act to expand the Collaborative Care model, cover startup costs for practices, and invest in studies on effectiveness of integrated care. **The AAFP urges Congress to pass the COCM Act and direct the Center for Medicare and Medicaid Innovation to test and evaluate additional models for integrating behavioral health and primary care.**



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Family physicians are increasingly encountering patients with complex care needs due to mental health concerns; however current Medicare values for outpatient evaluation and management visits do not account for the additional cognitive effort, time, and resources these patients require. The infrastructure necessary to facilitate integrated behavioral health and robust care coordination can be costly, especially for small and solo physician practices. **The AAFP recommends Congress pass legislation establishing a Medicare add-on code to allow primary care clinicians that have the capacity to provide integrated behavioral health services to be reimbursed for the more complex services they provide**.

The AAFP also recognizes the school nurses and counselors play an important role in ensuring children and adolescents can access care. However, current coordination between primary care physicians and school-based clinics is limited, and many family physicians do not receive all relevant information to ensure care continuity, especially during school breaks. School-based clinics often do not have information on the child's or family's insurance coverage, making it difficult to receive accurate and affordable referrals. **The AAFP strongly recommends Congress make investments to improve care coordination between school-based health care providers and primary care physicians.**

Telehealth also serves as an important tool to expand access to mental health services, particularly in medically underserved areas, and reduce stigma related to seeking mental health care.[vi] When used within a patient's medical home for primary care or with a trusted mental health professional, telehealth can be a valuable tool in expanding access to timely, high-quality mental health care. 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. This is especially true for patients with complex medical needs including mental health concerns or substance use disorder. In fact, a 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.

**We urge Congress to permanently remove Medicare geographic and originating site restrictions to ensure that all beneficiaries can continue to access telehealth care at home and work with CMS to develop policies that protect patient safety, strengthen the physician-patient relationship, and safeguard the Medicare program.**

Additionally, 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. These services are important for patients without access to a smart phone and patients with limited English proficiency. **Requiring Medicare to cover audio-only evaluation and management services (E/M), in addition to mental health services, beyond the public health emergency will ensure equitable access to care.** As previously stated, primary care physicians see nearly 40 percent of all visits for depression, anxiety, or cases defined as "any mental illness" and are more likely to be the only source of care for patients of a lower socioeconomic status. Ensuring appropriate payment for audio-only E/M services will promote more equitable access to care.

**Ensuring Timely Access to Care and Coverage Parity**
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.[vii] Further, prior authorization interactions with insurers cost practices $82,975 per physician annually.[viii] **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.**

**Improve Access to Medication-Assisted Treatment (MAT):**
Physicians continue to face barriers to prescribing evidence-based treatment like buprenorphine and other MAT. Clinicians are required to obtain an X-waiver from the Drug Enforcement Administration (DEA) in order to prescribe MAT. To obtain the waiver, physicians must complete 8 hours of training and attest to meeting counseling and other requirements. Previous caps on patient volume for MAT administration have also hindered the expansion and accessibility of MAT. While documentation, counseling, and inspection requirements are important to ensuring practices follow recommended guidelines, they often make it difficult for small or rural practices to provide MAT given geographical and financial challenges.

These burdensome, redundant requirements create barriers to offering MAT in physician practices and have worsened access to this evidence-based treatment.[ix] The administration recently finalized new buprenorphine prescribing guidelines to exempt clinicians from certain training and reporting requirements if they provide buprenorphine to fewer than 30 patients. The AAFP recognized these new guidelines as a positive step toward improving access to MAT but additional action is needed to ensure patients with SUD can get the care they need. **We urge Congress to pass the Mainstreaming Addiction Treatment Act (S. 445) to eliminate the X-waiver and improve patients' access to MAT.**

The AAFP is concerned that DEA has not promulgated regulations to implement a special registration process for waivered clinicians to prescribe buprenorphine via telehealth, as mandated by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. Emerging evidence indicates that telehealth OUD treatment during the COVID-19 pandemic has improved access to MAT and helped patients stay in treatment, particularly for historically underserved populations. To ensure ongoing access to telehealth OUD treatment after the pandemic, **we urge Congress to ensure DEA swiftly publishes regulations establishing a special registration process for providing MAT via telehealth.**[x]

**Data Collection**

Accurate data collection is essential to understand areas most in need of behavioral health resources. The AAFP recognizes that integrated behavioral health services exist on a spectrum and can include consistent coordinate 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. **The AAFP recommends Congress pass legislation directing the Director of the Agency for Healthcare Research and Quality (AHRQ) and the Assistant Secretary for Mental Health and Substance Use to create and implement a plan to improve measurement of the extent to which children and adults have access to integrated mental health care** in primary care and the effectiveness of the care provided.

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

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