



March 30, 2022

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) and the 127,600 family physicians and medical students we represent, I applaud the Senate Finance Committee for its continued focus on mental and behavioral health. I write in response to the hearing: *“Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration.”* We are grateful to provide testimony in response to this hearing.

As detailed in our [recent testimony](#) and [RFI response](#), the AAFP is committed to improving behavioral health integration and upholding parity requirements for patients. Family physicians provide comprehensive mental health services and are a major source for mental health care in the U.S. While psychiatric and other mental health professionals play an important role in the provision of high-quality mental health care services, primary care physicians are the first point of care for most patients. Nearly 40% of all visits for depression, anxiety, or cases defined as “any mental illness” were with primary care physicians, and primary care physicians are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with comorbidities.ⁱ

The AAFP hopes to see timely action from Congress on the following recommendations.

Support Payment Flexibility for Behavioral Health Integration

Family physicians regularly cite the lack of sufficient payment for the technology, infrastructure, and staffing as a barrier to implementing and maintaining an integrated practice across a wide range of primary care practice settings. Many ultimately rely on grants or are forced to reappropriate other funds, which makes it difficult to sustain the model over the long-term. Additionally, our members often have difficulty finding appropriate mental health clinicians to make warm hand-offs to due to shortages and long wait times for existing clinicians. Further, the limited mental health workforce precludes many primary care practices from taking advantage of the integrated delivery models currently supported in Medicare. While primary care physicians are a critical resource for patients needing mental health screening and support, greater payment flexibility is needed to enable primary care physicians to coordinate with other mental health specialists.

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Value-based payment arrangements that incorporate prospective payments or a capitation, allow physicians the flexibility to innovate their practice to meet their patients' behavioral health needs. Alternative Payment Models (APMs) designed to support behavioral health integration should also be risk-adjusted promote quality care. APMs must also promote care provided within or in close coordination with a patient's medical home to avoid care fragmentation, such as from third-party 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 that is risk adjusted for the full range of care needs presented by their patients, primary care practices thrive, and patients have better outcomes.

Currently, existing collaborative care codes are primarily paid on a fee-for-service (FFS) basis, and many APMs for primary care have generally not included collaborative care 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 AAFP has [applauded](#) the inclusion of collaborative care management CPT codes (99492, 99493, 99494, HCPCS G2214) 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 Collaborate in an Orderly and Cohesive Manner (COCM) Act to expand the availability of the Collaborative Care model (CoCM). However, the AAFP remains concerned that current payment mechanisms limit adoption of this and other behavioral health integration models. Uptake of collaborative care management codes has remained low since their introduction, likely due to the complexity of the billing and coding requirements, relatively low payment levels, a shortage of necessary behavioral health practitioners, and the need for improved training for staff and physicians alike.

The Primary Care Behavioral Health (PCBH) model has also shown to be an effective delivery model.^{ii, iii} It allows primary care physicians to provide treatment aligned with their training, like screening and prescribing, while coordinating with other behavioral health clinicians for treatment like cognitive behavioral therapy. **The AAFP urges Congress to support and expand CoCM, PCBH, and other models that will meet practices where they are and provide flexible payment to meet the needs of their community.**

As mentioned, primary care physicians need flexibility for their practices to meet the unique behavioral health needs of their patients and coordinate with other behavioral health clinicians. While the AAFP strongly supports movement toward value-based care, the reality is that most physicians are still paid FFS. Therefore, to advance the integration of behavioral health and primary care, it is also necessary to improve FFS payment.

Family physicians report that the payment provided by existing general behavioral health integration (BHI) and collaborative care codes alone is insufficient to sustain an integrated practice. **The AAFP urges Congress to pass legislation establishing a Medicare add-on code to increase payment for primary care physicians that have the capacity to provide integrated behavioral health services.** This will ensure primary care physicians, especially those in small and solo practices, receive appropriate payment to enable them to provide fully integrated primary and behavioral health care to their often complex patients. The add-on code would be applied to evaluation and management (E/M) visits when the physician or practice has the ability to provide integrated behavioral health care, regardless of whether the patient seen is diagnosed with a mental health condition or received specific mental health care. To use the proposed add-on code, clinicians would

attest to having implemented a set of evidence-based integrated care practices. Physicians would still bill the existing BHI and COCM codes when they provide specific behavioral health services, as this add-on code is designed to sustain the infrastructure components that are not completely paid by the BHI and E/M codes. Payment for the add-on code should be exempt from the budget neutrality requirements of the fee schedule.

The general behavioral health integration care management code (general BHI code) (CPT code 99484) has become increasingly popular over traditional CoCM codes. Medicare claims data indicates the general BHI code is used nearly 10 times more than CoCM codes.¹ One primary difference is that the general BHI code covers a wider array of action and does not require consultation with a specified type of behavioral health clinician, while CoCM requires a psychiatric consult. It is possible that primary care physicians have greater access to and need for other behavioral health provider types and are therefore more likely to bill for general BHI instead of CoCM. Over-burdened primary care physician may struggle to find time to reach the 60- or 70-minute threshold. **The general BHI code should be appropriately valued to reflect the important role it plays in ensuring practices can provide behavioral health services beyond the primary care physician.**

Additionally, most states allow federally qualified health centers (FQHCs) to bill for physical and mental health visits that occur on the same day. However, some states and localities do not allow this, which means a warm hand-off is nearly impossible. Lack of guidance has resulted in some FQHC clinicians being unable to appropriately reimbursed from providing integrated services. Clinicians need further clarification on same-day billing and FQHC payment methodology should not undermine the ability of safety-net clinicians to provide integrated behavioral health care.

By making the aforementioned adjustments to Medicare payment, primary care practices reliant on FFS will have more opportunity to meet the needs of their patients and maintain an integrated practice.

Bolster Medicaid Programs to Improve Access to Care

Medicaid is a critical component of the response to the unmet needs of low-income adults and child impacted by the mental health crisis. Medicaid provides health insurance to 1 in 5 Americans and covers some of our most vulnerable populations. This includes low-income children, pregnant women, and families, children with special health care needs, non-elderly adults with disabilities, and other adults. Specifically, in July 2021 nearly 40 million children were enrolled in Medicaid and CHIP.^{iv}

The AAFP strongly recommends Congress pass legislation to establish a Medicaid demonstration program providing infrastructure, technical assistance, and sustainable financing for expanding access to integrated mental health care for children in primary care, schools, or other critical settings, including through telehealth. Such program should be designed to ensure long-term and sustainable access to integrated mental health care for children, with a special focus on improving access for traditionally marginalized populations. Integrating behavioral health in primary care requires significant upfront investment, which can be a barrier to implementation for physician practices. This demonstration program would provide practices with the support they need to integrate behavioral health into their practices, ultimately improving access to care for beneficiaries.

¹ Medicare claims data, 2020: 99492 (Initial psychiatric collaborative care management, 70 min) billed 6,958 times; 99493 (Subsequent psychiatric collaborative care management, 60 min) billed 23,187 times; 99494 (Initial or subsequent psychiatric collaborative care management, 30 min) billed 13,820 times; 99484 (Care management services for behavioral health conditions, 20 min) billed 128,255 times;

Additionally, when Congress raised Medicaid primary care payment rates to Medicare levels in 2013 and 2014, patient access improved.^v Improving access to primary care through improved payment will in turn improve screening, diagnosis, and treatment of mental health and behavioral health needs for the 40 million children enrolled in Medicaid and CHIP. **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.

Existing programs under Medicaid, like the early, periodic, screening, diagnostic, and treatment (EPSDT) benefit, have potential to improve access to early prevention and treatment for children and adolescents presenting with behavioral health concerns. However, state Medicaid programs implement EPSDT and medical necessity determinations differently, especially when contracting with Medicaid managed care plans. This variation has resulted in barriers to accessing mental health services treatment for children in some states. **To this end, the AAFP recommends Congress direct CMS to review EPSDT implementation in states and release an informational bulletin clarifying coverage of EPSDT services to facilitate access to prevention, early intervention, and mental health services.**

Ensure Timely Access to Care and Coverage 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.** It is imperative that private health insurance coverage offer adequate and equitable coverage of mental and behavioral health services, and the AAFP has long supported [mental health 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.

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, which can include screening for and addressing mental health needs.** The AAFP supports the legislative proposal in President Biden's FY23 to require commercial insurers to cover three behavioral health and primary care visits without cost-sharing

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.^{vi} Further, prior authorization interactions with insurers cost practices \$82,975 per physician annually.^{vii} **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.**

Thank you for your consideration of our recommendations. The AAFP looks forward to working with the committee to develop and implement policies to ensure that patients and their families have equitable and timely access to the comprehensive, high-quality care—including behavioral health support services—that they need. Should you have any questions, please contact Erica Cischke, Director of Legislative and Regulatory Affairs at ecischke@aafp.org.

Sincerely,

A handwritten signature in cursive script that reads "Ada D. Stewart, MD". The signature is written in black ink and is positioned below the word "Sincerely,".

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

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- 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>
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- ⁱⁱⁱ Landoll, R. R., Nielsen, M. K., Waggoner, K. K., & Najera, E. (2019). Innovations in primary care behavioral health: a pilot study across the U.S. Air Force. *Translational behavioral medicine*, 9(2), 266–273. <https://doi.org/10.1093/tbm/iby046>
- ^{iv} CMS. July 2021 Medicaid and CHIP Enrollment Trends Snapshot. <https://www.medicare.gov/medicaid/national-medicare-chip-program-information/downloads/july-2021-medicarechip-enrollment-trend-snapshot.pdf>
- ^v 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>
- ^{vi} Council for Affordable Quality Health Care. (2020). “2019 CAQH Index: Conducting Electronic Business Transactions: Why Greater Harmonization Across the Industry is Needed.” Web.
- ^{vii} 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.