

November 15, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
219 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
219 Senate Dirksen Office Building
Washington, DC 20510

Re: Recommendations to Improve Access to Behavioral Health Care

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the physician and medical students of the American Medical Association (AMA), I am pleased to offer our recommendations in response to your request for information (RFI) on improving access to health services for individuals with mental health and substance use disorders (SUD). There is no question that the COVID-19 pandemic has exacerbated the nation's drug overdose and death epidemic, as well as mental illness. Structural racism and health inequities have made the pandemic even worse for marginalized and minoritized individuals. The AMA is deeply committed to ending the drug overdose and death epidemic and to ensuring individuals with behavioral health needs and pain disorders have access to evidence-based treatment. We are actively engaged at the federal and state levels in a number of areas to help physicians meet their patients' needs, some of which are noted below in response to specific questions in the RFI. Further information can be found on our dedicated website: <https://end-overdose-epidemic.org>. The AMA applauds your leadership efforts in focusing on the unmet behavioral health needs of patients across the nation and looks forward to working with you as you move forward in developing a legislative package.

Strengthening Workforce

What policies would encourage greater behavioral health care provider participation in these federal programs?

As the nation faces a pandemic and multiple health professional shortages, sustained, long-term investments in workforce programs are necessary to help care for our nation's most vulnerable populations. The AMA recommends several policies to encourage an increase in physician participation in federal programs, including legislation that would extend the 10 percent Medicare's Merit-Based Incentive Payment System bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status; federal and state governments making available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; and legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more non-physician practitioners (NPPs).

There was already a shortage of mental health providers before the pandemic, and with the increase in illicit drug-related overdoses and deaths during the pandemic, the need has only increased. Data shows that only about 11 percent of Americans with a substance use disorder receive the treatment that they need. The lack of physicians with specialized expertise in treating substance use disorders is due to a multitude of factors, not least of which is a scarcity of residencies in addiction medicine and addiction psychiatry. The AMA supports S. 1438, the “Opioid Workforce Act of 2021,” (Hassan, D-NH/Collins, R-ME) which would provide 1,000 additional Medicare-supported graduate medical education (GME) positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine. This legislation would bolster the numbers of health care professionals dedicated to serving on the front lines and battling the nation’s drug overdose epidemic each day.

What barriers, particularly with respect to the physician and non-physician workforce, prevent patients from accessing needed behavioral health care services?

Workforce experts predict that the U.S. will face a significant physician shortage for both primary care and specialty physicians over the next 10 years if training positions are not expanded. When Congress enacted the Balanced Budget Act of 1997 (P.L. 105-33), it placed a limit (or cap) on the funding that Medicare would provide for GME. This meant that most hospitals would receive direct GME and indirect GME support only for the number of allopathic and osteopathic full-time equivalent (FTE) residents it had in training in 1996. In other words, the number of positions Medicare supported in each hospital in 1996 was established as the upper limit in terms of the number of positions or slots that Medicare would fund in those institutions thereafter. The cap prevents enough physicians from being able to enter the market and care for patients.

As U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for GME. According to the Association of American Medical Colleges (AAMC), there has been a 52 percent increase in medical student enrollment since 2002, but only an 18 percent increase in funded GME slots. The average number of applications for each slot has increased from approximately 10 to more than 60. Yet, there is expected to be a physician shortage of about 124,000 physicians by 2034. This is particularly alarming given that more than two of five currently active physicians will be 65 or older within the next decade, raising concerns about the impact of physician retirement. Additionally, the U.S. population in general is continuing to both grow and age, and access issues persist especially in rural and underserved areas.

Yet, while new medical schools are opening, and existing medical schools are increasing their enrollment to meet the need for more physicians, federal support for residency positions remains subject to the outdated cap that falls dramatically short of the needs of the U.S. population. As such, there is a bottleneck in allowing medical students to finish their training. The lack of slots for residents is ultimately leading to our current and projected shortage, including psychiatrists, addiction medicine specialists, and pain medicine physicians, as noted above.

Additionally, the way that the federal government defines HPSAs and thus the grants, scholarships, and loan forgiveness, etc. that is associated with this designation is often too restrictive and thus does not allow individuals to receive the mental health care that they need. CMS and other federal agencies often use primary care geographic HPSAs and mental health geographic HPSAs to determine if a hospital or its provider-based department is located in the HPSA. The Centers for Medicare & Medicaid Services

(CMS) and other federal agencies will then often prioritize applications from hospitals that serve specific designated underserved populations of a population HPSA. The AMA opposes requirements within federal programs that require that the hospital or provider-based department be physically located in a HPSA. Patients who live in HPSAs may choose to go to nearby hospitals that are adjacent to, but not located in a HPSA, often because it is the closest facility to their home, or it provides specialized services that are needed and are unavailable elsewhere. According to the AAMC's analysis of the FY 2019 American Hospital Association Annual Database, AAMC member teaching hospitals represent five percent of all inpatient, short-term, nonfederal, non-specialty hospitals yet they provide 26 percent of all Medicaid inpatient days and incur 32 percent of all charity costs. The AMA highly recommends that the commonly used definition of an HPSA, which determines scholarship and grant eligibility be altered so that a hospital will qualify if they are located within a certain distance, for example 10 miles of a HPSA or are in a geographic, primary care, mental health, or population HPSA. This will expand the number of providers that patients are able to see and thus will enable individuals to receive the mental care that they need more quickly and hopefully closer to home.

Another workforce-related barrier is the "X" waiver, which requires physicians to receive a waiver to administer, dispense, and prescribe buprenorphine for opioid use disorder so that it is available in primary care practices, emergency departments, and correctional facilities. We appreciate that the Administration loosened some of the federal restrictions on prescribing the medication to patients with opioid use disorder. Under Practice Guidelines issued by the Department of Health and Human Services, health care providers who treat up to 30 patients with opioid use disorder at a time no longer need to take mandatory training on buprenorphine or certify their ability to refer patients to counseling and ancillary services. However, before they can prescribe buprenorphine to patients with opioid use disorder, health care providers must still apply for a special registration with the federal government (a process that can take 2-3 months). If they treat more than 30 patients at a time, health care providers must still take 8-24 hours of training on the medication and comply with the counseling referral requirement. In issuing the Practice Guidelines, the Administration noted that these remaining restrictions are legislative and only an act of Congress can remove them. The AMA strongly supports S. 445, the "Mainstreaming Addiction Treatment (MAT) Act of 2021" (Hassan (D-NH), Murkowski (R-AK)), which would remove the remaining federal barriers to prescribing buprenorphine and treat it just like any other essential medicine. The bill allows all health care providers with a Drug Enforcement Administration (DEA) registration to prescribe buprenorphine for opioid use disorder in the course of their normal medical practice. The bill also launches a national education campaign to connect health care providers to already available, free education resources on best practices for treating substance use disorder (including programs such as the federally funded Substance Abuse and Mental Health Services Administration's (SAMHSA) Providers Clinical Support System. The MAT Act will prevent overdoses and help end stigma and the AMA urges Congress to pass it.

What policies would most effectively increase diversity in the behavioral health care workforce?

In general, reducing medical student indebtedness promotes diversity within medicine and may lead to an increase in psychiatrists and physicians who undertake behavioral health work. Rising medical school debt disproportionately impacts students who are low income. Due to the cost of medical school, many low-income individuals are completely deterred from attending medical school in the first place. According to a national survey, the cost of attending medical school was the number one reason why qualified applicants chose not to apply. Additional surveys by the AAMC support this conclusion and found that underrepresented minorities cited cost of attendance as the top deterrent to applying to medical school. With recent reforms seeking to eliminate health care disparities in the U.S. population, increasing

the number of historically underrepresented physicians is important to ensure a health care workforce that is more reflective of the general population.

Furthermore, while 20 percent of the U.S. population lives in rural communities, only 11 percent of physicians practice in such areas. The number of physicians who are most likely to practice in rural regions, such as those graduating from medical schools in rural areas, declined by 28 percent between 2002 and 2017. This decrease is compounded by the fact that in 2016 and 2017 only 4.3 percent of incoming medical students were from rural backgrounds.

Students need to be recruited earlier in life through pipeline programs. Programs should be created and must involve identification very early of students in rural and underserved high schools who want to commit to practice medicine in their hometowns. Communities that need health professionals must be educated about the value of programs that will train additional psychiatrists, addiction medicine specialists, pain specialists, and physicians who work in behavioral health; and they need encouragement to help groom and assist local students with getting into medical school. Additionally, by adding pipeline programs and holistic outreach (mentors, interview prep, etc.) there will be a larger candidate pool that understands what it means to live in a rural or underserved area. The future physicians coming out of this pipeline may also be willing to commit to that lifestyle and will increase the success of applicants from underrepresented communities. Furthermore, medical school rotations in rural and underserved settings could be key to recruitment. It will expose students to what it means to practice in a rural and underserved setting and might encourage more students to apply to residencies and programs in rural or underserved communities (it has been shown that where an individual does his or her residency highly correlates with where they later choose to practice).

What federal policies would best incentivize behavioral health care providers to train and practice in rural and other underserved areas?

Policies that provide payment for services and payment for educational debt would incentivize physicians. It is very important to ensure that physicians who participate in federal programs qualify for public service loan forgiveness (PSLF).

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. However, medical education remains the most expensive post-secondary education in the U.S. Nearly 75 percent of medical school graduates have outstanding medical school debt, with the median amount being \$200,000. This number will only continue to significantly increase as the cost of medical school continues to rise. In fact, for first year students in 2020-2021, the average cost of attendance increased from the prior year for public medical schools by 10.3 percent, making it likely that medical students will have to carry even larger student loans in the future in order to graduate.

The United States faces a looming physician shortage, the most drastic effects of which will disproportionately fall on rural and underserved communities. One tool Congress has implemented to address this is the PSLF program. By forgiving students' outstanding educational debt after 120 monthly payments made while working for government organizations or qualified nonprofit entities, this program has created a powerful incentive drawing aspiring physicians into such communities and jobs. In a Merritt Hawkins survey, 34 percent of physicians completing a residency in 2019 cited student loan debt as a major concern. As such, reliance on the PSLF program has only increased over the years, and according to the AAMC, in 2020 44.9 percent of medical student graduates intended to enter a loan forgiveness program. As a result, according to an Association of Program Directors in Surgery study, approximately

20 percent of physician trainees reported participation in the PSLF program impacted their career decisions.

Additionally, supporting other loan repayment or scholarship programs would likely enhance physician participation in federal programs. For example, increased funding for the expansion of the National Health Service Corps (NHSC) should be provided. A HPSA is used to identify areas, populations, groups, or facilities within the United States that are experiencing a shortage of health care professionals. The NHSC offers scholarship and loan repayment awards to primary care health professionals in exchange for practicing in these HPSAs. The NHSC is widely recognized as a success on many fronts and has improved access to health care for rural and urban underserved Americans, increased state investments in recruiting and retaining health professionals, provided incentives for practitioners to enter primary care, reduced the financial burden that the cost of health professions education places on new practitioners, and helped ensure access to health professions education for students from all backgrounds. Notwithstanding the NHSC's success, demand for health professionals across the country continues to grow. Nationwide, we have seen shortfalls in our health workforce capacity, especially in rural areas, where there is an inadequate number of providers to sufficiently meet the needs of the communities. With more than 16,000 physicians in the NHSC caring for more than 17 million patients, the NHSC still falls far short of fulfilling the health care needs of all 7,200 federally designated HPSAs. The Health Resources and Service Administration (HRSA) estimates that an additional 32,494 physicians are required to eliminate all current primary care, dental, and mental health HPSAs. With the current and projected physician shortage, and the increased demands that have been placed on all health care providers during the pandemic, additional support for these programs with a proven track record of success in our urban and rural areas of the country is desperately needed (especially since this program places an emphasis on mental health providers). Additionally, expanding programs like the HRSA-funded Rural Residency Planning and Development (RRPD) Programs which had 4 psychiatry programs in 2019, would also help to expand access to mental health care.

Moreover, providing additional funding for Title VII and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically underserved areas would help to promote physician participation in federal mental and behavioral health programs. In order to make applications to these types of programs easier for applicants, we would recommend the development of a centralized database of scholarship and loan repayment programs. Additionally, legislation making interest payments on student debt tax-deductible would also help to decrease the economic burden and would likely increase diversity in the physician workforce and enable some physicians to take on lower paying behavioral health jobs in underserved communities.

Are there payment or other system deficiencies that contribute to a lack of access to care coordination or communication between behavioral health professionals and other providers in the health care system?

Yes. The Commonwealth of Virginia is one prominent example of a state that has demonstrated that removing prior authorization for medication for opioid use disorder (MOUD), increasing payment for behavioral health services, and other evidence-based best practices, results in increasing access to evidence-based treatment, reducing utilization of emergency department services related to overdose, and making other positive impacts for Medicaid beneficiaries. The AMA urges all states to look to the [Department of Medical Assistance Services \(DMAS\)](#) as an example of how implementation of evidence-based policies leads to increases in evidence-based care.

Should federal licensing and scope of practice requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?

No. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients. There are stark differences between the education and training requirements for physicians and NPPs. Medical students spend four years learning both the physiologic and clinical components of evidence-based medicine before undertaking an additional three to seven years of residency training to further develop and refine their ability to safely evaluate, diagnose, treat, and manage the health care needs of patients. By gradually reducing teaching physician oversight, residents are able to develop their skills with progressively increasing autonomy, thus preparing these physicians for the independent practice of medicine.

While we greatly value the contribution of all non-physicians, no other health care professionals come close to the four years of medical school, three-to-seven-years of residency training, and 10,000-16,000 hours of clinical training that is required of physicians. But it is more than just the difference in hours of education and training, it is also the difference in rigor and standardization between medical school and residency and NPP programs. NPPs are integral members of the care team, but the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patients' care. Based on a series of nationwide surveys, patients overwhelmingly want physicians leading their health care team. Four out of five patients want a physician leading their health care team and 95 percent believe it is important for physicians to be involved in their medical diagnoses and treatment decisions (68 percent said it is very important). Patients understand the value that physicians bring to the health care team and expect to have access to a physician to ensure that their care is of the highest quality.

State scope of practice requirements exist to ensure patient safety and provider accountability and should not be modified. Removing scope of practice safeguards could allow for NPPs that have not been adequately trained to perform procedures that are outside the scope of their licensure, ultimately leading to a lower standard of care. Moreover, state licensing boards play an important role in ensuring that medical care is properly administered and that providers are disciplined when negligence is committed. However, removing state scope of practice laws and regulations would likely make it extremely difficult for state boards to adequately oversee NPPs. As such, the scope of practice requirements should not be modified.

What public policies would most effectively reduce burnout among behavioral health practitioners?

The AMA recognizes that a healthy workforce translates to a safe and productive health care system that provides the best patient care to our population. For nearly 10 years, the AMA has dedicated significant resources to identify, study, and address the drivers of burnout and the systems issues that contribute to workplace stress and demoralization. We remain committed to this and continue to build a system of evidence-based education and resources to guide organizations in developing and maximizing improvements in their practices to reduce stress and burnout among their care teams.

Physicians and other health care workers face excessive stress on multiple levels in their work, made worse in the past 18 months by the demands and challenges brought on by the COVID-19 pandemic. Nearly half of physicians in the United States experience burnout—40 percent more than the general population ([Prasad, 2020](#); [Shanafelt, 2019](#)). Burnout, characterized by emotional exhaustion,

depersonalization, and reduced feelings of personal accomplishment, also affects half of medical students and residents ([Dyrbye, 2008](#); [West, 2011](#)). This affects [behavioral health providers](#) as well, partly due to shortages in the workforce and the increased demands of a [surge](#) in patients seeking treatment for depression and anxiety during the pandemic. The consequences of burnout are far-reaching, impacting patients, physicians, medical practices, and the health care system. Burnout is associated with medical errors ([Tawfik, 2018](#); [Menon, 2020](#)), professional dissatisfaction ([Fargen, 2019](#)), and increased depression and other health concerns ([West, 2018](#)).

In terms of policy recommendations to help on the individual level, the AMA supports the “Dr. Lorna Breen Health Care Provider Protection Act” (S. 610/H.R. 1667). This bipartisan, bicameral legislation will help reduce and prevent mental and behavioral health conditions, suicide, and burnout, as well as increase access to evidence-based treatment for physicians, medical students, and other health care professionals, especially those who continue to be overwhelmed by the COVID-19 pandemic. The stigma surrounding mental illness is a well-known barrier to seeking care among the general population, but it can have an even stronger impact among health care professionals. For most physicians and other clinicians, seeking treatment for mental health sparks legitimate fear of resultant loss of licensure, loss of income, or other meaningful career setbacks as a result of ongoing stigma. Such fears have deterred them from accessing necessary mental health care, leaving many to suffer in silence, or worse. In fact, physicians have a significantly higher risk of dying by suicide than the general public. Ensuring clinicians can freely seek mental health treatment and services without fear of professional setback means their mental health care needs can be resolved, rather than hidden away and suffered through. Furthermore, optimal clinician mental health is essential to ensuring that patients have a strong and capable health care workforce to provide the care they need and deserve.

To ensure patient access to medically necessary care can be maintained, it is vital that we work to preserve and protect the health of our medical workforce. The Dr. Lorna Breen Health Care Provider Protection Act will help establish grants for training health profession students, residents, or health care professionals to reduce and prevent suicide, burnout, substance use disorders, and other mental health conditions; identify and disseminate best practices for reducing and preventing suicide and burnout among health care professionals; establish a national education and awareness campaign to encourage health care workers to seek support and treatment; establish grants for employee education, peer-support programming, and mental and behavioral health treatment; and commission a federal study into health care professional mental health and burnout, as well as barriers to seeking appropriate care.

While burnout manifests in individuals, it originates in systems and is exacerbated by the work-related stress these systems create. While self-care and self-compassion are important in managing work-related stress, in the last decade research has revealed that the primary contributors to physician burnout and work-related stress are systems issues, rather than individual factors. Electronic health record (EHR) use, increased administrative burden, and clerical work associated with documentation and reporting requirements have contributed to increased rates of burnout ([Shanafelt, 2016](#)). This is not surprising, considering that for every hour a physician spends on direct patient care, they spend nearly two additional hours on EHR and desk work ([Sinsky, 2016](#)). Regulatory burdens, such as insurance authorizations, appeals processes, and other gatekeeping requirements, are also significantly and negatively correlated with physician satisfaction ([Friedberg, 2013](#)). Not having control of one’s work environment, feeling undervalued ([Prasad, 2020](#)) and not feeling like values are aligned with management also increase the likelihood of burnout ([Linzer, 2016](#)).

The AMA supports interventions at all levels to reduce burnout and work-related stress, but strongly

encourages system-driven solutions that create efficiencies in practice and reduce the amount of time spent on non-clinical aspects of patient care. Advising physicians, who are already highly resilient, to become more resilient is not the most effective approach. It is more effective to investigate and promote changes to the care environment. In addition to organizational and cultural changes, opportunities exist for payers and regulators to improve processes and policies that contribute to physician burnout. The AMA urges policymakers and other stakeholders to take meaningful action to remove barriers and increase patients' access to evidence-based care to save lives and help end the epidemic. For example, payers should reduce or eliminate burdensome prior authorization and step therapy for medications to treat opioid use disorder and the corresponding documentation requirements.

Increasing Integration, Coordination, and Access to Care

What are the best practices for integrating behavioral health with primary care? What federal payment policies would best support care integration?

While primary care physicians are often the first line of contact with a patient who may have a mental health condition, there are many challenges to them providing the care that patient needs, whether it be training or resources. Because of this the primary care physician will often refer the patient to a specialist and many times, these referrals go uncompleted by the patient. Behavioral health integration (BHI) helps meet both physician and patient needs. There are many ways to approach BHI, and practices have several models to choose from. Many practices have taken a hybrid approach, implementing elements from available models of care and picking and choosing based on the needs of their patient population and the resources available in their community. What is possible and what works in a large, urban setting may not be feasible in a rural or frontier setting. Models of care vary depending on patient population needs and practice capabilities. One size does not fit all. The AMA recently has released four new behavioral health guides to provide physician practices and health systems with practical strategies for overcoming obstacles to accessible and equitable treatment for their patients' behavioral, mental, and physical health needs. Two of these BHI practice guides are focused on [SUD screening and treatment](#) and [suicide prevention](#).

There are a few key best practices associated with effective integrative models: 1) Identify a champion of behavioral health integration on staff—whether a physician or behavioral health providers (generates momentum for the program by engaging leadership and staff and serving as a point person for implementation); 2) Optimize non-grant revenue to sustain the program (includes understanding and properly leveraging all available billing/coding options); 3) Employ a care manager or coordinator as part of the care team (plays an essential role in following up with patients and connecting them to any needed external resources. Even in smaller practices without a designated 'care manager' role, nurses or front office staff have successfully stepped in to serve this important function); 4) Formalized staff training and coaching (allows practices to systematically think through their approach to behavioral health integration and guide them through the unique integration challenges their practice encounters); 5) Utilization of digital tools/telehealth (allows practices to expand the reach of their behavioral health services and can increase efficiency); and 6) Partnerships with local organizations (helps practices to more efficiently expand services offered, coordinate care and share the work of delivering behavioral health care). Many successful programs have also incorporated non-clinical services to address the gaps that exacerbate behavioral health conditions.

Broad implementation of coordinated primary and behavioral health care models is key to increasing

access to the care patients need in an unimpeded, timely manner. One of the most promising strategies for providing prevention, early intervention, and timely treatment of mental illness and substance use disorders is the implementation of evidence-based integrated care models using a population-based approach. The Collaborative Care Model (CoCM) is a proven, measurement-based approach to providing treatment in a primary care office that is evidenced-based and already reimbursed by Medicare, with established CPT codes. CoCM involves a primary care physician working collaboratively with a psychiatric consultant and a care manager to manage the clinical care of behavioral health patient caseloads. This model allows patients to receive behavioral health care through their primary care physician, alleviating the need to seek care elsewhere unless behavioral health needs are more serious. CoCM demonstrably improves patient outcome because it facilitates adjustment to treatment by using measurement-based care. Additionally, CoCM is supported by over 90 randomized control studies which indicate that implementing the model improves access to care and has been shown to reduce depression symptoms by 50 percent. It is currently being implemented in many large health care systems and group practices, along with a growing number of private physician practices, throughout the country and is also reimbursed by several private insurers and Medicaid programs.

In terms of Federal policies, BHI adoption has been hindered by lack of overall federal funding and support. Many physicians have not participated in promising innovations in care delivery such as the Collaborative Care Model because they lack the financial reserves to make the up-front investments needed for practice transformation. Policy options to help address these issue include: 1) Providing grants and other funding opportunities for PCPs attesting to adopt/implement integrated behavioral health programs; 2) Passing H.R. 5218, the “Collaborate in an Orderly and Cohesive Manner Act” (Fletcher, D-TX/Herrera Beutler, R-WA), which provides an important bridge to help medical practices, especially small and medium practices, make investments in accessible and equitable treatment for their patients’ behavioral, mental, and physical health needs; 3) Increasing federal funding to support growing the behavioral health workforce overall (e.g., through loan forgiveness programs, new residency, and training programs, as discussed in the workforce section); and 4) Funding national research efforts to explore and define the most effective, high-quality, and sustainable interventions to promote integration and advance the impact of BHI.

What policies could improve and ensure equitable access to and quality of care for minority populations and geographically underserved communities?

The AMA recognizes racial and ethnic health inequities as a major public health problem in the U.S. and as a barrier to effective medical diagnosis and treatment. The elimination of racial and ethnic inequities in health care is an issue of highest priority for the AMA, and we advocate that health equity—defined as optimal health for all—be a goal for the U.S. health system. In order to address social determinants of health (SDOH) and health inequities, the AMA has created a new [Center for Health Equity](#) whose mission is to strengthen, amplify, and sustain the AMA’s work to eliminate health inequities—improving health outcomes and closing disparity gaps—which are rooted in historical and contemporary injustices and discrimination.

To properly address SDOH and inequities, physicians and health systems must collect data on their patient population by screening for individual social needs, as well as understanding how these factors impact the community, at large. According to a [study](#) published in the *Journal of the American Medical Association (JAMA)*, approximately 24 percent of hospitals and 16 percent of physician practices reported screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal

violence. When researchers asked about barriers to screening, practices and hospitals primarily reported that the lack of screening was attributed to insufficient financial resources, time, and incentives. Data sharing is another barrier to addressing SDOH. This includes data sharing between health systems and physicians, as well as between physicians and community-based organizations that assist individuals and localities with getting access to essential social services. A system-level gap that also serves as a main barrier to addressing SDOH is an insufficient financing or physician payment structure. Payments must be adequate in traditional fee-for-service systems, capitation, and value-based payment models to support physicians taking into account and addressing their patients' SDOH, for example, by compensating practices for identifying and coordinating provision of appropriate non-medical support services for their patients.

Federal policies and strategies that further strengthen efforts to address SDOH include (but are not limited to): removing barriers to access to health insurance coverage and care (including expanding access to insurance subsidies to promote purchasing of health insurance coverage offered on the Affordable Care Act exchanges and the expansion of Medicaid); directing CMS to incorporate SDOH data and provide support for addressing patients' SDOH in Medicare and Medicaid payment systems and alternative payment models; funding efforts to address SDOH along with identifying and overcoming existing barriers to implementing SDOH-related programs; and increasing funding to community-based organizations to strengthen infrastructure and capacity to coordinate and collaborate with patients and health care organizations.

One of the policies that is critical to addressing inequities, particularly with regard to individuals with behavioral health needs, is the Medicaid Reentry Act of 2021, S. 285 (Baldwin, D-IL/Braun, R-IN) and H.R. 955 (Tonko, D-NY/Turner, R-OH). The Medicaid Reentry Act would allow Medicaid to cover health services—including physical, mental health, and substance use disorders care—in the last 30 days of incarceration for people who meet Medicaid eligibility criteria. This would help connect people to the care they need as they return to their communities. The Medicaid Reentry Act would save lives, reduce drug overdoses, advance equity, save money, and increase reentry success. The AMA and more than 100 groups across the country from local and state government, health care, criminal legal system reform, law enforcement, faith, reentry, substance use disorders, and mental health constituencies support this life-saving policy and urge its passage by Congress.

At a threshold level, there also needs to be transparency about substance use disorder and mental health networks. The AMA has consistently advocated for departments of insurance and other stakeholders to require payers to provide accurate, timely information about who in an enrollee's network is accepting new patients. The AMA has pursued this type of action due to the fact that patients routinely report an inability to access evidence-based care for mental health, an opioid use disorder or other SUDs. The reasons include wide disparities in access to in-network care; prior authorization and other utilization management hurdles both for providers and medication; difficulties in determining which in-network providers are accepting new patients; and cost-sharing decisions that may place some medications or other treatments out of reach. These disparities often fall hardest on historically marginalized and minoritized populations. To help address this, the AMA [urges](#) actions such as those being pursued by the [Colorado Division of Insurance](#).

How can providers and health plans help connect people to key non-clinical services and supports that maintain or enhance behavioral health?

The AMA supports two crucial pieces of legislation that offer federal solutions to address these non-

clinical factors, specifically H.R. 2503, “the Social Determinants Accelerator Act of 2021,” and S. 509, “the Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act.” H.R. 2503 (Bustos, D-IL/Cole, R-OK) would provide \$25 million in planning grants to state, local, and tribal governments to design “social determinants accelerator plans” to improve the health and well-being of individuals, especially those participating in the Medicaid program. The legislation stipulates that 20 percent of the funding be reserved for policy plans that assist rural populations. These plans could be targeted at a group of high-need Medicaid patients, as well as identify key outcomes to be achieved through improved coordination of health and non-health services and use of evidence-based treatments. S. 509 (Sullivan, R-AK, Murphy, D-CT) would require the HHS Secretary to award grants to states, on a competitive basis, to support the establishment of new or enhancement of existing community integration network infrastructure to connect health care providers to social services organizations in order to help patients overcome longstanding accessibility challenges related to various SDOH (e.g., food, housing, child development, job training, transportation, etc.). This federal effort to enhance communication between physicians and community social services infrastructure will undoubtedly improve patient outcomes.

Ensuring Parity

How can Congress improve oversight and enforcement of mental health parity laws that apply to private plans offering coverage under the federal health programs? How can we better understand and collect data on shortfalls in compliance with parity law?

We urge the Department of Labor (DOL), as well as the states, to increase efforts to review plans on a regular basis to ensure they are in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and hold them accountable if they are not. As part of the AMA’s recommendations to the Office of National Drug Control Policy regarding its 2022 National Drug Control Strategy, the AMA [urged](#) the Biden Administration to provide the DOL with the necessary resources and make clear that strong parity oversight and enforcement must be of the highest priority. The AMA believes that such enforcement is particularly important given that the DOL now can require health insurance carriers to submit a comparative analysis that their mental health and substance use disorder benefits are in parity compared with the plan’s medical/surgical benefits. Health plans’ history of more than a decade of noncompliance must not be tolerated, and the [DOL’s leadership](#) in this area is greatly appreciated.

The AMA, American Society of Addiction Medicine (ASAM), and American Psychiatric Association (APA) believe that the obligation of demonstrating compliance with the law is something payers can and should do. Because the MHPAEA is a comparative law—payers should prospectively do the comparisons to analyze whether they are in compliance with the law. Requiring prior comparative analysis can help streamline oversight, can help payers identify gaps, and most important—may help ensure patients have the coverage required by the law. “Enhanced Attestation” can help provide streamlined comparative analysis. Fortunately, there is an [“Enhanced Attestation” form](#) that can help streamline oversight and, hopefully, increase MHPAEA compliance. The “Enhanced Attestation” guides payers through the necessary analyses to demonstrate compliance with the law, which can then be made available to a state department of insurance upon request for its own regulatory review. An “enhanced attestation” form requires issuers to attest that they have performed analyses in each the categories of compliance covered by the federal parity law.

How can Congress ensure that plans comply with the standard set by Wit v. United Behavioral Health? Are there other payer practices that restrict access to care, and how can Congress address them?

The AMA is not surprised that DOL and state DOI investigations consistently find violations that go back nearly a decade. United's failures, for example, to comply with the law for patients with mental illness and substance use disorders is hardly limited to recent DOL findings. As the AMA highlighted in our [July 24, 2020 letter](#) to the DOL, there is increasing evidence of widespread, frequent violations by many different insurers—but these violations only come to light because of meaningful oversight and enforcement actions. It is deeply concerning that each time regulators investigate, they find violations. In Delaware recently, regulators announced more than \$1.3 million in fines for repeated discriminatory violations of mental health and substance use disorder parity requirements. Previous examples of payer failures to comply with parity requirements are included in our July 24, 2020 letter to the DOL. At this point in MHPAEA's existence, there is no reason for health insurers to continue to violate the law—violations that harm patients with mental illness and invariably cause considerable harm and suffering, including long-term disability and death.

We urge Congress to consider ongoing oversight of payers' obligations under the law. While there is increasing state and federal enforcement of MHPAEA, the AMA is deeply concerned that payers continue to violate the law. Further Congressional inquiry to health plans as to why they regularly fail to comply with state and federal parity laws could have a positive effect in demonstrating that payers need to reform their practices with increased urgency.

Are there structural barriers, such as the size of the provider network, travel time to a provider, and time to an appointment, that impede access to the behavioral health care system?

These all represent challenges, but they do not excuse payers from complying with state and federal network adequacy laws and regulations. An important step to understanding the scope of the problem is to require health plans to provide detailed information on the size and reach of their mental health and substance use disorder treatment networks. The AMA has consistently advocated for this type of action due to the fact that patients routinely report an inability to access evidence-based care for a mental illness, OUD, or other SUDs. The reasons include wide disparities in access to in-network care; prior authorization and other utilization management hurdles both for providers and medication; difficulties in determining which in-network providers are accepting new patients; and cost-sharing decisions that may place some medications or other treatments out of reach. To directly confront these issues, [Colorado](#) is undertaking a [first-of-its-kind regulation](#) that will provide essential information to provide the Colorado Division of Insurance (CDI) a foundation on which to understand precisely where problems exist. It will also provide information to CDI on how it can continue its efforts to bridge gaps between what services and benefits health plans are required to provide for patients, and what they actually deliver. Health plans in the state vehemently opposed this, but the CDI wisely is moving forward to identify where problems may exist so as to efficiently target resources and potential interventions to help patients access the care for which they have paid.

To what extent do payment rates or other payment practices (e.g., timeliness of claims payment to providers) contribute to challenges in mental health care parity in practice?

The actuarial firm Milliman has looked at multiple areas of noncompliance with parity laws. Milliman [reports](#) that out-of-network utilization rates for behavioral health and substance use disorder treatment are

both significantly higher than compared to medical-surgical care. This includes rates to see behavioral health providers, substance use disorder treatment providers, in-patient, out-patient and for office visits. In addition, in-network reimbursement rates for behavioral health services were found to be consistently lower than for medical/surgical services. Not only are these disparities in utilization and reimbursement indicative of potential parity violations, but they also demonstrate and exacerbate longstanding challenges faced by patients in accessing timely, affordable care.

How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicaid fee-for-service programs impact access to care and patient health?

Medicaid enrollees and patients covered by Medicare or Medicare fee-for-service plans deserve the same level of mental health and substance use disorder parity protections as patients in any other health plan. This means that more needs to be done than simply extending parity “principles;” rather, there is a need to extend the strong parity protections that exist under current law governing commercial plans to Medicaid, Medicare Advantage, and Medicare fee-for-service. This also includes conducting oversight and enforcement actions as explained above. A [report](#) earlier this year by the Legal Action Center, for example -highlighted that “Medicare generally covers SUD prevention, early intervention, and treatment in office-based and hospital inpatient settings—the bookends for health care delivery—but does not cover intermediate levels of care that are required to treat individuals with a chronic disease.” The AMA supports all patients—regardless of insurance type—receiving parity protections under state and federal laws.

Expanding Telehealth (Response incorporates several of the questions)

The AMA believes that telehealth is a critical part of the future of effective, efficient, and equitable delivery of health care in the United States. Efforts must continue to build capacity and support access to care centered on where the patient is located to the greatest extent it is clinically efficacious and cost effective, and to ensure physicians and other health care providers have the tools to optimize care delivery. The AMA has been a leader in advocating for expanded access to telehealth services for Americans because it believes that it has the capacity to improve access to care for many underserved populations and improve outcomes for at-risk patients, particularly those with chronic disease and impairments, including mental health, substance use, and pain disorders.

Telehealth usage has expanded tremendously during the COVID-19 pandemic, helping Americans access health care services while maintaining social distancing and reducing strain on hospitals and physician clinics. With this expansion of services has come a recognition from patients, physicians, and other providers that telehealth services offer effective and convenient health care in many circumstances. Congress must act now to pass S. 368, the “Telehealth Modernization Act,” (Scott, R-SC/Schatz, D-HI), which would remove the origination and geographic restrictions on telehealth coverage for Medicare patients and ensure that Medicare patients can continue to access telehealth services, including mental health services, from wherever they are located after the pandemic ends by modernizing the Social Security Act to keep pace with our digital future. Continued access to telehealth services beyond the PHE is critical for patient populations that have come to rely on its availability.

The AMA strongly supports coverage and payment of telehealth services for mental and behavioral health and commends Congressional efforts to ensure that all Medicare beneficiaries can access tele-mental health services regardless of where they are located both during the pandemic and afterwards. However,

in addition to removing barriers to care by removing the origination and geographic restrictions in Section 1834(m) of the Social Security Act, we urge Congress to remove arbitrary restrictions to accessing mental health telehealth services including the restriction requiring an in-person visit to a provider within six months of a service being offered. Not only is there no clinical evidence to support these requirements, but they also exacerbate clinician shortages and health inequities by restricting access to care for those individuals who are not able to travel for in-person care. The AMA is concerned that removing geographic and originating site restrictions only to replace them with in-person restrictions is short-sighted and will create additional barriers to care.

The AMA also strongly supports coverage and payment of audio-only services in appropriate circumstances to ensure equitable coverage for patients who need access to telecommunication services but who do not have access to two-way audio-visual technology. Increasing access to audio-only services for behavioral health care can help ameliorate inequities in health care, particularly for those who lack access to broadband and/or audio-visual capable devices, including seniors in minoritized and marginalized communities where there were significant health disparities before COVID-19 that have become much worse during the pandemic. A key finding of the COVID-19 Health Coalition Telehealth Impact Study was that audio-only coverage is important to allow patients to access their physician when audio-visual service is not available. Analysis of the Coalition's patient survey found that 20.6 percent of survey respondents over 65 accessed their most recent telehealth service through audio-only telephone. The AMA's analysis of Medicare claims data for 2020 shows that Medicare spent \$736 million on the three CPT codes for audio-only visits over the entire year, which was 18 percent of total 2020 Medicare spending on telehealth services. Office visits for Medicare patients using audio-visual telecommunications accounted for 52 percent of 2020 Medicare telehealth spending. Overall, telehealth services accounted for 4.9 percent of Medicare spending in 2020.

While not a high percentage of office visits provided to Medicare patients via telehealth in 2020, access to audio-only services is critical for patients who do not have access to audio-visual telehealth services. Discontinuing payment for these services would exacerbate inequities in health care, particularly for those who lack access to broadband and/or audio-visual capable devices. For example, according to the Federal Communications Commission, 628,000 tribal households lack access to standard broadband. Based on data from 14 participating states, the Centers for Disease Control and Prevention (CDC) reported that age-adjusted COVID-19—associated mortality among American Indian and Alaska Native persons was 1.8 times that among non-Hispanic Whites. Likewise, an October 2020 article in Government Technology reported that less than half the population in the parts of Alabama defined as the “Black Belt” have internet access, and two of these Alabama counties have no internet access at all. Marginalized urban communities have also been excluded from broadband service and need to rely on audio-only visits, because even when cities have broadband, many residents of these communities do not have access to it in their homes. A June 2020 report of the National Digital Inclusion Alliance describes data showing that the U.S. has more than three times as many urban as rural households living without home broadband of any kind.

Broadband and audio-visual telehealth services are clearly not accessible by all Medicare patients. We urge CMS to continue covering audio-only evaluation and management services through 2023 like the currently proposed Category 3 services. The AMA has adopted significant policy to address equity in telehealth. We recognize access to broadband internet as a social determinant of health and encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. We also support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology,

such as older adults, individuals with vision impairment and individuals with disabilities.

Finally, flexibilities for the treatment of substance abuse disorders should be continued. Early in the COVID-19 Public Health Emergency (PHE), the Drug Enforcement Administration (DEA) and SAMHSA put several important flexibilities in place to help DEA-registered physicians manage care for their patients with opioid use disorder. During the PHE, physicians who have a waiver allowing them to prescribe buprenorphine for the treatment of OUD can initiate and continue this treatment based on telehealth visits and audio-only visits with patients. Opioid Treatment Programs (OTP) can also initiate new patients and treat existing patients being managed with buprenorphine based on telehealth and phone visits. Patients cannot be initiated with methadone treatment based on telehealth visits, but existing patients on methadone can be managed via telehealth or phone. OTPs can also provide patients who are stable with take-home medication. Based on a survey led by the American Academy of Addiction Psychiatry and conducted last summer of more than 1,000 physicians and other health professionals who treat OUD, these new flexibilities were extremely important in allowing them to continue to manage their patients' care. A major finding of the survey is that more than 80 percent of X-waivered survey respondents want the telehealth options to continue after the COVID-19 PHE. The AMA has written to the DEA [urging](#) that these flexibilities remain in place at least until the end of the opioid PHE and believes Congress should support these continued flexibilities.

Improving Access for Children and Young People

Between 2011 and 2019, fewer than 12 percent of adolescents with major depression and substance use disorder were treated for both conditions. As has happened with adults, demand for behavioral health services has only escalated during the pandemic for children and young people. According to HHS, epidemiological data now show alarming rates of behavioral health needs among school-age youth, with significant increases in the number experiencing moderate to severe anxiety and depression. According to CDC data, from April 2020 the proportion of youth mental health-related emergency department (ED) visits increased and remained elevated through October of 2020. Compared with 2019, the proportion of mental health-related visits for youth aged 12-17 years increased approximately 31 percent. Studies have also identified increased rates of suicide ideation and suicide attempts in 2020 during the COVID-19 pandemic as compared with 2019 rates. Reportedly, less than half of young people who have died by suicide had received psychiatric care. Increased access to mental health services is needed in addition to community supports, peer supports, school-based programs, college counseling services and social services designed to prevent youth and young adult suicide.

In June of 2021, the AMA adopted new policies on youth and young adult suicide that may be of interest to the Finance Committee, including the following:

- Supporting collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- Encouraging efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;

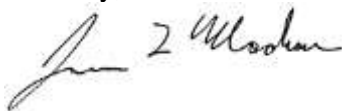
- Encouraging continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/LatinX, and Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
- Supporting the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults; and
- Supporting research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.

In terms of strategies for prevention more specifically related to substance use disorders, the AMA urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level; changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction; and development of innovative programs that train and involve parents, educators, physicians, and other community leaders in “state of the art” prevention approaches and skills.

Conclusion

The AMA appreciates the opportunity to provide our thoughts and recommendations on improving behavioral health treatment and filling the gaps in care. We agree with you that every American must be able to access high-quality behavioral health care when they need it and look forward to working with you to meet that goal.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD