Statement for the Record
American College of Physicians
Hearing Before the United States Ways and Means Committee
on "America's Mental Health Crisis"
February 2, 2022

The American College of Physicians (ACP) is pleased to submit this statement and offer our views on America's mental health crisis and how to improve mental health and addiction services during and after the COVID-19 pandemic. ACP appreciates the opportunity to provide information to the Ways and Means Committee on legislative proposals that will improve access to health care services for Americans with mental health and substance use disorders (SUD). We commend Chairman Neal and the Ways and Means Committee's sustained commitment to crafting bipartisan legislation in the 117th Congress to improve care for individuals in need of mental health care, a crisis that has only been exacerbated by the COVID-19 pandemic. ACP recommends that the Committee adopt recommendations outlined in this statement to improve access and care for individuals with behavioral health disorders through policies that would reduce the mental strain on physicians due to the pandemic, promote the integration of primary and behavioral health, expand physician workforce and access to telehealth services, and improve oversight and enforcement of mental health parity laws.

The American College of Physicians is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

Mental Health and Addiction Services Workforce Shortage Made Worse by COVID-19

The number of individuals in need of mental or behavioral health services has significantly increased during the COVID-19 pandemic. The Centers for Disease Control and Prevention (CDC) found that 38 percent of individuals surveyed reported symptoms of anxiety or depression from April 2020 to February 2021. This was a 27 percent increase from 2019 for the same time period. CDC data found that emergency department visits for overdoses were 26 percent higher and suicide attempts were 36 percent higher for the time period of mid-March through mid-October 2020 when compared to that period during 2019. Meanwhile, persistent mental health and addiction services workforce shortages from before the pandemic only worsened during the public health emergency (PHE) caused by COVID-19. Before the pandemic, the Health Resources and Services Administration (HRSA) found that by 2025, shortages of seven different types of mental health clinicians were anticipated, with shortages of

10,000 and above in some clinician fields of practice. In September 2020, HRSA designated over 5,700 mental health clinician shortage areas with 119 million people living in one of these areas. HRSA estimated that available mental health clinicians in these areas were only adequate enough to meet 27 percent of the need for services.[1] SAMHSA reported that due to a combination of reasons, including laying off staff and the closure of clinicians' offices that could not sustain themselves financially, led to a decrease in access. In February 2021, NCBH reported that member organizations had decreased staff and services because of the pandemic caused by COVID-19, including 27 percent laying off staff and 23 percent furloughing staff, resulting in 68 percent of member organizations canceling, rescheduling, or turning away patients.[2] Not unexpectedly, the demand for mental health and addiction services rapidly increased during the PHE caused by COVID-19 while at the same time access to these services diminished.

Support Physicians by Final Passage of the *Dr. Lorna Breen Health Care Provider Protection Act*

The current pandemic has added a tremendous level of strain on medical professionals, many of whom are experiencing personal hardships as they care for distressed patients and manage their own families and their own health. In a Primary Care Collaborative (PCC) survey conducted during the pandemic, 45 percent of physicians surveyed reported that their ability to bounce back or adjust to adversity had become limited and 38 percent report being maxed out with mental exhaustion. Another PCC survey found that 24 percent of practices still rate pandemic-related strain at severe and near severe levels. Among these, 50 percent struggle with constant lethargy, lack of joy in anything, and clear thinking. America's physicians are at a critical breaking point that must be urgently addressed.

Mental health data show that physicians in the U.S. face higher incidents of suicide than almost any other profession. The 2018 Medscape National Physician Depression and Burnout Report showed 66 percent of male physicians and 58 percent of female physicians revealed they were experiencing burnout, depression, or both. The study also discussed that many of the professionals were not seeking help and had no plans to do so because of barriers such as stigma and the professional risks associated with disclosing their treatment activities to medical boards.

While both chambers of congress have passed a version of legislation to reduce incidences of physician burnout through S. 610, H.R. 1667, the *Dr. Lorna Breen Health Care Provider Protection Act,* we urge congress to reconcile any technical differences and pass the legislation. The *Dr. Lorna Breen Health Care Provider Protection Act* is an important proposal because it aims to prevent and reduce incidences of suicide, mental health conditions, SUDs, and long-term stress, sometimes referred to as "burnout." Through grants, education, and awareness campaigns - the legislation will help reduce stigma and identify resources for health care clinicians seeking assistance. The legislation also supports research on health care professional mental and behavioral health, including the effect of the COVID-19 pandemic.

Integrate Primary Care and Behavioral Health

ACP strongly supports integration of behavioral health care into primary care and encourages our members to address behavioral health issues within the limits of their competencies and resources.

Accordingly, ACP supports using the primary care setting as the springboard for addressing both physical and behavioral health care. The basis for using the primary care setting to integrate behavioral health is consistent with the concept of "wholeperson" care, which is a foundational element of primary care delivery. It recognizes that physical and behavioral health conditions are intermingled: many physical health conditions have behavioral health consequences, and many behavioral health conditions are linked to increased risk for physical illnesses. In addition, the primary care practice is currently the entry point and the most common source of care for most persons with behavioral health issues—it is already the de facto center for this care. The degree of medical practice integration can vary, from basic coordination between a primary care physician and behavioral health clinicians, to colocation with a behavioral health clinician practicing in close proximity to the primary care physician, to a truly integrated care approach in which all aspects of care delivered in the primary care setting recognize both the physical and behavioral perspective.

We released a policy paper Concerning the Integration of Care for Mental Health, Substance Abuse, and other Behavioral Health Conditions into Primary Care that recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work toward removing payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care. The barriers to seamless integration of behavioral and primary care are both administrative and financial. Behavioral and physical health care clinicians have a long history of operating in different care silos. The artificial separation of behavioral and physical health care is reflected in many ways. For example, primary care physicians generally lack extensive clinical training in behavioral health, and traditional medical and mental health training models and practice environments are substantially different, which may lead to cultural clashes if they are not thoughtfully integrated.

ACP also strongly supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting and Congress should prioritize research in this area. Although a review of the current literature supports the efficacy of the integration of behavioral health care in the primary care setting, it is limited and filled with many gaps. Substantial research is needed to focus on the efficacy of various models of integration, as well as the diagnostic and treatment interventions most appropriate for use in these models. The following additional factors should be considered within research efforts: specific conditions addressed, populations involved (such as child vs. adult), funding structures, personnel employed, and resources available to the participating practices.[3] Federal research agencies, such as the Agency for Healthcare Research and Quality (AHRQ) are well suited to study the best ways of integrating behavioral health care in the primary care setting and Congress should provide the resources to enable this type of care.

Provide Incentives for Physicians to Participate in the Collaborative Care Model

We urge Congress to pass legislation, H.R. 5218, the *Collaborate in an Orderly and Cohesive Manner Act* (CoCM) that would provide grants through the Department of Health and Human Services to primary care physicians that choose to deliver behavioral health care through the Collaborative Care Model. 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 doctor while alleviating the need to seek care elsewhere, unless behavioral health needs are more serious. CoCM demonstrably improves patient outcomes because it facilitates adjustment to treatment by using measurement-based care. It is currently being implemented in many large health care systems and group practices throughout the country and reimbursed by several private insurers and Medicaid programs. Although the collaborative care model is well-studied and evidence-based, policymakers also need to test other integration models that are suitable for different practice needs.

Improve Treatment for Behavioral Health through the Patient-Centered Medical Home

The patient-centered medical home (PCMH) has been proposed as an appropriate model to address the integration of primary and behavioral care, highlighting its emphasis on primary care, care coordination, and delivery of care by a team of professionals. In several states, including Oregon, Washington, and Vermont, the Primary Care Behavioral Health approach has been used. This approach uses behavioral health consultants to deliver brief interventions to help primary care physicians treat a variety of issues like depression, substance use, and sleep disorders. Evidence also shows opportunities in the primary care setting not only to address current behavioral health conditions but also to serve as a platform to promote prevention in at-risk patients or populations and address behavioral health conditions before symptoms can occur in patients.[4]

Even though there are challenges, the evidence shows that integrating behavioral health and primary care leads to improved mental health outcomes, improved physical health, improved quality of life, and lower costs. The available evidence, while limited, does support the efficacy of this approach.[5] The Behavioral Health Integration (BHI) Collaborative, in which ACP participates, has found that benefits of integration can improve patient satisfaction, and reduce the stigma of mental health issues and SUD.[6] Other important potential benefits include higher physician and clinician satisfaction as well as decreased burnout.

Ensure Adequate Physician Workforce to Integrate Behavioral Health and Primary Care

ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting. Cross-discipline training is needed to prepare behavioral health and primary care physicians to effectively integrate their respective specialties. Primary care physicians need to be trained to screen, manage, and treat common behavioral health conditions, and behavioral health providers need to be trained to understand care for common medical needs. Both sectors need to overcome the operational and cultural barriers that prevent seamless integration. A report from the SAMHSA–HRSA Center for Integrated Health Solutions cited inadequate skills for integrated practices and reluctance to change practice patterns.[7] The workforce of professionals qualified to treat behavioral health and substance use disorders should be expanded. ACP supports policies to increase the professional workforce engaged in treatment of behavior health and substance use disorders. Loan forgiveness programs, mentoring initiatives, and increased payment may encourage more individuals to train and practice as behavioral health professionals.[8]

Primary care physicians, including internal medicine specialists, continue to serve on the frontlines of patient care during this pandemic with increasing demands placed on them. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals providing care for all communities, including for racial and ethnic communities historically underserved and disenfranchised.[9] According to the Association of American Medical Colleges (AAMC), before the Coronavirus crisis, estimates were that there would be a shortage of 21,400 to 55,200 primary care physicians by 2033. In addition, the federal government determined that an additional 14,900 primary care physicians and 6,894 psychiatrists were needed in 2018 to provide services that would have eliminated a HPSA designation for areas with primary care and mental health shortages.[10] Now, with the closure of many physician practices and near-retirement physicians not returning to the workforce due to COVID-19, it is even more imperative to assist those clinicians serving on the frontlines and increase the number of future physicians in the pipeline.

ACP supports several pieces of legislation introduced in the 117th Congress to assist medical graduates and the overall physician workforce as well as address the mental and behavioral health needs of physicians themselves.

- *The Resident Physician Shortage Reduction Act of 2021* (H.R. 2256/S. 834) is bipartisan legislation that would take steps to alleviate the physician shortage by gradually providing 14,000 new Medicare-supported graduate medical education (GME) positions.
- *Conrad State 30 and Physician Access Reauthorization Act* (H.R. 3541, S. 1810) allows states to sponsor foreign-trained physicians to work in medically underserved areas in exchange for a waiver of the physicians' two-year foreign residence requirement.
- *The Student Loan Forgiveness for Frontline Health Workers Act* (H.R. 2418) would forgive student loans for physicians and other clinicians who are on the frontlines of providing care to COVID-19 patients or helping the health care system cope with the COVID-19 public health emergency.
- *The Resident Education Deferred Interest Act* (H.R. 4122) would make it possible for residents to defer interest on their loans.

ACP supports provisions in the House-passed H.R. 5376, the *Build Back Better Act* (BBBA), that seek to improve the nation's healthcare infrastructure and workforce. That legislation creates a new Pathway to Training Program to provide scholarships for tuition and other fees to underrepresented and economically disadvantaged students planning to attend medical schools. ACP is pleased that an additional 4,000 Medicare-supported GME slots were included in the House-passed BBBA in Sec. 137405 pertaining to the Pathways to Practice Training Program. A thousand slots associated with the Pathways to Practice Training Program can be found in Sec. 137404. Other provisions affecting the health care workforce include: $3.37 billion in supplemental Teaching Health Center (THC) Graduate Medical Education; $200 million for Children's Hospital GME; $2 billion for the National Health Service Corps (NHSC); $20 million for training physicians in palliative care; $85 million for healthcare professions schools to identify and address risks associated with climate change; and 500 new residency positions at Veterans Affairs Medical Centers. ACP also considers it vital for Congress to support ongoing funding for Community Health Centers, NHSC and THC Graduate Medical Education

sites nationwide. These programs are essential to expanding primary care services to serve those needing primary and behavioral care.

Improve the Use of Telehealth to Provide Mental Health Care

As the number of patients in need of treatment for mental health care has risen, the use of telehealth to access mental and behavioral health services has also increased and has proven to be an effective method of treatment. According to a recent article published by the Commonwealth Fund, "tele-mental health has a robust evidence base and numerous studies have demonstrated its effectiveness across a range of modalities (e.g. telephone, videoconference) and mental health concerns (depression, substance use disorders)." During this pandemic, internal medicine specialists continue to deliver care to their patients with the expanded utilization of telehealth made possible by new policies enacted by Congress and implemented by the U.S. Department of Health and Human Services (HHS), as well as private payers. We are pleased that the 2021 Medicare Physician Fee Schedule Final Rule provided coverage through the end of the PHE for more than 100 services via the creation of a temporary Category 3 status. While the College appreciates and supports this extension, we strongly recommend that Category 3 be made permanent as to provide for a more consistent and efficient on-ramp for new telehealth services to be added.

Pay Parity for Audio-Only and Telehealth Services

The College wholeheartedly supports many actions taken by CMS to provide additional flexibility for patients and their doctors by providing payment for telephone services. During the PHE, Medicare has covered some audio-only services and will reimburse for both telehealth services and audio-only services as if they were provided in person. Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, or do not feel comfortable using video visit technology. In addition, these changes have greatly aided physicians who have had to make up for lost revenue while still providing appropriate care to patients.

ACP is extremely supportive of continuing to allow audio-only services. Therefore, the College has recommended that CMS maintain coverage of audio-only mental health visits even after the PHE is lifted. This extension should last at least through the end of 2023 with an option to extend it even further or consider making it permanent, based on the experience and learnings of patients and physicians who utilize these visits. This would require further study of its effect upon access and the clinical effectiveness of audio-only services by the Agency. Since the beginning of the COVID-19 pandemic, we have repeatedly called attention to the need for patients to access care by phone. In fact, because the College believes audio-only telehealth is such an important component tool for physicians to improve health equity and patient access, ACP has recommended that CMS not limit these extensions to only patients seeking behavioral and mental health services, but also broaden the flexibility and continue to allow other Evaluation and Management (E/M) services to be provided using audio-only communication, as well.

We are pleased that in the 2022 Medicare Physician Fee Schedule Rule, CMS is revising its definition of "telecommunications system" to permit use of audio-only communications technology for mental health telehealth services under certain conditions when provided to beneficiaries located in their home. In support of this rule, CMS cites the possible negative effect on access to care if a sudden discontinuation were allowed, as well as its belief that mental health services are distinct from most other services on the telehealth list in that they do not necessarily require visualization of the patient to fulfill the full scope of service elements. While ACP continues to recommend that mental health telehealth services not be the only services for which these extensions are permitted, the College is greatly supportive of all revisions that make mental health services most accessible and beneficial to patients.

Geographical Site Restriction Waivers

ACP strongly supported CMS' policy changes to pay for services furnished to Medicare beneficiaries in any health care facility and in their home—allowing services to be provided in patients' homes and outside rural areas. ACP has long-standing policy in support of lifting these geographic site restrictions that limit reimbursement of telehealth services by CMS to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in health professional shortage areas. While limited access to care is prevalent in rural communities, it is not an issue specific to rural communities alone. Underserved patients in urban areas have the same risks as rural patients if they lack access to in-person primary or specialty care due to various social drivers of health such as lack of transportation or paid sick leave, or sufficient work schedule flexibility to seek in-person care during the day, among many others.

Even before the pandemic, mental health professionals were limited, and the need for mental health and substance use treatment is growing exponentially. The pandemic and fear of seeking in-person care has exacerbated this issue. Accordingly, we are pleased that in the 2022 Medicare Physician Fee Schedule Rule that CMS is broadening the scope of services for which the geographic restrictions do not apply and for which the patient's home is a permissible geographic originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the PHE. ACP supports any efforts to expand access to mental and behavioral health services, including allowing beneficiaries to access services from home, or if the technology is not available at home, from a rural health clinic or hospital.

Telehealth Cost Sharing Waivers

ACP appreciated the flexibility previously provided by CMS to allow clinicians to reduce or waive cost-sharing for telehealth and audio-only telephone visits for the duration of the PHE. This critical action has led to an increased uptake of telehealth visits by patients. At the same time, we call on CMS, or preferably Congress, to make up the difference between these waived copays and the Medicare allowed amount of the service. Many practices are struggling or closing. It is critical that CMS and other payers not add to the financial uncertainties already surrounding physicians. Given the enormity of the COVID-19 pandemic, cost should not be a prohibitive factor for patients in attaining telehealth services, including those related to mental and behavioral health treatment.

The College believes that the patient care and revenue opportunities afforded by telehealth functionality will continue to play a significant role within the U.S. healthcare system and care delivery models, even after the PHE is lifted. At the conclusion of the COVID-19 PHE, ACP recommends that Congress urge, or if necessary, require CMS to continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare allowed amount of the service. This action in concert with others has the potential to be transformative for practices while allowing them to innovate and continue to meet patients where they reside.

Ensure Health Equity in Access to Telehealth Services

A February 2021 study in Health Affairs examined data of 16.7 million commercially insured and Medicare Advantage enrollees from January to June 2020 and noted that telemedicine use was lower in communities with higher rates of poverty (31.9 percent versus 27.9 percent for the lowest and highest quartiles of poverty rate, respectively). Across specialties, the use of any telemedicine during the pandemic ranged from 68 percent (endocrinology) to 35 percent (primary care), to 9 percent (ophthalmology).

As noted in another recent study, health equity in medicine is a real issue and there are disparities in access to telehealth technology. For those in rural and underserved communities, the nearest clinic may be hours away. Unfortunately, rural communities also suffer from more limited access to broadband internet, which restricted the ability of many in rural communities to access telemedicine pre-pandemic. Additionally, research shows that Black and Hispanic Americans own laptops at lower rates than White Americans, further dividing pre-pandemic access to telemedicine. Equitable access to broadband internet is critical to the promotion of health equity and quality of care outcomes through telehealth. ACP is supportive of provisions in the Infrastructure Investment and Jobs Act that was enacted into law providing $65 billion to upgrade our broadband infrastructure to ensure that every American has access to a reliable high-speed internet. This investment is key to eliminating the digital divide, the gap between those who have access to technology or the Internet and those who do not, typically on the basis of higher versus lower socioeconomic status.[11]

Improve Mental Health Parity with Increased Federal Oversight and Enforcement

One of the barriers to true integrated primary and behavioral health care are the likely instances of noncompliance by insurance plans with mental and SUD coverage parity required by federal law. While the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity for mental health and SUD coverage, state and federal oversight and compliance efforts have been uneven. Unfortunately, according to the Government Accountability Office (GAO), the true nature of the problem of noncompliance with MHPAEA is not well known.[12] While noncompliance violations have been reported, these complaints were relatively small in number and not considered a true snapshot of the magnitude of noncompliance. While the GAO found that insurance-plan compliance with federal parity law was key to coverage parity, federal agencies are only aware of a small number of patient complaints and discovered violations of coverage parity law.

In addition, the GAO found that when federal agencies did engage in compliance reviews for coverage parity that there was a high rate of insurance plan violations. This frequency, the GAO determined, could indicate that insurance-plan noncompliance with mental health and SUD coverage parity law could be a common occurrence.[13] In response, the GAO recommended that the federal government should determine whether current targeted oversight of compliance efforts are sufficient and effective and then develop better ways in which to enforce MHPAEA as well as attain greater oversight authority if needed.[14] ACP strongly recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that remain barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws, including oversight and compliance efforts by federal and state agencies.[15]

Conclusion

We appreciate the commitment of the Ways and Means Committee to examine the state of mental health in America and to craft solutions both during and post-COVID-19 so that patients will receive the treatment and services necessary to improve their physical and mental health. We look forward to working with the Committee to adopt the recommendations outlined in this statement and are happy to provide guidance of internal medicine physicians as a resource as you draft legislation concerning this issue. Please contact George Lyons, Jr., Director of Legislative Affairs, by phone at (202) 261-4531 or via email at glyons@acponline.org with any further questions or if you need additional information.

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