



**Statement for the Record
American College of Physicians**

**To the United States Senate Committee on Health, Education, Labor and Pensions
On**

**“Examining Our COVID-19 Response: Using Lessons Learned to Address Mental Health and Substance
Use Disorders”**

April 28, 2021

The American College of Physicians (ACP) is pleased to submit this statement and offer our views regarding mental health and substance use disorders (SUDs) and how they relate to the public health emergency (PHE) caused by Coronavirus (COVID-19). We greatly appreciate that Chair Murray, Ranking Member Burr, and the Health, Education, Labor and Pensions (HELP) Committee have convened this hearing, “Examining Our COVID-19 Response: Using Lessons Learned to Address Mental Health and Substance Use Disorders,” held on April 28, 2021. Thank you for your commitment to ensuring that clinicians have the opportunity to share their views about the response to the PHE caused by COVID-19 including how we can use the lessons learned during the PHE caused by COVID-19 to improve how the medical community treats patients with mental health and SUDs. Through the experiences of its physicians on the frontlines of furnishing primary care during the COVID-19 pandemic, ACP would like to share its input and recommendations surrounding COVID-19 and mental health and substance use disorders (SUDs), including integrating primary care and behavioral health, expanding the available tools to treat mental health SUDs, and increasing the physician workforce.

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 163,000 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.

The Pandemic Increased Demand for Mental Health and Substance Use Disorder Services

Recently, the U.S. Government Accountability Office (GAO) released a report, [Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID-19 Pandemic](#). The purpose of the report was to determine if the need for and access to mental health and SUD services varied as the availability to care diminished during the PHE caused by COVID-19. The report showed several concerning trends. 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 was 26 percent higher and suicide attempts was 36 percent higher for

the time period of mid-March through mid-October 2020 when compared to that period during 2019. The Substance Abuse and Mental Health Services Administration (SAMHSA) found that in September 2020 opioid deaths in certain sections of the United States increased anywhere from 25 to 50 percent when compared to the same time during 2019. SAMHSA data also showed that contacts by individuals to the Disaster Distress Helpline increased during the PHE caused by COVID-19 in 2020 over comparable timeframes in 2019. For example, between March and August 2020, calls hit a high in April 2020 at almost 10,000 calls, which is an 890 percent increase over April 2019. In August 2020, a survey conducted by the National Council for Behavioral Health's (NCBH), found that over half of their member organizations an increased in demand for their services in the three-month period before the survey. A February 2021 follow-up survey by NCBH discovered that the demand for services had increased by 67 percent.¹ Clearly, the U.S. population has experienced a sharp increase in mental health issues and SUDs during the COVID-19 pandemic.

Mental Health and Substance Use Disorder Workforce Shortage Made Worse by the COVID-19 Pandemic

Meanwhile, persistent mental health and SUD workforce shortages from before the pandemic only worsened during the 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 provider 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.² SAMHSA reported that due to a combination of reasons, including laying off of staff and the closure of clinicians 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 of staff and 23 percent furloughing staff, resulting in 68 percent of member organizations canceling, rescheduling, or turning away patients.³ Not unexpectedly, the demand for mental health and SUD services rapidly increased during the PHE caused by COVID-19 while at the same time access to these services diminished.

Integrate Primary Care and Behavioral Health

ACP strongly supports the integration of behavioral health care into primary care and encourages its 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 "whole-person" 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. For example, 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. The Affordable Care Act incentivized the development of Medicaid health homes, which promote addressing behavioral health issues in the primary care setting. 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

ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work to remove 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.⁵

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 research evidence, while limited, does support the efficacy of this approach.⁶ The Behavioral Health Integration (BHI) Collaborative, in which ACP participates, has found that benefits of integration can include promoting long-term value, improved patient satisfaction, and reducing the stigma of mental health issues and SUD.⁷ Primary care physicians also support integrated care and report that the integrated care model encourages better communication and coordination among behavioral health and primary care physicians and reduces mental health stigma.⁸

Accordingly, Congress can and should take action to encourage primary care and behavioral health integration. Congress could establish grant programs with adequate funding to incentivize primary care uptake of the various integrated care models. These grants could help defray costs of establishing and delivering integrated primary and behavioral health services. These costs can include but are not limited to, hiring additional staff such as behavioral health managers, contracts with other needed healthcare clinicians such as psychiatrist consultants and behavioral health managers, and purchasing or upgrading software and other resources to provide new services such as more coordinated care. Congress could also encourage additional payment models that potentially facilitate integrated care include bundling payments, partial and full capitation, and even fee-for-service. For example, additional fee-for-service payment codes could be aligned to incentivize integration by establishing payment for behavioral health–primary care consultations, multidiscipline care plan development, and related activities.⁹

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.¹⁰ Federal research agencies, such as the Agency for Healthcare Research and Quality (AHRQ) are well situated to study the best ways of integrating behavioral health care in the primary care setting and Congress should provide the resources to so.

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 GAO, the true nature of the problem of noncompliance with MHPAEA is not well known.¹¹ 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.¹² 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.¹³ 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.¹⁴

Make Naloxone More Available to Prevent Overdoses

ACP supports funding to distribute naloxone to individuals with opioid use disorder to prevent overdose deaths and train law enforcement and emergency medical personnel in its use. A 2019 CDC report found that not all individuals in need of naloxone are receiving it due to prescribing and dispensing variations across the country. The CDC recommended actions to improve naloxone access such as reducing patient insurance copays, enhancing clinician training and education, and focusing allocation, especially to rural areas.¹⁵ Legal protections (that is, Good Samaritan laws) should continue to be established or refined to encourage use of naloxone and the reporting of opioid overdoses in instances where an individual's life is in danger. A GAO review found that overall state Good Samaritan laws helped in reducing deaths by overdose and that states that enacted such laws have lower rates of opioid overdose deaths when compared to before the law's enactment or to states without these laws at all.¹⁶ Physician standing orders to permit pharmacies to provide naloxone to eligible individuals

without a prescription should be explored. Insurance and cost related barriers that limit access to naloxone should also be addressed. As the need for naloxone has grown, so has its price. In response, government representatives and private sector entities have partnered to make bulk purchases of naloxone at substantial discounts for state and local jurisdictions fighting the opioid epidemic. These and other efforts must be accelerated to ensure that naloxone continues to reach those in need.¹⁷

Expand Medication-Assisted Treatment (MAT) for Physicians

In order to expand access to medication-assisted treatment (MAT) of opioid use disorders, improved training in the treatment of substance use disorders is necessary, including for buprenorphine-based treatment. Pre- and postbuprenorphine training support and education tools and resources should be made available and widely disseminated to assist physicians in their treatment efforts. Physician support initiatives, such as mentor programs, shadowing experienced providers, and telemedicine, can help improve education and support efforts around substance use treatment.¹⁸ In addition, continued efforts are needed to remove barriers or administrative burdens for physicians to fully take advantage of using MAT to treat their patients, such as eliminating burdensome prior-authorization requirements. These roadblocks can delay or deny needed treatment that utilize already approved medications in the course of MAT to treat SUDs. Several states have already taken action to eliminate or reduce prior authorization requirements for MAT and Congress should explore legislative options on the federal level.¹⁹

Establish a National Prescription Drug Monitoring Program (PDMP)

ACP reiterates its support for the establishment of a national Prescription Drug Monitoring Program (PDMP). Until such a program is implemented, ACP supports efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting program. The College strongly urges prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) before writing and filling prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to ensure confidentiality and privacy. In addition to a national PDMP, ACP strongly encourages Congress to be helpful in this area by requiring efforts to facilitate the use of PDMPs, such as by linking information with electronic medical records and permitting other members of the health care team to consult PDMPs.²⁰

Conduct Research to Implement Effective Public Health Interventions

ACP believes more federal research is needed. The effectiveness of public health interventions to combat substance use disorders and associated health problems should be studied further. Public health-based substance use disorder interventions, such as syringe exchange programs (SEPs) and safe injection sites that connect the user with effective treatment programs should be explored and tested. Risky injection drug use habits, such as needle sharing, contribute to the spread of HIV, hepatitis C virus, and other blood-borne pathogens. Several SEPs have shown the potential to reduce the spread of these diseases. Indeed, the federal government has already established and funded Syringe Services Programs (SSPs) through the CDC.²¹ These community-based prevention programs have a track record of furnishing much-needed services, such as disposal of sterile syringes, vaccination, testing, infectious disease care, and most critically, SUD treatment.²² These programs may also connect individuals with other health and social services, as well as referrals to SUD treatment, as mentioned above, prevention supplies, and health screenings. As the opioid epidemic continues to increase the number of people

who inject drugs, federal and state funding should be directed to communities to prevent the spread of blood-borne diseases, such as HIV infection and hepatitis C, as well as connect people to social and health care services that can provide necessary assistance. Because safe injection facilities have not been extensively tested in the United States, state and local health officials need the resources to conduct pilot tests prior to any possible full implementation.²³

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.²⁴

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 disorder. Loan forgiveness programs, mentoring initiatives, and increased payment may encourage more individuals to train and practice as behavioral health professionals.²⁵

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.²⁶ 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.²⁷ 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 increasing the number of future physicians in the pipeline.

For example, many residents and medical students are playing a critical role in responding to the COVID-19 crisis all while they carry an [average debt of over \\$200,000](#). In addition, international medical graduates (IMGs) are currently serving on the frontlines of the U.S. health care system, both under J-1 training and H-1B work visas and in other forms. These physicians serve an integral role in the delivery of health care in the United States. IMGs help to meet a critical workforce need by providing health care for underserved populations in the United States. They are often more willing than their U.S. medical graduate counterparts to practice in remote, rural areas and in poor underserved urban areas. More must be done to support their vital role in health care delivery in the United States.

ACP supports several pieces of legislation from the 116th and 117th Congresses that should be reintroduced, if applicable, and passed in the current 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 Education Deferred Interest Act* (H.R. 1554, 116th Congress) would make it possible for residents to defer interest on their loans.
- *The Conrad State 30 and Physician Access Reauthorization Act* (S. 948, 116th Congress) and *the Healthcare Workforce Resilience Act* (S. 3599, 116th Congress), would help with medical student loan forgiveness and support IMGs and their families by temporarily easing immigration-related restrictions so IMGs and other critical health care workers can enter the U.S. to train in internal medicine residency programs, assist in the fight against COVID-19, and provide a pathway to permanent residency status.
- *The Student Loan Forgiveness for Frontline Health Workers Act* (H.R. 2418, 117th Congress) would assist frontline clinicians as they provide care during the pandemic.
- *The Dr. Lorna Breen Health Care Provider Protection Act* (H.R. 1667/S. 610, 117th Congress) is an important proposal because it aims to prevent and reduce incidences of suicide, mental health conditions, substance use disorders, and long-term stress, sometimes referred to as “burnout” among physicians themselves. 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. View ACP’s letter of support to the [House](#) and [Senate](#) for H.R. 1667 and S. 610.

In addition, ACP was encouraged that bipartisan congressional leaders worked together last year to provide 1,000 new Medicare-supported Graduate Medical Education (GME) positions in the Consolidated Appropriations Act, 2021 (H.R. 133)—the first increase of its kind in nearly 25 years—and that some of those new slots will be prioritized for hospitals that serve Health Professional Shortage Areas (HPSAs).

- ACP now calls on Congress to pass the *Resident Physician Reduction Shortage Act of 2021* (H.R.2256/S. 834, 117th Congress) which would provide 14,000 new GME positions over seven years, or 2,000 per year to build on the 1,000 new GME slots mentioned above.
- Congress should also pass the *Opioid Workforce Act of 2021* (S. 1483, 117th Congress). This bill would provide Medicare funding for 1,000 more GME positions over five years in hospitals that already have established, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

ACP also supports other physician and clinician workforce programs and we strongly supported providing \$800 million for the National Health Service Corps (NHSC) and \$330 million to expand the number of Teaching Health Centers (THC) Graduate Medical Education (GME) sites nationwide and increase the per resident allocation that were enacted in the American Rescue Plan (ARP) Act, H.R.

1319. Indeed, a recent study appearing in the *Annals of Internal Medicine* showed that in counties with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy.²⁸ Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed in order to furnish primary care, behavioral health, and SUD services. Enhanced investments in programs such as the NHSC and THCGME that increase the physician workforce should be sustained after the pandemic caused by COVID-19 has come to an end.

Conclusion

We commend you and your colleagues for working in a bipartisan fashion to examine any lessons learned about treating mental health and SUD during the COVID-19 pandemic to improve health outcomes and to develop legislative proposals to combat not only the ongoing Coronavirus crisis—but to address any issues caused by the current pandemic as well as future pandemics. We wish to assist in the HELP Committee’s efforts in this area by offering our input and suggestions about ways that Congress and federal health departments and agencies can intervene through evidence-based policies both now and beyond the PHE. Thank you for consideration of our recommendations that are offered in the spirit of providing the necessary support to physicians and their patients going forward. Please contact Jared Frost, Senior Associate, Legislative Affairs, by phone at (202) 261-4526 or via email at jfrost@acponline.org with any further questions or if you need additional information.

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