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November 15, 2021

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

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

Dear Chair Wyden and Ranking Member Crapo:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide comments on the Senate Finance Committee's request for input from health care stakeholders on legislative proposals to help improve access and address barriers to health care services for people with mental health and substance use disorders. The AAMC and our academic medicine colleagues strongly support these efforts and look forward to working with the Senate Finance Committee, policymakers, and other health care stakeholders to engage in and provide input to this important conversation.

The AAMC is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the sciences.

We appreciate your efforts to improve patient access to quality mental health care and to ensure our nation's health infrastructure is able to support the increasing demand in the wake of the public health emergency (PHE). In addition to exacerbating longstanding barriers and challenges among adults, the PHE has also affected the mental health of the pediatric population. The American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Children's Hospital Association (CHA) have declared a national emergency in children's mental health, citing the serious toll of the COVID-19 pandemic on top of existing challenges. This declaration is unprecedented. To address this crisis, the AAMC has endorsed specific stakeholder recommendations to increase support for pediatric mental health such as strengthening Medicaid, extending and preserving telehealth flexibilities, strengthening care through better coordination and integration, and supporting an increase in the number or pediatric mental health workforce.[1]

[1] https://www.aamc.org/media/55726/download?attachment

The AAMC is committed to doing our part in addressing the significant mental and behavioral health challenges in the U.S. The AAMC Strategic Plan, comprised of ten action plans and released in October 2020, was developed to have an impact on a broad array of critical national health issues that span academic medicine's missions of care delivery, medical education, research, and community collaborations. A key action plan is "Improving Access to Care for All," with a special focus on mental and behavioral health and, specifically, integrated behavioral health care and maternal mental health. This work builds on our efforts over several years to support medical schools and teaching hospitals in better preventing, identifying, and treating substance use disorders. We look forward to helping inform the Committee's understanding of these important issues and working together as you develop policy proposals.

Integrated Behavioral Health Care

Integrated Behavioral Health (IBH) involves medical and behavioral health clinicians working as a multidisciplinary team partnering with their patients and patient families to address medical conditions and behavioral health factors that affect health and well-being. The general aim is to integrate mental/behavioral health with primary and/or specialty medical services. This multidisciplinary team can include mental health care providers with a range of training/credentials including licensed clinical social workers, licensed mental health therapists, psychologists, psychiatrists, peer support, and community health workers. These providers can function in many different roles including direct care, care coordination, providing consultation to the medical team, and through the use of different care modalities—in-person and telehealth.

IBH models help to reduce the stigma around mental health services, as patients can conveniently receive mental health care within the primary care (medical home) or specialty care clinical setting, rather than seeking out a mental health provider in another setting. This model is especially beneficial in rural settings where many patients may be reluctant to seek care in community behavioral health settings because it may be obvious in their small communities that they are receiving mental health care. This model also reduces the risk of fragmentation and improves care coordination, as medical and mental health conditions are co-managed. There is significant research that shows that this model improves mental health outcomes, patient satisfaction, and reduces health care costs. More in-depth information on these issues can also be found in a March 2021 Bipartisan Policy Center report, "Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration." IBH models can also incorporate services for substance use disorders (SUDs). Integrated care including medication assisted treatments, and support services— hold potential to offer tangible clinical benefit in the form of reductions in substance use and marginalization and stigmatization of SUDs.

Academic medical centers (AMCs) have implemented a wide variety of IBH models. The University of Washington, who developed the Collaborative Care Model, uses IBH throughout their primary care and specialty clinics. The mental health delivery models are determined based on the patient needs in each clinic. The University of Colorado has an extensive IBH program in their Family Practice division, but with strong senior leadership commitment is looking to expand the model system-wide. IU Health has an IBH model that supports all their primary care clinics in both rural and urban areas utilizing on-demand telehealth consults with a psychiatrist. And while these programs are looking to expand, a critical issue across the board is sustainability given that many of these programs are supported through grant funding. Thus, sustainability for IBH broadly has been variable.

Recommendations to Facilitate IBH Expansion

The many evidence-based benefits of these IBH models, current payment structures, workforce training, and inadequate interoperability in health information technology are some of the challenges faced by AMCs in implementing them. To facilitate behavioral health integration that will improve clinical outcomes for mental health, several recommendations are described in further detail below.

Appropriate Payment for the Psychiatric Collaborative Care Model (CoCM)[2]

The Psychiatric Collaborative Care Model (CoCM) is a type of BHI model that enhances primary care by including mental/behavioral care management support, regular psychiatric inter-specialty consultation, and the use of a team that includes the Behavioral Health Care Manager, the Psychiatric Consultant, and the Treating (Billing) Practitioner. It was developed through the AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington and is used throughout their system. Various AAMC-member institutions across the country use modified versions as well, and it has also been modified to incorporate telehealth visits.

Improvements in payment for the CoCM would facilitate expansion of integrated care. The CoCM model promotes care integration within Medicare but does not extend to all insurance and/or Medicaid plans. Even within Medicare the payment codes are severely limited, allowing for only 70 minutes of integrated care the first month, 60 minutes in subsequent months, and 30 minutes of additional time each month. We recommend the Committee explore policy proposals to expand coverage and payment under this model.

Eliminate Mental Health Carve-Outs

Mental health carve-outs that occur when mental health services are removed from a policyholder's medical coverage and are provided through a contract with a separate mental/behavioral provider or insurance company are the antithesis of integrated behavioral health and should be re-evaluated. When mental health is carved out, patients are forced to navigate another network where they often cannot find the services they need due to lack of provider availability and coverage. Care coordination, which is challenging within the same network, is even more complicated when working with outside networks. The Committee should re-evaluate carve-outs, and ensure payors move towards models that support increased access to mental/behavioral health and coordination of care.

Improve Coverage for Behavioral Health Services and Inclusion in Networks

The number of mental health providers in many insurance plan networks is often inadequate and can result in very long wait times for patients. Despite the enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA), there remains a disparity in both out-of-network utilization rates for behavioral health services as well as provider reimbursement rates.[3] Primary care physicians often are

[2] Behavioral-Health-Integration-Services-(MLN909432)-2021-3 (hhs.gov)

[3] https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx

unable to identify available behavioral health providers within the network for timely patient referral. Additionally, it is cost prohibitive for patients to access mental health providers that are out of network. The Committee should consider policies to increase coverage and payment and improve network adequacy standards for mental health services across insurance providers to ensure sufficient provider participation.

Address Workforce Shortages

There is currently a shortage of mental health providers. Data from the Health Resources and Services Administration shows that an estimated 122 million Americans, or 37% of the population, lived in one of 5,833 mental health professional shortage areas as of March 31, 2021. The nation needs an additional 6,398 mental health providers to fill these shortage gaps. In many cases, providers that do offer behavioral health services do not accept insurance, which further exacerbates the shortage of available providers. Patients and primary care providers need to be able to access behavioral health care providers for consultations and referrals. This is discussed further in the following section.

Allow Payment for Services of All IBH Team Members

Currently not all members of the collaborative care team and IBH team members can bill for services because they do not fall under the definition of qualified providers. We recommend the Committee consider policies to ensure that the services provided by the IBH care team are billable. This includes, for example, peer support specialists and community health workers.[4] These specialists can assist with coordination and integration of behavioral care.

Improve Value-Based Payment Models to Promote Integration

Value-based payment models can act as a mechanism for promoting behavioral health integration. In order to do so, quality measures need to be updated to accurately represent behavioral health metrics and to ensure the measures improve health disparities in behavioral health outcomes. Currently, there are very few metrics that measure behavioral health care or that promote its integration. Appropriate financial incentives should also be established so that providers in value-based models provide coordinated behavioral health. While we believe integrated behavioral health models are the best way to accomplish this, there may be other models that increase access to care and achieve the same goal in improving patient outcomes.

Ensure Mental Health Parity Enforcement

In both the Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act Congress required health plans to cover treatment for mental health in a manner that is equivalent to their coverage of physical health conditions. The Committee should consider a comprehensive parity enforcement program to ensure that plans are adhering to these requirements.

[4] BPC_Behavioral-Health-Integration-report_R01 rcm highlights and comments 7-21.pdf (page 69)

Promote the Use of Telehealth

Telehealth can increase access to mental health services. During the PHE, telehealth flexibilities and waivers have been effective in improving access to these services. Recognizing the important role of telehealth for mental health services, in the Consolidated Appropriations Act, 2021 (CAA), Congress removed geographic restrictions and permits the home to be an originating site for telehealth services for the treatment of mental health disorders. However, the statute requires an initial in-person visit no more than six months prior to the first telehealth visit. We believe the in-person requirement is unnecessary and that it will disincentivize patients from seeking the care they need. This is discussed further in the telehealth section.

Increase Funding to Support IBH Programs

Behavioral health services are traditionally underfunded. In order to incentivize providers to participate in IBH, reimbursement needs to be increased to accurately represent the time, cost, and expertise necessary to provide this care. Reimbursement challenges and the lack of financial incentives for IBH models make it difficult to maintain long-term viability of the limited programs that already exist, and disincentive new programs from starting. Additionally, many of the current programs experience financial limitations, as they are supported by grant funding, which is not sustainable for the long-term. There are also significant up-front costs associated with the IBH model. For example, space is needed to accommodate additional team members and rooms suitable for a behavioral health visit. Increased reimbursement would help offset the costs associated with the education and additional training for PCPs, specialists, and other members of the IBH team to effectively implement and operationalize the IBH model. Lastly, electronic medical record (EMR) integration is required to support effective communication and coordination between IBH team members.

I. Preventing Emergency Department Overcrowding

The issue of patients experiencing mental health challenges presenting to the emergency department (ED) is a complex one. The ED is usually not the most appropriate care site for such patients and can result in fragmentation of care. Most EDs are not equipped to develop a coordinated care plan including follow-up outpatient care, and many such patients return to the ED frequently. This can also result in ED overcrowding and diversion of resources from cases that need emergency/urgent medical intervention. Some institutions have implemented virtual mental health consultations from the ED; however, this has been limited and can only serve a small percentage of patients. It also does not address longer term follow-up care needs.

The key to addressing this issue is to move upstream and identify and treat patients before they present in the ED. Approaches to accomplish this include expanding the availability of mental/behavioral health providers within health plan networks to ensure enough providers are available to patients. Additionally, improvements can be achieved by educating and training law enforcement professionals to ensure those patients suffering a mental health breakdown are treated through community mental health resources and not systematically brought to the ED or, even worse, sent through the correctional system inappropriately. In addition to law enforcement, it is also important to train mobile crisis teams that can help prevent the unnecessary use of law enforcement when situations can safely be handled by teams that are expert in de-escalation. There is significant urgency to find solutions to the issues of ED

overcrowding, particularly in pediatric settings. A recent article in the NEJM Catalyst in September 2021 summarized the problem: "The profound lack of both inpatient and outpatient psychiatric and substance use services, and the labyrinthian processes for psychiatric services driven by byzantine insurance coverage, have placed extraordinary pressure on EDs. Further, inpatient psychiatric beds have decreased." [5]

Since all health care is local, it is difficult to fully address mental health services and the social determinants of health of a community at a federal or national level. However, programs such as the Crisis Assistance Helping Out On The Streets (CAHOOTS) program in Oregon, championed by Chair Wyden, or the RIGHT Care Program at Parkland in Texas are examples of programs that could be supported at the federal level to address these patients and provide the services they need, and the AAMC urges the Committee to examine them. The Committee should also build on previous investments in community-based mental health services to assist communities across the country with CAHOOTS-like services. Capitalizing on these models on a larger scale will require establishing sustainable financing models, supported by public payers and commercial plans whose members rely on these services.

II. Increasing Mental Health Support During the Perinatal Period

Broadly defined as the time frame from one year before to 18 to 24 months after the birth of the child, the perinatal period is critically important to the psychological health and wellbeing of both mother and child. Supporting women during this time-period, and beyond, is essential to helping reduce the rates of perinatal depressive symptoms and pregnancy-related complications, such as premature birth. Mental health issues including, but not limited to, anxiety, depression, psychosis, and postpartum obsessive-compulsive disorder affect thousands of pregnant women each year. Yet, few are screened or treated for these various disorders. Additionally, it is crucial to note that socioeconomic stressors, history of substance use, and family mental health history can exacerbate symptoms of the disorder. More needs to be done at both the federal and state levels to close this unacceptable gap in care. Universal screening and improved coordinated services between the physician, mental health provider, and patient, as well as early intervention are all necessary components to increase support during the perinatal period.

The AAMC is supportive of congressional efforts to improve maternal health outcomes and was pleased to see Congress support policies that would require states to provide continuous Medicaid coverage for pregnant individuals up to 12 months postpartum. This would improve maternal morbidity and mortality by ensuring that women are able to access the postpartum care they need longer than the current 60 days required by law. Other crucial investments under consideration include increased funding to grow and diversify the maternal mental health and substance use disorder treatment workforce and much needed support for maternal mental health equity grants. The AAMC is supportive of these investments and urges Congress to pass them.

[5] Emergency Department Crowding: The Canary in the Health Care System Gabor D. Kelen, MD, Richard Wolfe, MD, Gail D'Onofrio, MD, MS, Angela M. Mills, MD, Deborah Diercks, MD, Susan A. Stern, MD, Michael C. Wadman, MD, Peter E. Sokolove, MD DOI: 10.1056/CAT.21.0217

III. Strengthening the Physician Workforce

Physicians are a critical component of our nation's health care infrastructure, and we must train more to meet both the current and future needs of our nation. The COVID-19 pandemic exposed significant barriers to primary and specialty care and highlighted the rising concerns of physician burnout and retirement. Additionally, it exacerbated and exposed the critical shortage of behavioral and mental health providers that patients face. According to the AAMC Consumer Survey of Health Care Access in 2016, 23% of respondents who said they needed mental or behavioral health care in the previous 12 months reported that they were unable to access the care and most of the reasons were related to not being able to find a provider[6]. This is on top of the fact that as our population grows and ages, the demand for physicians continues to grow faster than the supply, resulting in an estimated overall shortfall of between 37,800 and 124,000 primary care and specialty physicians by 2034.[7]

To help meet this growing need, bipartisan health care leaders in the Senate introduced both the Resident Physician Shortage Reduction Act of 2021 (S. 834) and the Opioid Workforce Act of 2021 (S. 1438). The Resident Physician Shortage Reduction Act would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. These new positions would be targeted to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas, hospitals in states with new medical schools or branch campuses, and hospitals already training over their Medicare caps. The Opioid Workforce Act would increase support for the number of physicians trained in pain medicine, addiction medicine, or addiction psychiatry, thereby increasing and improving access to the treatment these patients need.

At the end of 2020, a broad bipartisan coalition of members of Congress representing diverse districts, states, and communities worked together to provide, 1,000 new Medicare-supported graduate medical education (GME) positions in the CAA – the first increase of its kind in nearly 25 years. This increase in residency positions was an important initial investment and first step, but more is needed to help ensure that patients throughout the country can access the primary and specialty care they need.

The Committee should build on this bipartisan success by enacting policies that would provide additional Medicare-supported training GME positions. We strongly support this policy approach and urge the Committee to continue investment in Medicare support for GME as it is critical to increasing access to behavioral and mental health care.

IV. Telehealth

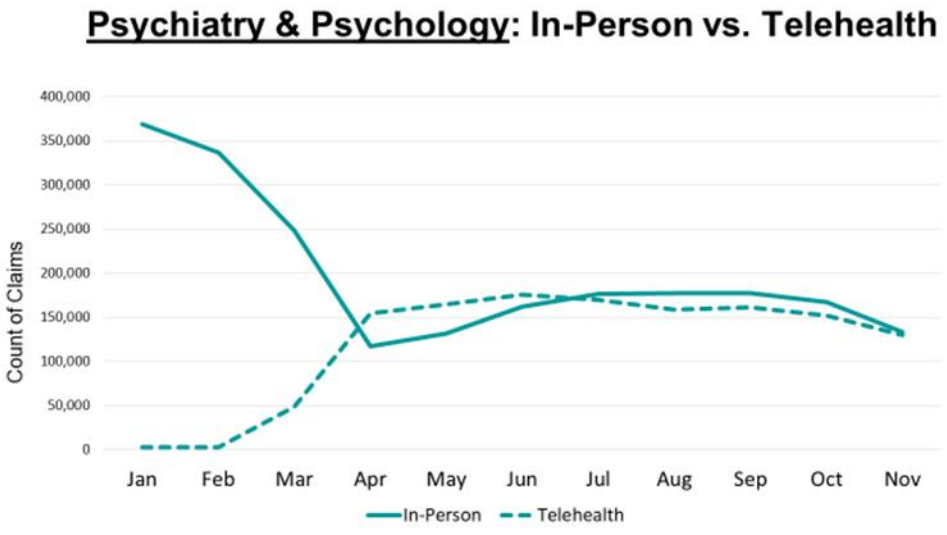
The AAMC appreciates the work that Congress and the Centers for Medicare and Medicaid Services (CMS) have done to improve access to behavioral health during the PHE by creating flexibility around the use of telehealth. However, there is still more work that needs to be done to address barriers to telehealth services and ensure access to care. We recommend the Committee explore and consider the following options to enhance the delivery of telehealth services and increase patients' access to behavioral and mental health care.

[6] https://www.aamc.org/what-we-do/mission-areas/health-care/workforce-studies/resources

[7] The Complexities of Physician Supply and Demand: Projections from 2019-2034, Association of American Medical Colleges: https://www.aamc.org/media/54681/download

Expanding Coverage of Telehealth for Mental Health Services and the Impacts of Expansion

During the PHE, telehealth has significantly increased accessibility of behavioral health services. The removal of Medicare's geographic and site of service limitations on behavioral telehealth services allowed for these services to continue, particularly when in-person visits were not possible. There has also been a reduction in missed appointments in behavioral health services because telehealth expansion has made it easier for patients to receive care. The AAMC analyzed data from the Clinical Practice Solutions Center (CPSC)[8] for psychiatry and psychology services submitted by faculty physician practices. The graph below illustrates psychiatry and psychology services that were furnished in-person or via telehealth from January 2020 to November 2020. In April, at the height of the PHE, telehealth visits for psychiatry and psychology surpassed fifty percent of total services. The use of telehealth remained high throughout the year, at roughly 50 percent. Data also show that there were fewer missed appointments for behavioral health services provided by telehealth compared to in person visits.



Source: AAMC analysis of physician claims billed by Faculty Practice Plan members of the Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a jointly owned product of the Association of American Medical Colleges (AAMC) and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

Note: 70 CPSC members had shared their claims data through November at the time of this analysis (March 2021). "Total encounters" includes all in-person and telehealth claims payable under the Medicare Physician Fee Schedule when furnished via telehealth, as outlined by CMS for the COVID-19 Public Health Emergency, effective March 1, 2020 and updated 4/30/2020: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. Telehealth encounters were identified based on place of service = 02 or modifiers 95, GT, GQ, G0 on the claim; CPT codes G2010, G2012, 99451, 99452, 99446-99449, 99421-99423, 99091, 99457, 99458, 99473, 99474, and 99493-99495 were also counted as telehealth. Claims are across all payers and from service sites 02 – Telehealth, 11 – Office, 19 – Off Campus Outpatient Hospital, 21 – Inpatient Hospital, and 22 – On-Campus Outpatient Hospital

AAMC

We commend Congress for passing the CAA, which enabled Medicare beneficiaries which made permanent the option to receive services via telehealth for purposes of diagnosis, treatment, or evaluation of mental health disorders (in addition to substance use disorders, which was previously allowed) in all geographic regions of the country and locations, including the home. To be eligible to receive the services via telehealth, the beneficiary must have been seen in person at least once by the physician or nonphysician practitioner during the six-month period prior to the telehealth service, and subsequent periods as determined by the Secretary of HHS.

[8] The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance

In the Medicare 2022 Physician Fee Schedule Final Rule CMS implemented the CAA provisions that removed geographic location requirements and allowed patients in their homes access to telehealth services for mental health disorders. The statutory language requires an in-person visit during the six months before a telehealth visit and gives CMS authority to determine a "regular" interval for subsequent in person visits. In the physician fee schedule rule, CMS required an initial in-person visit within 6 months and subsequent in person visits every 12 months. An exception to the subsequent in-person visit requirement is permitted based on a patient's circumstances. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can receive payment for mental health services provided by telehealth and audio-only technology under the same limitations and restrictions.

We believe that an in-person visit requirement is unnecessary and that it acts as a significant barrier to care for those who rely on mental health services. This barrier will disproportionally affect more vulnerable populations who — because of their job, lack of others to help care for their dependents, transportation issues, and other limitations — are not able to attend an in-person visit.

In order to prevent this, the Committee should consider policies to remove the initial 6-month in-person requirement. While some exceptions are allowed for the 12-month subsequent in person visit requirement, we remain concerned that this requirement could also jeopardize patient access to care.

Equally Reimburse Behavioral Health Services Furnished via Telehealth

Behavioral health furnished via telehealth should be paid at the same rate as in-person visits because these crucial services incur additional costs and require additional time and effort on behalf of the providers. The development of video capabilities requires health systems to invest significant resources in technology, training, and infrastructure. Achieving this efficiency for patients requires substantial effort – a fact that may be easily overlooked.

There are many key components to conducting an efficient, effective, patient-focused video visit. A video visit requires infrastructure and support (both ancillary provider and technical), just as is needed for a successful in-person visit.

Before offering video visits to patients, the following components must be in place to conduct seamless, high-quality video visits:

- A video platform that is HIPAA compliant, accessible, user-friendly, and compatible with patient-owned devices, integrates with EMR scheduling, and enables multiple concurrent participants (e.g., learners, patient family members);
- Sufficient internet access and bandwidth for providers and patients;
- Devices (e.g., webcams, headsets, peripheral devices) for providers and patients;
- Established workflows and staffing in place to ensure effective appointment scheduling, notifications, reminders for providers and staff, and learner supervision as necessary;
- Protocols and infrastructure in place for managing patient side emergencies;
- Effective technology training for providers and staff, including real time technical support for providers and patients with contingency plans in place for when failures occur; and
- Private location where others cannot hear or see the patient interaction.

It is important for payors to recognize and reimburse for the infrastructure and staffing costs associated with telehealth care, beyond the clinician's time and clinical expertise. Providers need to employ nurses, medical assistants, and other staff to engage patients before, during, and after telehealth visits to coordinate pre-or-post visit care and ensure a seamless experience. For telehealth to effectively enable better access to care for patients, and better care through timely and effective management of patients' needs, reimbursement for services needs to be commensurate with the costs of providing care through video visits. As telehealth options continue to grow, recognizing the core elements needed for a successful video visit will help providers, patients, health systems, and payors assess cost, appropriately assign resources, and be better prepared for the future of health care.

Behavioral Health Services Furnished by Audio-only Technology

During the PHE, coverage and payment for audio-only calls has been critical to ensure access to care for some patients. Physicians have been able to provide a wide array of services efficiently, effectively, and safely to patients using the telephone. Coverage of these audio-only behavioral health services is particularly important for patients who may not have access to, or may not feel comfortable with, interactive audio/video technologies. Initial reports suggest that lack of audio-only services particularly affects vulnerable populations, including the elderly, those with low socioeconomic status, and certain races and ethnicities. Providers have also found that when treating certain mental health conditions, such as post-traumatic stress disorder, patients often benefit from obtaining services without visual contact with their provider. Audio-only technology allows patients to communicate with providers while maintaining a sense of privacy. The AAMC commends CMS for finalizing payment for audio-only mental health services in the 2022 physician fee schedule.

To avoid exacerbating disparities in access to behavioral health care, it is important that payors continue to pay for audio-only services while improving access to broadband. Patients in rural areas, those with lower socioeconomic status, and those of certain races and ethnicities are more likely to have limited broadband access and may not have access to the technology needed for two-way audio-visual communication. The Pew Research Center found that about a third of adults with household incomes below $30,000 per year do not own a smartphone and about 44% do not have home broadband services.[9]

The AAMC was pleased to see that Congress included $65 billion in the bipartisan Infrastructure Investment and Jobs Act to expand broadband across the country, but more is undoubtedly needed to ensure adequate patient access to care.

Enabling Peer-Mentored Care and Provider-to-Provider Telehealth Modalities to Support Behavioral Health Access

Provider-to-provider telehealth modalities and peer-mentored care are key tools to help support access and care coordination through IBH. These tools include interprofessional consults (e.g., eConsults), synchronous tele- and video-consultation, and Project ECHO, which help to expand the scope of practice for primary care and community-based providers and other front-line staff. eConsult programs

[9] ASPE Issue brief: Medicare beneficiary use of telehealth visits: Early Data from the Start of the COVID-19 Pandemic (7/18/2020); Health Affairs Blog; Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19. July 15, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/abs

help to increase primary care comprehensiveness and provide a pathway for PCPs to solicit feedback and guidance from their specialist colleagues. The AAMC has worked with over 40 academic health systems across the country to support implementation of eConsults throughout their health care systems. One of these partners, Oregon Health & Science University (OHSU), launched their eConsult program in March 2016 and it is now available in 26 adult and seven pediatric specialties throughout OHSU, including Adult and Women's Psychiatry, with over 13,300 eConsults completed. Improvement in the current structure of the interprofessional consult codes used by eConsults would benefit patients by removing barriers and promoting the use of interprofessional consults.

Remove Coinsurance Requirement for Interprofessional Consults

CMS requires that providers collect coinsurance from their patients when billing for CPT codes 99451 and 99452 for all interprofessional consults. We believe the coinsurance requirement is a barrier to providing these important services for several reasons. First, given the structure of two distinct codes, patients are responsible for two coinsurance payments for a single completed interprofessional consult - one for the treating provider (99452), and one for the consulting provider (99451). While we believe that it is appropriate to reimburse both providers for their work in conducting the internet interprofessional consultation, two coinsurance charges to the patient for what they perceive is a single service will predictably introduce confusion.

Interprofessional consults are often used for patients with new problems who are not established within the consulting specialty's practice and therefore do not have an existing relationship with the consultant. A coinsurance bill for a service delivered from a provider that is unknown to the beneficiary could cause the patient to believe a billing error has occurred. This would place an undue burden on the practice's billing staff to address questions about billing. Additionally, if presented with the option of an interprofessional consult coinsurance payment versus a visit coinsurance payment, patients may elect to see the specialist in-person, which would be unnecessary and negatively impact the potential savings of these interprofessional consults.

While the AAMC recognizes there are typically limited scenarios where coinsurance is waived in the Medicare program, we continue to believe that the "two coinsurances" issue will stifle use of these value-promoting, physician-to-physician services that analyses of the Center for Medicare and Medicaid Innovation (CMMI)-funded CORE model show to be cost-saving to the Medicare program. Therefore, waiving coinsurance for these codes under the Medicare fee-for-service program would remove barriers and improve patient access to care.

Ensure Access to Behavioral Health via Telehealth Delivered Across State Lines

Congress should allow patients to access behavioral health services via telehealth delivered across state lines on a permanent basis. As part of the COVID-19 response, Congress and CMS have allowed providers to be reimbursed by Medicare for telehealth services across state lines. This waiver creates an opportunity to improve patient access to services and to help improve continuity of care for patients who have relocated or who have traveled to receive their surgery or other services from a specialist in another state. While CMS has the authority to allow for payment under federal programs, states need to act to

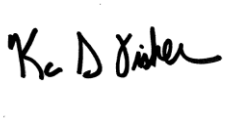
allow practice across state lines to occur. The AAMC urges Congress to pass the Temporary Reciprocity to Ensure Access to Treatment (TREAT Act, S. 168). This bipartisan, bicameral legislation would expand care for patients by creating a temporary uniform licensing standard for all practitioners and professionals that hold a valid license in good standing in any state to be permitted to practice in every state – including in-person and telehealth visits – during the COVID-19 public health emergency.

Addressing Issues in Health Information Exchange

As health systems and community-based organizations implement technology-based solutions and programs to improve behavioral health care, addressing the various technology barriers must be acknowledged and addressed. First, lack of interoperability prevents communication across platforms and providers, which is a barrier to providing seamless and holistic care for patients. Second, the barrier referred to as the digital divide prevents certain populations, particularly the underserved and vulnerable, from fully accessing digital services. Additionally, there is a need for greater infrastructure of health systems and community resource partners to implement and use the technology, including training and educating both providers and patients. Addressing these barriers can ensure that technology narrows today's disparities rather than exacerbating them. Congress and the federal government have a role to play in addressing these barriers and can help to alleviate these issues by promoting the use of technology without mandates and incentives which impede reaching interoperability, investing in infrastructure to support technology, including broadband for all, and banning the practice of digital redlining that primarily impacts low-income communities.

Thank you for the opportunity to share our input regarding the complex issues associated with mental health and substance use disorder care access. We appreciate your efforts to address the barriers to care and welcome the opportunity to expand on the information we have provided above and serve as a resource to you as you continue these efforts. Please feel free to contact Len Marquez, Senior Director, Government Relations & Legislative Advocacy (lmarquez@aamc.org), with any questions or concerns.

Sincerely,



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