



**Association of
American Medical Colleges**
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October 21, 2022

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

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

The Honorable Debbie Stabenow
Committee on Finance
United States Senate
731 Hart Senate Office Building
Washington, DC 20510

The Honorable Steve Daines
Committee on Finance
United States Senate
320 Hart Senate Office Building
Washington, DC 20510

Dear Chair Wyden, Ranking Member Crapo, Senator Stabenow, and Senator Daines:

On behalf of the Association of American Medical Colleges (AAMC), I thank you for your recent [discussion draft](#) of legislation designed to strengthen the behavioral health workforce. The AAMC appreciates your thoughtful, bipartisan efforts, which would help to address the mental health crisis by investing in Medicare-supported graduate medical education (GME), strengthening access to care for Medicaid beneficiaries, and removing regulatory barriers to wellness programs for physicians.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. In 2022, the Association of Academic Health Centers and the Association of Academic Health Centers International merged into the AAMC, broadening the AAMC's U.S. membership and expanding its reach to international academic health centers.

The AAMC's member teaching hospitals and faculty physicians are directly responsible for providing timely, accessible, and culturally respectful physical and behavioral health care. Our members have witnessed firsthand the devastating toll of the COVID-19 public health

emergency (PHE) on the nation's collective mental health and well-being. The pandemic and associated stressors have negatively impacted many people's well-being, resulting in a [marked increase](#) in the prevalence of mental health symptoms and substance use, as well as [suicidal ideation](#). In particular, the pandemic has had a profound impact on the mental health of children and young people, including a [troubling rise](#) in mental health-related emergency department visits among this population.

In response to this crisis, the AAMC and our members have stepped up to address the growing demand for mental health services, as well as advocate for policies that promote the mental and emotional health of people everywhere. In fact, the AAMC [held an October 11th virtual congressional briefing](#), "Confronting the Mental Health Crisis: The Value of a Team-Based Approach," focusing on the value of "integrated behavioral health (IBH)," a model of care in which primary and specialty care providers work directly with behavioral health clinicians to address the medical, behavioral, and social determinants of health and well-being. The briefing featured behavioral health experts from AAMC member institutions, who shared how they have implemented IBH in their practices to promote equity and access to behavioral health care, reduce wait times for mental health services, and extend the scarce behavioral health workforce.

In November 2021, we [responded to the Senate Finance Committee's request for information](#) with a set of recommendations to strengthen the behavioral health workforce, extend tele-behavioral health flexibilities, encourage the integration of physical and behavioral health care, and promote parity and access. We appreciate the tremendous thought and care that each of the bipartisan working groups placed in the stakeholder engagement process. In particular, we were grateful for the opportunity to collaborate with the "Strengthening the Workforce" working group, co-chaired by Sens. Stabenow (D-Mich.) and Daines (R-Mont.), and we look forward to continuing the conversation.

Physicians are a critical component of our nation's health care infrastructure, and we must train more to help 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. According to the [AAMC Consumer Survey of Health Care Access in 2022](#), 35% of respondents who said they needed mental or behavioral health care in the previous 12 months reported that they were not always able to access that care. Provider shortages and network adequacy challenges are [cited as a challenge](#) to accessing mental health services. This is on top of the fact that as our population grows and ages, the demand for physicians continues to outpace supply, resulting in an [estimated overall shortfall](#) of between 37,800 and 124,000 primary care and specialty physicians by 2034.

We are pleased that the "Strengthening the Workforce" working group's discussion draft proposes to bolster the physician workforce by providing 400 additional Medicare-supported GME slots for psychiatry and psychiatry sub-specialties. As previously mentioned, the United States currently [lacks an adequate number of physicians](#), and the Health Resources and Services Administration (HRSA) estimates that an additional [7,632 mental health](#)

[providers](#) are needed to eliminate current mental health professional shortage areas. The provision of additional Medicare-supported GME slots in this discussion draft represents an important step to addressing this growing crisis. Given the severity of the current and projected workforce shortage, we believe that a greater investment is necessary to increase the supply of providers. **We recommend that the committee increase the number of GME slots provided by this discussion draft from 400 to at least 1,000, with 500 slots allocated per fiscal year.**

The discussion draft outlines prioritization criteria for the proposed 400 positions and asks for input on the appropriate allocation to each category of teaching hospital. The AAMC recommends that teaching hospitals should be allowed no more than 10 slots in one year, and that the committee use the following percentages:

- 20% to hospitals located in rural areas;
- 30% to hospitals over their cap;
- 20% to hospitals in states with new medical schools or branch campuses;
- 20% to hospitals the serve areas designated as health professional shortage areas (HPSAs); and
- 10% to hospitals local in states with less than 27 residents per 100,000 people.

The AAMC also recommends that the committee include language to ensure that the Centers for Medicare and Medicaid Services (CMS) implements these slots in a manner that is consistent with the statute and congressional intent. We recommend including a provision that would direct CMS to refrain from prioritizing hospitals in multiple categories over those in an individual category for the purpose of allocating slots. In order to help enhance the distribution of these new positions, we urge the committee to include language specifying that if any category of hospitals cannot use their allotted slots, then these slots would be made available to hospitals in other categories. We also urge the committee to include language that would prevent the use of Health Professional Shortage Area (HPSA) scores when determining priority for the provision of slots. As [we emphasized](#) as part of distribution of the Consolidated Appropriations Act, 2021 slots, while HPSA scores are an accurate indicator of the need for a subset of practitioners in a given state, they do not speak to the ability of hospitals in those states to train additional residents or provide care for patients who live in HPSAs. It is our concern the use of HPSA scores to prioritize the distribution of GME slots would disadvantage teaching hospitals that, although physically located outside of the boundaries of a HPSA, serve as the primary point of care for a HPSA population.

The AAMC supports the approach outlined above because it would provide for a broad distribution of slots to a diverse array of teaching hospitals. We also believe the committee should take steps to ensure hospitals that are best positioned to make immediate use of these new slots are able to do so, including those who have demonstrated their continued institutional commitment to training over and above their Medicare caps. Under current statute, rural teaching hospitals already have the ability to increase their residency cap by starting new residency programs. While we continue to support the inclusion of dedicated rural hospital positions, we recommend that the committee include language that would specify that new positions awarded

to rural hospitals are used to grow their existing medical residency training programs, rather than establish new programs. It is important these new slots are used to increase teaching hospitals' Medicare GME caps where there are no other opportunities or alternatives to do so.

We appreciate the specific focus on investing in psychiatry and psychiatry subspecialties. As the committee considers the specialty-level distribution of these slots, we urge you to consider the [AAMC-supported](#) bipartisan Opioid Workforce Act ([S. 1438](#)) led by Sens. Hassan (D-N.H.) and Collins (R-Maine). This legislation would increase the number of Medicare-supported GME slots available to hospitals that have or are in the process of establishing approved residency programs in addiction medicine, addiction psychiatry, or pain medicine. While there is a definite need for more psychiatrists and psychiatric subspecialties, the AAMC recommends the approach that this legislation takes, as it expands the type of eligible residency programs to include the aforementioned specialties, or an associated pre-requisite program (such as internal medicine). This change would provide hospitals and community health care leaders with the flexibility needed to respond to local factors and develop the behavioral health workforce necessary to meet the needs of the communities and patients that teaching hospitals serve. We also recommend that the committee clarify that the GME slots provided by this discussion draft would include residencies in addiction medicine, addiction psychiatry, pain medicine, child and adolescent psychiatry, geriatric psychiatry, brain injury medicine, forensic psychiatry, hospice and palliative medicine, and sleep medicine among others.

We also greatly appreciate the committee's acknowledgment of the importance of investing in the physician workforce. To help meet the growing need for physicians in many specialties, bipartisan health care leaders in the Senate introduced both the Resident Physician Shortage Reduction Act of 2021 ([S. 834](#)) and the aforementioned Opioid Workforce Act of 2021 ([S. 1438](#)). The Resident Physician Shortage Reduction Act, introduced by Sens. Menendez (D-N.J.) and Boozman (R-Ark.) and Leader Schumer (D-N.Y.), would gradually increase 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.

In addition, we are heartened by the inclusion of a demonstration model to help states improve behavioral health provider network adequacy for Medicaid beneficiaries. Medicaid is the [largest payer](#) for behavioral health services in the United States and a key source of coverage for [perinatal individuals](#) and [children](#). Our members play an important role in providing specialty and sub-specialty care, including behavioral health care, to Medicaid beneficiaries. Research shows that physicians who provide clinical care through faculty practice plans are [more likely to accept new patients covered by Medicaid](#) than their counterparts in other clinical settings. In order to strengthen provider network adequacy and ensure access to care for beneficiaries, it is essential that Medicaid provides adequate reimbursement for all services, including behavioral health services. The proposed demonstration project would help states recruit and retain additional behavioral health providers to their Medicaid programs through increased

reimbursement, training, and technical assistance. We believe that this represents an important first step to addressing the unmet behavioral health needs of Medicaid beneficiaries.

We also recognize that this is a challenging time for state Medicaid officials, who will be responsible for navigating the ["unwinding" of the continuous enrollment requirement](#) of the Families First Coronavirus Response Act. Under the proposed demonstration model, state Medicaid officials must participate in an extensive 18-month planning process as a prerequisite for accessing federal funds. However, some states have independently begun to assess and improve the financing and provision of mental health and substance use disorder care under their Medicaid programs. For example, Delaware recently passed legislation that would require coverage of an [annual behavioral health wellness visit](#), and California has made strides towards transforming behavioral health care delivery through its [CalAIM Behavioral Health Initiative](#). We encourage the committee to consult with CMS regarding options to leverage existing state-level efforts and provide Medicaid officials with the maximum flexibility to implement this demonstration model as quickly as possible.

In addition, we are concerned that, following the conclusion of the demonstration period, states may discontinue enhanced Medicaid reimbursement for mental health services. In order to help maintain access to care and keep mental health providers engaged in the Medicaid program, **we recommend that the committee consider policies to provide state Medicaid programs with consistent and reliable financing streams to support this work.** To this end, we encourage you to consider the Investing in Kids' Mental Health Now Act ([S. 4747](#)), introduced by Sens. Portman (R-Ohio) and Casey (D-Pa.), which would provide enhanced federal matching funds to support an increase in Medicaid payment rates for pediatric mental health services. This legislation would provide a template to incentivize states to invest in behavioral health services for both children and adults.

The AAMC is deeply troubled by the detrimental impact of the COVID-19 pandemic on the mental health of our faculty members, clinicians, researchers, residents, students, and all employees, and we are committed to [addressing burnout and fostering well-being](#) across all career stages. We are thankful for the recent passage of the [AAMC-supported Dr. Lorna Breen Health Care Provider Protection Act \(H.R. 1677, S. 610\)](#), which would authorize key Health Resources and Service Administration (HRSA) programs aimed at improving the mental health and well-being of health care providers and trainees. Nonetheless, health care providers continue to face hurdles to accessing essential mental health services. Under the Stark Law, physicians are prohibited from making referrals for services payable by Medicare to an entity with which they have a financial relationship. In some cases, this prevents hospitals from providing mental health and resiliency programs for physicians and trainees. We strongly support the discussion draft's removal of this regulatory barrier by including a much-needed exemption for such programs, thereby increasing access to mental health care for frontline health care providers.

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The AAMC appreciates your leadership on this bipartisan discussion draft, and we welcome the opportunity to provide additional feedback or information. If you have any further questions, please feel free to contact my colleague, Len Marquez, Senior Director of Government Relations & Legislative Advocacy at lm Marquez@aamc.org.

Sincerely,

A handwritten signature in black ink that reads "Tannaz Rasouli". The signature is written in a cursive, flowing style.

Tannaz Rasouli, MPH
Acting Chief Public Policy Officer
Association of American Medical Colleges

CC: David J. Skorton, MD
President and CEO
Association of American Medical Colleges