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September 25, 2023

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Washington, DC 20224

Mr. Xavier Becerra  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
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Ms. Lisa M. Gomez  
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Employee Benefits Security  
Administration  
U.S. Department of Labor  
ATTN: 1210-AC11  
Room N-5653  
200 Constitution Avenue, NW  
Washington DC 20210

***Re: Requirements Related to the Mental Health Parity and Addiction Equity Act (CMS-9902-P)***

Dear Mr. O'Donnell, Ms. Gomez, and Mr. Becerra:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the proposed rule entitled "Requirements Related to the Mental Health Parity and Addiction Equity Act," 88 *Fed. Reg.* 51552 (August 3, 2023), issued by the Departments of Treasury, Labor and Health and Human Services (Departments).

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 are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 12 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, 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, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

America is suffering a mental health crisis and more must be done to ensure that patients can access mental and behavioral health services. In response to this crisis, AAMC members have stepped up to address the growing demand for mental and behavioral health services. The AAMC's member teaching health systems and associated faculty physicians are directly responsible for providing timely, accessible, and culturally respectful behavioral health care. Our members have witnessed firsthand the devastating toll the COVID-19 public health emergency (PHE) had on the nation's collective mental health and well-being; Americans continue to struggle even after the end of the PHE. Teaching health systems and their associated providers are important access points for care for many patients; often, they are the providers

of last resort for under- or uninsured individuals. While only 5 percent of all U.S. hospitals, they provide 32 percent of hospital charity care.<sup>1</sup>

The AAMC supports the Administration's efforts to expand access to mental and behavioral health services. The proposals put forth in this rule seek to strengthen the protections included in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.<sup>2</sup> Specifically, the proposals would strengthen enforcement of the parity requirements to ensure that mental and behavioral health benefits are not subject to greater restrictions – such as prior authorization requirements, limitations on annual and lifetime dollar amounts or limited number of treatments – than medical-surgical benefits under a plan. (p. 51564). We support this goal and feel that better enforcement of these parity requirements will lead to a decrease in onerous barriers instituted by insurers that limits patients' access to mental and behavioral care.

The AAMC applauds the Administration's recognition that the lack of affordable, comprehensive insurance coverage, that includes mental and behavioral health coverage, limits access to needed care. Moreover, plans that offer limited benefits, impose high cost sharing, and utilize narrow networks impede consumers' ability to access all medical services, including mental and behavioral health services. Patients suffering from medical conditions who lack access to needed medical care often present to emergency departments with advanced disease that requires acute, more expensive medical care. Individuals suffering from mental and behavioral health issues are no different. Further, mental health and physical health are closely connected; individuals with chronic medical conditions tend to also struggle with mental health issues.<sup>3</sup> Patients experiencing complex health issues often find limited supports for providing mental health care, exacerbating mental health access and increasing disparities. The Departments' efforts to ensure that health insurance products include robust mental and behavioral health benefits that do not present burdensome barriers to access care is an important step toward addressing the mental health crisis.

Ensuring reimbursement rates are adequate to maintain access must be a priority to achieve the Departments' goal of improving timely access to care and addressing health equity issues. Many mental and behavioral health providers are not accepting new patients. Further, reimbursement rates for mental and behavioral health services that are not on par with reimbursement rates for medical-surgical services disincentivizes providers from accepting insurance rates. Raising reimbursement rates and decreasing providers' administrative burden imposed by insurers should be prioritized.

However, insurance coverage does not guarantee access to care. Insured individuals seeking mental and behavioral health care often experience significant barriers accessing that care; approximately 34 percent of patients say they had difficulty finding a therapist who would accept their coverage.<sup>4</sup> The 2022 AAMC Consumer Survey of Health Care Access<sup>5</sup> revealed that 35 percent of respondents who reported they needed mental or behavioral health care in the previous 12 months were not always able to access that care.

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<sup>1</sup>AAMC analysis of AHA Annual Survey Database FY 2020 and NIH Extramural Research Award data. Note: Data reflect all short-term, general, nonfederal hospitals.

<sup>2</sup> Pub. L. 104-204

<sup>3</sup> <https://mhanational.org/conditions/co-occurring-mental-health-and-chronic-illness>

<sup>4</sup> <https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut>

<sup>5</sup> <https://www.aamc.org/about-us/mission-areas/health-care/workforce-studies/datasets>

The COVID-19 PHE exposed the critical shortage of behavioral and mental health providers. According to September 2023 data from the Health Resources and Services Administration (HRSA), approximately 164 million people currently reside in Health Professional Shortage Areas (HPSAs) for mental health. Around 32 percent of mental health HPSAs are in non-rural areas, and 7.5 percent are in partially non-rural areas. Further, many individuals receive mental and behavioral health care from primary care providers. Currently, around 100 million people reside in Primary Care Shortage Areas, which equates to the need for 17,303 more primary care practitioners.<sup>6</sup> A June 2021 AAMC report predicts a nationwide shortage of up to 124,000 physicians by 2034.<sup>7</sup> Lastly, the COVID-19 PHE exposed significant barriers to primary and specialty care and highlighted the rising concerns of physician burnout and retirement. Physicians are a critical component of our nation's health care infrastructure; it is imperative that we train more physicians, including those specializing in mental and behavioral health, to help meet the current and future needs of our nation.

### ***Prioritize Prevention for Mental and Behavioral Health***

Prevention of mental and behavioral health conditions is critical. About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime.<sup>8</sup> Mental and behavioral health disorders affect people of all ages and racial / ethnic backgrounds with some populations being disproportionately impacted. There are many factors impacting mental and behavioral health that are not part of the health care system. For example, social factors such as where someone lives, the way they live, and their profession are important for health outcomes. Individuals who have trouble accessing mental and behavioral health services often struggle with social needs that are a source or significantly contribute to their mental and behavioral health status. AAMC-member health systems are integrating screenings to better understand patients' social needs<sup>9</sup> (e.g., social determinants of health). Expanding coverage and reimbursement for social needs screening is necessary to adequately address the current crisis and attempt to mitigate future challenges.

Estimates suggest that only half of all people with mental and behavioral health disorders will get the treatment they need.<sup>10</sup> Mental and behavioral health issues impact all facets of a patient's life. For example, depression and anxiety can affect people's ability to take part in healthy behaviors. Some physical health problems can make it harder for people to get treatment for mental health disorders. Increased screening for mental and behavioral health disorders can help people get the treatment they need.<sup>11</sup> Mental and behavioral health prevention efforts should be similar to those focused on medical and dental prevention.

Mental and behavioral health issues are not limited to adults, however. Many children and adolescents are experiencing poor mental and emotional health. The growing body of research about the potential harms of the nearly universal use of social media by youth may be contributing to poor mental and emotion health.<sup>12</sup> Further, the Centers for Disease Control and Prevention's survey revealed that 44

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<sup>6</sup> <https://data.hrsa.gov/topics/health-workforce/shortage-areas>

<sup>7</sup> <https://www.aamc.org/media/54681/download>

<sup>8</sup> [https://www.cdc.gov/mentalhealth/data\\_publications/index.htm](https://www.cdc.gov/mentalhealth/data_publications/index.htm)

<sup>9</sup> Social determinants of health screening: housing, food insecurity or hunger, utility needs, interpersonal violence, transportation, employment or income, education, social isolation, and health behaviors.

<sup>10</sup> <https://www.nimh.nih.gov/health/statistics>

<sup>11</sup> <https://health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders>

<sup>12</sup> <https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf>

percent of American high school students said they had “persistent feelings of sadness or hopelessness” from 2009 to 2021.<sup>13</sup> This is the highest level of teenage sadness ever recorded.

Prevention efforts should start early in life to identify at-risk children. More than 14 million children and adolescents in the U.S. – 1 in 5 – have a diagnosable mental health disorder. However, of those that seek treatment for a mental health disorder, only 20 percent receive needed services.<sup>14</sup> The lack of robust insurance coverage for mental and behavioral health services limits access to care. Although primary care providers such as pediatricians attempt to identify and sometimes treat mental and behavioral health needs in the pediatric population, they should not be the only avenue for treatment. Expanding the mental and behavioral health workforce is key to ensuring access.

School-based mental health services can improve access to care and allow for early identification and treatment of mental health issues for school-aged children. These school-based services can also reduce access to barriers for underserved populations, including children from low-income households and children of color.<sup>15</sup> Commercial insurers should be encouraged to cover mental and behavioral health services furnished by school-based programs. However, these school-based services face barriers that include mental health provider shortages and inadequate funding.<sup>16</sup> While some state Medicaid programs have expanded coverage of school-based mental and behavioral health services, many children and adolescents may lose this coverage as a result of the “unwinding” of the continuous enrollment requirement.<sup>17</sup>

Lastly, consideration should be given to providing coverage for services furnished by community-based entities that serve as a resource for individuals struggling with social needs. Community partnerships are most successful when they are built on trust, respect, and a shared vision. The Departments should continue to work with states and communities to identify ways to proactively engage with community partners who are trusted, respected and knowledgeable individuals, institutions, or organizations. Partnerships like this can facilitate meaningful interaction between the state and community members/community partners to communicate such things as the importance of responding to requests for information and alternative health insurance options. Effective bi-directional communication channels help build and sustain a shared leadership and trust to meet the needs of all individuals. We believe that leveraging these connections will facilitate greater support for individuals facing challenges related to social needs. The [AAMC Center for Health Justice](#) has valuable resources on engaging with community leaders as outlined in its [10 Principles of Trustworthiness](#).

### ***Increase Reimbursement Rates for Mental and Behavioral Health Providers***

Low reimbursement rates exacerbate patients' ability to access mental and behavioral health services and disincentivize providers to accept patients with certain insurance. Commercial insurance rates are typically set as a percentage of Medicare rates which frequently do not cover the costs of furnishing services to beneficiaries. A 2022 Kaiser Family Foundation analysis found that 40 percent of psychiatrists are not accepting new Medicare patients.<sup>18</sup> Medicaid, which typically pays even less than Medicare, now covers more than one-fifth of all Americans with mental health disorders and many of

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<sup>13</sup> <https://www.cdc.gov/mmwr/volumes/71/su/pdfs/su7103a3-H.pdf>

<sup>14</sup> <https://www.aap.org/en/patient-care/mental-health-initiatives/>

<sup>15</sup> <https://www.kff.org/mental-health/issue-brief/the-landscape-of-school-based-mental-health-services/>

<sup>16</sup> Ibid.

<sup>17</sup> <https://www.medicaid.gov/sites/default/files/2022-03/sho22001.pdf>

<sup>18</sup> <https://www.aarp.org/health/medicare-qa-tool/does-medicare-cover-mental-health.html>

these enrollees report difficulty accessing treatment. On average, Medicaid pays 81 percent of Medicare rates.<sup>19</sup> Only 36 percent of psychiatrists accept new Medicaid patients.<sup>20</sup>

When mental and behavior health providers choose not to accept insurance it leaves patients with two options – pay out-of-pocket or forgo needed care. And the financial burden of lacking coverage does not solely impact uninsured patients or patients with no coverage for mental and behavioral health services. Individuals with commercial insurance who submit claims for reimbursement after paying out-of-pocket typically receive less reimbursement from their insurance carriers than the already low reimbursement rate that providers would have received. Payer reimbursement for out-of-network services is not based on the provider's charges but rather on the payers' *allowed charges* which can be significantly lower than what the provider charges and what the patient paid out-of-pocket. Insurer payments to patients are then a percentage of the *allowed charges* which in some cases could be 50 percent less. This reduction in payment is *in addition* to any cost-sharing liabilities – e.g., deductibles and copayments – that patients must fulfill. In some cases, the amount the patient receives in the end can be negligible. Medicare beneficiaries are worse off because they have no coverage for out-of-network services. If a provider has opted out of Medicare, the beneficiary is responsible for the entire bill; Medicare will not reimburse the beneficiary.<sup>21</sup> For many patients, the financial toll they incur when seeking care from out-of-network providers is just not sustainable.

The Departments should focus on ways to increase reimbursement rates for mental and behavioral health services in order to improve access to care. To achieve true parity for mental and behavioral health services, reimbursement rates must align with higher rates for medical-surgical services and be increased across all insurance products, including Medicare and Medicaid. If patients are forced to seek care from an out-of-network mental health provider, the insurer should be required to pay based on the providers' charges, not the "allowed amount." States have flexibility to set provider payment rates in Medicaid fee-for-service and should be encouraged to raise reimbursement for mental and behavioral health services. Medicaid managed care organizations (MCOs) are contractually responsible to ensure adequate provider networks and ratesetting for providers. States should evaluate MCO provider networks and reimbursement rates to ensure access to mental and behavioral health services for Medicaid beneficiaries.

#### ***Decrease Administrative Burden to Improve Access***

Reimbursement rates are not the only reason some mental and behavioral health providers choose to be out-of-network. The upfront and ongoing costs and administrative requirements to interact with insurance companies, including Medicare and Medicaid, can also be a deterrent. Providers must balance the costs associated with investing in the infrastructure to manage accounts receivable with the reimbursement they receive. For example, the infrastructure needed to bill insurance, track accounts receivable and patients' cost-sharing demands significant administrative resources that many sole proprietors and small group practices do not have. The cost to engage a third party to process claims can often be prohibitive.

Providers that choose to be in-network with many health plans must juggle different requirements for coverage for each plan, which can be many. For example, in 2023, Medicare beneficiaries, on average,

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<sup>19</sup> <https://www.healthaffairs.org/eu1.proxy.openathens.net/doi/10.1377/hlthaff.2022.00805>

<sup>20</sup> <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf>

<sup>21</sup> <https://www.aarp.org/health/medicare-qa-tool/does-medicare-cover-mental-health.html>

have a choice of 43 Medicare Advantage plans.<sup>22</sup> Consumers purchasing insurance in the Marketplace in 2023, on average, have a choice of 3 or more insurers.<sup>23</sup> Lastly, 66 percent of private industry workers receive health insurance coverage through their employer.<sup>24</sup> There is no standard benefit design for employer-based plans.<sup>25</sup> Our members report that most plans have different reimbursement rates and patient cost sharing requirements. This can be overwhelming and sometimes impossible to manage, particularly for sole proprietors and small practices.

Lastly, commercial insurers often do not accept all mental and behavioral health providers into their networks. Rather, some insurance companies create quotas for how many therapists they will work with in a certain geographic area. This forces providers to decide between investing in billing systems or remaining out of network. Additionally, there is an array of compliance requirements – credentialing, for example – that providers must meet in order to be able to bill Medicare. Insurers can require providers to provide documentation to justify payment for patients' treatments and plans of care. Some insurers require that treatment plans be update monthly. When faced with these administrative requirements, coupled with low reimbursement, it is not surprising that many mental and behavioral health providers choose to not participate in insurance. Increasing reimbursement and eliminating some of the administrative burdens could entice some providers to be in-network.

#### ***Strengthen Network Adequacy Requirements to Ensure Access to Needed Care***

The use of narrow networks by insurers has expanded, often excluding teaching health systems and their associated providers who furnish primary, specialty and sub-specialty care which includes mental and behavioral health services. Teaching health systems and their associated hospitals, physicians and other providers are an important part of ensuring access to high-quality, cutting-edge treatments. Excluding these institutions and physicians from networks limits patients' access to specialized and sub-specialized care and mental and behavioral health services that often is only furnished by providers at these institutions. Ensuring that insurers have robust mental and behavioral health provider networks will safeguard patients' access to a greater number and type of providers, to meet their health care needs. However, as noted earlier, we believe robust networks will only materialize if reimbursement rates are substantially increased, and administrative burdens are lessened.

#### ***Remove Barriers to Treatment Such as the Excessive Use of Utilization Management Tools***

Utilization management tools are designed to contain spending and prevent patients from receiving low-value items and services. But over the years, insurers have expanded the use of these tools, specifically prior authorization, which has limited patients' access to medically necessary care; created barriers and delays in receiving care; imposed additional burden and stress on providers leading to burnout; and forced some patients to forgo needed care or prescription drugs due denials of prior authorization requests. This rule is proposing changes designed to prevent plans and issuers from designing and implementing

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<sup>22</sup> <https://www.kff.org/medicare/press-release/the-average-medicare-beneficiary-has-a-choice-of-43-medicare-advantage-plans-and-24-part-d-stand-alone-plans-for-coverage-in-2023/>

<sup>23</sup> <https://www.mckinsey.com/industries/healthcare/our-insights/the-individual-health-insurance-market-in-2023>

<sup>24</sup> <https://www.bls.gov/opub/ted/2023/coverage-in-employer-medical-care-plans-among-workers-in-different-wage-groups-in-2022.htm#:~:text=FONT%20SIZE%3A%20PRINT%3A-.Coverage%20in%20employer%20medical%20care%20plans%20among.different%20wage%20groups%20in%202022&text=Seventy%20percent%20of%20private%20industry.up%20rate%20of%2066%20percent.>

<sup>25</sup> <https://www.shrm.org/resourcesandtools/tools-and-samples/hr-qa/pages/offeringdifferentbenefitsfordifferentemployees.aspx>

nonquantitative treatment limitations (NQLTs) that impose greater limits on access to mental health and substance use disorder benefits as compared to medical-surgical benefits. (p. 51568). We support proposals that reform onerous treatment limitations, including prior authorization requirements, that payers impose.

The use of prior authorization has grown dramatically. The process can be time-consuming for providers resulting in time away from patient care because there is no standard process for prior authorization requests. Failing to get approval before providing care can result in denied claims. The burden to respond to these denials rests squarely on providers and contributes significantly to burnout. If the patient is required to follow-up on the denial, they often forgo care due to the complexities of filing an appeal. To meaningfully exact change to reduce the number of prior authorization requests, we encourage the Departments to review AAMC comments on a system that standardizes prior authorization requests across all payers and programs (e.g., Medicare, Medicaid, commercial insurance).<sup>26,27</sup>

Clinicians increasingly cite the use of electronic health records, including prior authorization requests, as a cause of burnout. The American Medical Association surveyed<sup>28</sup> more than 1,000 practicing physicians regarding their experience with prior authorization; 88 percent reported that prior authorization interferes with continuity of care. More than 80 percent reported that in the last five years they have seen an increase in the number of prior authorizations for medical services and prescription drugs, with almost 20 percent of prescription drugs requiring prior authorization. To meet billing rules the medical record has become bloated, thereby impeding physicians' ability to focus on delivering high quality care. Adding to this burden is the requirement for clinicians to navigate coverage requirements for an array of insurance plans and a lack of standardized transmissions for this information, including the submission of prior authorization requests. We support proposals that seek to minimize burden on providers. The Departments should evaluate commercial insurers' prior authorization process related to mental and behavioral health services and the clinical workflow factors contributing to the burden associated with utilization management tools to see how these factors can be reduced. We support changes to reduce the number and burden of prior authorizations in health care.

The AAMC is concerned that its members who provide specialized and sub-specialized care will be unreasonably subjected to prior authorization requirements. Tertiary and quaternary institutions and their associated providers who provide patient-specific specialized care, and which can be more costly, may be unjustly targeted for increased prior authorization requests. The Departments should monitor whether providers that furnish specialized mental and behavioral health services are not disproportionately subjected to a higher level of prior authorization requests to ensure that patients that need this specialized care have access to it.

Lastly, insurers also limit access to needed prescription drugs by steering patients to less expensive medications through the use of step therapy protocols. Research on the use of step therapy protocols among some of the largest U.S. commercial health plans showed that plans applied step therapy in 38.9 percent of drug coverage policies.<sup>29</sup> Prior authorization denials and step therapy requirements delay

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<sup>26</sup> <https://www.aamc.org/advocacy-policy/washington-highlights/aamc-responds-onc-rfi-electronic-prior-authorization>

<sup>27</sup> <https://www.aamc.org/advocacy-policy/washington-highlights/aamc-submits-comments-cms-proposals-improve-prior-authorization>

<sup>28</sup> <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

<sup>29</sup> <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00822>

needed care or force patients to forgo care or disrupt adherence to prescription drug regimens. For example, low-income Medicare beneficiaries may not fill a prescription due to formulary restrictions such as prior authorization and step therapy imposed by the Medicare Part D plan.<sup>30</sup>

Mental health medications affect people in different ways, and individuals need to be able to access the medication that works best for them and their individual health needs. It is important that medication decisions are carefully considered with a health care provider who has both extensive knowledge of the individual and available medication options. Step therapy can be a danger to the health and well-being of the person taking the medication, and result in a worsening of symptoms and undermining the decisions made between individuals and their health care providers. Instead, policies should maintain access to provider-recommended medications and should specifically prohibit step therapy for psychiatric medications, or, at a minimum, establish clear, rapid timelines for insurer responses to requests for exceptions and ensure that people who have previously used a medication do not have to switch.<sup>31</sup>

### ***Invest in Integrated Behavioral Health Models***

The AAMC supports expanding the use of Integrated Behavioral Health models to improve access to mental and behavioral health care.<sup>32</sup> Accessing adequate patient-centered mental and behavioral health care is a challenge for all Americans but particularly so for historically under-resourced and marginalized groups, who face unique barriers to care. Integrated behavioral health involves a multidisciplinary team of medical and behavioral health providers working together to address the medical, behavioral, and social factors that affect a patient's health and wellbeing. Integrated behavioral health models embed behavioral health services in primary or specialty care settings, thereby reducing the stigma surrounding mental health care and expanding access to care. Providing reimbursement for behavioral health services furnished in the primary care and specialty settings expands access for many individuals, including beneficiaries enrolled in Medicaid, which is the largest payer for mental health and substance use disorder treatment in the United States.<sup>33</sup>

The AAMC recommends that policymakers take steps to promote access to integrated behavioral health models. This includes ensuring coverage and payment for telehealth services, which have shown to be part of the continuum of services for successful integrated behavioral health models, increasing payment for Collaborative Care Model (CoCM CPT codes), and extending reimbursement to all IBH team members. In addition, policymakers should reexamine behavioral health carve-outs, which limit the success of IBH models. As an example, certain state Medicaid agencies and some commercial payors have elected to carve-out behavioral health care from their managed care contracts and instead provide these services through a separate managed behavioral health organization. These services are often delivered in silos and not coordinated with the patient's medical/primary care providers.

### ***Expand the Use of Telehealth to Furnish Mental and Behavioral Health Services***

The COVID-19 PHE revealed the value of telehealth as a means to furnish needed medical care, particularly mental and behavioral health services. The AAMC strongly supported the telehealth waivers and regulatory changes established by Congress and HHS in response to the COVID-19 PHE that

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<sup>30</sup> <https://www.healthaffairs.org/eu1.proxy.openathens.net/doi/10.1377/hlthaff.2021.01742>

<sup>31</sup> <https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Medications-Step-Therapy>

<sup>32</sup> <https://www.aamc.org/media/61651/download>

<sup>33</sup> Centers for Medicare and Medicaid Services. Behavioral Health Services.

<https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html>



facilitated the widespread use of telehealth and other communication technology-based services that improved access to health care. In response to the COVID-19 PHE, teaching hospitals, faculty physicians, and other providers have responded by rapidly implementing telehealth in their settings and practices to provide continued access to medical and mental and behavioral health care for their patients. Telehealth provides both patients and providers with a variety of benefits and expands access to care, especially to those in rural and other underserved areas.

### ***Telehealth Services Should be Paid the Same Rates as Services Delivered In-Person***

The AAMC strongly recommends that providers be reimbursed the same rates for furnishing telehealth services as services delivered in-person. The value of the care delivered does not differ because it is furnished via telehealth. In fact, more frequent monitoring of the patient in their home via telehealth has provided insight to improved care in some cases. However, health care services furnished via telehealth does not mean that the services are cheaper to provide than an in-person visit.

Teaching health systems and faculty practice plans have highlighted significant infrastructure costs to fully integrate their electronic health record systems with HIPAA-compliant telehealth programs. Physicians and hospitals employ medical assistants, nurses, and other staff to engage patients during telehealth visits and to coordinate care, regardless of whether the services are furnished in person or via telehealth. Before the virtual visit occurs, the physicians and other health care professionals must be provided the technology they need and acquire a platform to use for the visits. Other staff will contact patients to complete registration, obtain consent for a telehealth visit, and ensure that the patient receives the email with a link to participate in the virtual visit. In addition, staff will educate the patients on the use of technology as needed to ensure they are able to participate in the visit.

On the date of the visit, clinical staff reach out to the patient to provide intake services (e.g., ask for chief complaint, symptoms, weight, temperature and help the patient identify a review of current medications and therapies) prior to the patient visit with the physician or health care professional. The patient then participates in the visit with the physician, and at the conclusion of the visit, the physician must arrange any follow-up plan for the patient related to their care. Staff will follow-up as needed to schedule any additional visits for the treating physician or subspecialty referral, tests, or laboratory studies. Without sufficient reimbursement, providers may no longer be able to continue to provide the current level of telehealth services to their patients.

### ***Provide Payment for Audio-Only Telehealth Services***

Audio-only calls improve access to virtual care for patients who do not have access to the devices or broadband for audiovisual calls, are not comfortable with digital technology, or do not have someone available to assist them. During the PHE, coverage and payment for audio-only calls has been critical to ensure access to care for many patients. Physicians have been able to provide a wide array of services efficiently, effectively, and safely to patients using the telephone.

Many factors contribute to the high use of audio-only services. Patients in rural areas or those with lower socioeconomic status 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 percent do not have home broadband services.<sup>34</sup>

Some providers report that even when their patients have access to technology that would allow for audio-visual communication, they may be unable to use the technology without assistance, thus limiting them to telephone use. For these patients, the only option to receive services remotely is through a phone. Without coverage and payment for these audio-only services, there will be inequities in access to services for these specific populations.

### ***Promote the Use of Interprofessional Consults for Mental and Behavioral Health Services***

The AAMC and its member health systems have found the use of provider-to-provider telehealth modalities and peer-mentored care as important ways to improve access to care, particularly for behavioral health where there are significant access and workforce challenges. However, services like interprofessional consults have been underutilized due to obstacles related to payment policies, particularly related to CPT<sup>®</sup> codes 99451 and 99452.

By way of background, the AAMC has partnered with over 50 adult and pediatric health systems through Project CORE (Coordinating Optimal Referral Experiences) to implement interprofessional consults (“eConsults”) and continues to engage new health systems and other health care organizations, including payers, interested in implementing and scaling this high value service. In the CORE model, eConsults are an asynchronous exchange in the electronic health record that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The goals of the program include increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP. When eConsults can take the place of a referral, patients benefit from more timely access to the specialist’s guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream costs.

In a 2022 survey of health systems participating in Project CORE, 90 percent reported having integrated behavioral health in their primary care clinics and over 50 percent offered eConsults in Psychiatry. Some of the common conditions or problems that have made good use cases for eConsults in Psychiatry include ADHD, anxiety, and depression. By managing a subset of consultations via eConsults, patients can receive input through their PCP on next steps to advance their care or treatment plan, avoid waiting for an in-person visit, and access is enabled in the Psychiatry clinic for patients who need an in-person visit. CORE health systems have found eConsults to be a part of the continuum of services for successful integrated behavioral health models. The AAMC believes that investing in these technologies will extend the capacity of the existing behavioral health workforce and promote access to care in historically underserved communities. The AAMC continues to develop resources for health systems to aid in the adoption and evaluation of both synchronous and asynchronous telehealth modalities.

### ***Strengthen the Physician Workforce***

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 PHE exposed significant

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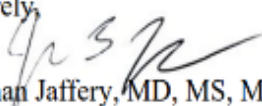
<sup>34</sup> Pew Research Center, Digital divide persists even as lower-income Americans makes gains in tech adoption. May 7, 2019. <https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-incomeamericans-make-gains-in-tech-adoption/>

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. Provider shortages and network adequacy challenges are cited as a barrier 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.<sup>35</sup> The U.S. currently lacks an adequate number of physicians, and HRSA estimates that an additional 7,632 mental health providers are needed to eliminate current mental health professional shortage areas.<sup>36,37</sup> Given the severity of the current and projected workforce shortage, we believe that a greater investment is necessary to increase the supply of providers.

## CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with the Departments on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact Mary Mullaney ([mmullaney@aamc.org](mailto:mmullaney@aamc.org)).

Sincerely,



Jonathan Jaffery, MD, MS, MMM  
Chief Health Care Officer  
AAMC

Cc: David Skorton, MD, AAMC President and CEO

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<sup>35</sup> <https://www.aamc.org/media/54681/download>

<sup>36</sup> Ibid.

<sup>37</sup> Health Resources and Services Administration. Bureau of Health Workforce. Designated Health Professional Shortage Areas Statistics. Third Quarter of Fiscal Year 2023 Designated HPSA Quarterly Summary as of Jun 30, 2023.