Improving Access to Mental Health and Substance Use Disorder Care
7/1/22

Joint principles of the following organizations representing frontline physicians:

American Academy of Family Physicians
American Academy of Pediatrics
The American College of Obstetricians and Gynecologists
American College of Physicians
American Psychiatric Association
American Osteopathic Association

On behalf of the more than 560,000 physicians and medical students represented by the combined memberships of the above organizations, we have adopted the following principles on mental and substance use disorder (MH/SUD) care.

Nearly 20% of Americans are affected by a mental health or substance use disorder annually and 50% of all lifetime mental illnesses begin by age 14, and 75% by age 24. The COVID-19 pandemic has exacerbated existing issues with anxiety, depression, and post-traumatic stress disorder amid a growing shortage of mental health and behavioral health providers.[i] Since the start of the pandemic, death by suicide and overdose deaths have increased, in addition to increased rates of stress in parents, children, and adolescents, anxiety, depression, substance use and trauma.[ii] Additionally structural racism and discrimination adversely impacts the emotional and economic well-being of families of color and individuals who identify as lesbian, gay, transgender, non-binary, or gender diverse.[iii, iv]

The mental health and wellbeing of children and adolescents is especially concerning. Suicide is the second leading cause of death of youth ages 10-24 in the U.S. and rates have been rising for decades.[v] Between March and October 2020, the percentage of emergency department visits for children with mental health emergencies rose by 24% for children ages 5-11 and 31% for children ages 12-17.[vi] The CDC also found a more than 50% increase in suspected suicide

attempt Emergency Department (ED) visits among girls ages 12-17 in early 2021 as compared to the same period in 2019.[vii]

Identifying and treating MH/SUD is essential to improving overall health outcomes across the lifespan. Mental health disorders make individuals more vulnerable to poor health outcomes for other primary medical disorders, such as diabetes, heart disease, and cancer.[viii, ix] Without proper treatment and care, minor medical conditions can lead to long-term chronic conditions, increased use of emergency care, and require higher levels of care.[x] Tackling the mental health crisis requires a comprehensive approach that addresses the full continuum of healthy mental development and includes promotion and prevention, early intervention and treatment, as well as crisis response.

Accessing mental and substance use services can be a challenge. Today, fewer than half of individuals with MH/SUD receive treatment.[xi] 139 million Americans live in mental health professional shortage area and roughly two-thirds of primary care physicians are unable to connect their patients to outpatient mental health services.[xii, xiii]

Across the U.S, there is a dire shortage of health professionals specializing in MH/SUD. This results in the need for primary care physicians to assume a leading role in the management of mental health care services.[xiv] Meanwhile, nearly 40 percent of visits for depression, anxiety, and other mental illness are with primary care physicians, while other patients are forced to obtain care in emergency departments due to a lack of access to care in the community.[xv, xvi] We must quickly meet an increasing demand for prevention, early identification and intervention, and treatment of MH/SUD conditions.

Current payment models are not well designed to promote the integration of MH/SUD services into primary care settings despite the fact that primary care physicians are often the first to identify MH/SUD in their patients.[xvii] In many cases, patients may prefer to receive care in a primary care setting because of their relationship with their physician or stigma of mental health settings.[xviii] However, primary care physicians often face significant barriers to providing appropriate and timely care to their patients and may need to refer patients to specialists.[xix] Many referrals go uncompleted by the patient due to lack of providers, cost, time, or stigma.[xx] Additionally, physicians and mental health professionals maintain strict compliance with patient privacy laws while coordinating with other health professionals, which contributes to complexity of care coordination.

Despite these barriers, many primary care physicians are seeking opportunities to integrate behavioral health services because behavioral health integration (BHI) saves patients, payers, and practices money in the long-term.[xxi] Additionally, BHI improves health outcomes and promotes care coordination between physicians and mental health professionals.[xxii] Integrating care can happen along a continuum including screening, consultation and colocation. Current evidence supports the Collaborative Care Model (CoCM) in adult populations, which has demonstrated efficacy in improving patient outcomes, reducing costs, and increasing patient and provider satisfaction.[xxiii, xxiv]

Finally, reducing administrative burden and streamlining physician-led, team-based care reduces the stress placed on physicians.[xxv] Physician wellbeing is critically important to ensuring a healthy health care workforce. Physicians deserve the same whole-person approach that they provide to their patients.

Our organizations ask Congress and the administration to support the following policy recommendations that will improve access to M/SUD care. We encourage Congress and the administration to work with us to accomplish these goals:

1. **Support and promote MH/SUD integration into primary care settings**
    - Provide funding for practices to implement evidence-based models of care
    - Establish national and regional technical assistance centers for educate primary care practices on how to integrate care for persons with mental health and substance use conditions in their practice.
    - Support evidence-based integrated care models like tele-health consultation to pediatric primary care sites and perinatal health providers for maternal depression (e.g., HRSA Pediatric Mental Health Care Access Program; s HRSA Screening and Treatment for Maternal Depression Program), and population health models (e.g. the Collaborative Care Model).
    - Expand research on promising integrated care models and establish an interagency commission to study and make recommendation for sustainable financing models to support the integration of behavioral health into primary care.
    - Remove the in-person requirement for new MH/SUD patients electing to use telehealth

2. **Strengthen the Mental and Behavioral Health Workforce**
    - Increase in graduate medical education funding for psychiatric residencies and psychiatric subspecialties.
    - Training for mental health providers like social workers, peer support specialists, and other professionals, including in trauma-informed care.
    - Increase funding for training primary care clinicians in treating patients with MH/SUD, including through the Substance Use Disorder Loan Repayment program.
    - Increase funding for training the behavioral health workforce on working in an integrated practice and in a primary care setting.

3. **Address Payment Barriers that Impact Access to Mental Health and SUD**
    - Increase payment for existing CPT codes for the Collaborative Care Model and general BHI code, and ensure Medicaid payment for these codes.
    - Allow payment for services provided to patients without a diagnosis.
    - Eliminate restrictions on same-day billing for MH/SUD and primary care services

- Ensure Medicaid payment parity with Medicare for mental and behavioral health care including care provided by primary care clinicians.

4. Enhancing MH/SUD Care Promotion, Prevention, and Early Intervention

- Increase funding to community health and mental health centers and ensure federal funding can go toward prevention and early intervention programs (i.e mental health services block grant; coordinated specialty care).
- Ensure schools provide students with access to qualified mental health professionals.

5. Strengthen Mental Health Parity Law

- Ensure that implementation of the mental health parity law is enforced by regulators and states and put into practice by insurers in a way that increases access to appropriate care for patients.
- Ensure payment parity in Medicaid fee-for-service between MH/SUD care and primary care services.
- Implement prior authorization, step therapy, and other non-quantitative treatment limits for MH/SUD.
- Apply the mental health parity law to Medicare and provide access to key mental health and substance use treatment benefits that, while recognized as necessary by other insurance platforms, remain excluded from the Medicare program.

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