



June 22nd, 2015

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219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing more than 36,000 physicians specializing in psychiatry, I am writing in response to your May 22nd solicitation for stakeholder feedback on the impact of chronic disease and on recommendations for improving care for Medicare beneficiaries.

The prevalence of mental illness and substance use disorders is widespread. Over 40 million Americans are affected by a diagnosable mental disorder every year. The National Institute of Mental Health (NIMH) reports that 13.6 million Americans suffer from serious mental illness, such as bipolar disorder, major depression, and schizophrenia. Moreover, both mental illness and substance use disorders place a significant economic burden on our society. For example, NIMH reports that the annual economic cost of mental disorders is \$444 billion each year. This unacceptably high figure illustrates a broken mental healthcare delivery system in our country – a system marked by inadequate or uncoordinated services, unnecessary hospitalizations and incarcerations, inadequate reimbursements, and the ongoing social stigma around mental illness and substance use disorders. As a result, individuals suffering from mental illness and substance use – especially individuals suffering from serious mental illness – often face impenetrable barriers when trying to access the treatment that would put them on the path to resiliency and productivity.

While significant scientific advances have been made in the understanding and treatment of mental illnesses and substance use disorders, these diseases overwhelmingly remain chronic conditions and cannot be cured. Individuals with mental illness and substance use disorders often carry a co-morbid medical condition, such as heart disease, diabetes, and hypertension. For example, 68% of adults with a mental disorder suffer from a medical comorbidity. Thus, it is imperative that any Congressional initiative designed to formulate new policies concerning chronic care management adequately take into consideration mental illness and substance use disorders.

We appreciate the opportunity to offer thoughts and recommendations in the following areas:

Integrated Care

The integration of psychiatric and medical care is a significant part of a solution to reducing overall health care costs, improving quality and population health, and reducing excess morbidity and mortality among patients with psychiatric and substance use disorders. According to an APA-commissioned Milliman report released in 2014, effectively integrating primary and mental healthcare could net an annual savings of \$26-\$48 billion to Medicare, Medicaid, and private insurers. APA has identified five core models of integrated care, which stand to improve services provided to Medicare and Medicaid beneficiaries: collaborative care, care management, reverse co-location, medical homes, and Accountable Care Organizations (ACOs).

There is a robust evidence base for some collaborative care models for patients with co-morbid conditions. Collaborative care models have been studied most extensively and rigorously for patients with comorbid depression, although models are being extended to patients with other co-morbidities, including anxiety, substance use, and multiple medical co-morbidities. A meta-analysis of 37 trials demonstrated that collaborative care compared with basic primary care was associated with a two-fold increase in antidepressant adherence, improvements in outcomes for depression that lasted between two and five years, and increased patient satisfaction with depression care and primary care. The Impact Collaborative Care model, developed by the AIMS Center in Washington state, which is consistent with patient-centered principles and cost and quality objectives, needs to be supported as an effective way of providing effective psychiatric care for patients in a primary care setting. This model has a large body of peer-reviewed evidence supporting its effectiveness.

Some care management models are also yielding positive results. One study assessed the two-year outcomes, costs, and financial sustainability of a medical care management intervention for a Community Mental Health Center (CMHC). It found that sustained improvements were made in the intervention group in the quality of primary care preventive services, the quality of cardio-metabolic care, and the mental health-related quality of life. Data was also collected on Missouri Medicaid enrollees in CMHCs. Overall, case management services were found to be effective in reducing total healthcare costs for seriously mentally ill patients with moderate to severe illness.

There are also a number of pilots integrating primary care into specialty public sector mental health settings – a move known as reverse co-location. One study tested a population-based medical care management intervention designed to improve primary medical care in CMHCs. At a 12-month follow-up, the intervention group received an average of 59 percent of recommended preventive services compared with a rate of 22 percent in the usual care group. Overall, medical care management was associated with significant improvements in the quality and outcomes of primary care. The State of Missouri also initiated several programs to improve the health of patients with serious mental illness. One involved providing primary care nurse liaisons on site at all CMHCs. Preliminary results found that

the program almost broke even after 18 months. A follow-up analysis demonstrated a cost savings of 17 percent off expended trends.

Conclusive data for medical home and ACO models is still pending for psychiatry. The Patient Centered Primary Care Collaborative (PCPCC) is tracking 54 pilot projects nationwide that cover nearly 5 million patients. In these pilots, primary care physicians are creating a patient-centered medical home (PCMH) for their patients in which some level of care coordination (including the treatment of psychiatric and substance use disorders) is provided. Data collected thus far, as reported on the PCPCC website, show that medical homes in primary care have decreased emergency room visits, decreased hospitalizations, and decreased the number of outpatient visits per person.

Medicare's move to pay-for-performance and new structures like ACOs that support collaborative care are a step in the right direction. A large percentage of patients with chronic diseases also have chronic mental health or substance use disorders—and this patient population has been shown to cost the system far more than patients with chronic diseases alone. **Access to psychiatric treatment must be considered an essential part of the care a patient gets through an ACO, and quality measures must be developed that accurately reflect psychiatric care so that the psychiatrists who provide that care will be reimbursed appropriately for the care they provide. Practical payment methodologies for this patient population must support delivery systems that have actually been shown to be effective. Furthermore, consideration must be given to payment methodologies that could include more than one type of payment structure (e.g., traditional services-based payments, capitated contracts, per-member-per-month payments, etc.) to account for the work required for population-based management and care.**

Financing of coordinated care and non-face-to-face consultative activities

Recent changes to CMS policy that allow for the reimbursement of some non-face-to-face coordination of care activities are a beginning, but mechanisms must be put in place that provide adequate payment for additional coordination of care and non-face-to-face consultative activities. To support off-site consultative care, coverage of telehealth services needs to be extended to include consultative care even in geographical areas where telehealth would normally not be covered. These are components of delivery system models that have been proven to improve care and lower overall costs.

Improvements to Medicare Advantage for patients living with multiple chronic conditions

It is essential that Medicare Advantage has state of the art approaches toward providing long-term services and supports (LTSS), which are essential to providing optimal, cost-effective care for patients with multiple chronic conditions. Furthermore, it is imperative that network adequacy standards related to managed care provision of LTSS ensure access to the full range of clinicians providing these services. In as much as this is a developing area, there should be a routine assessment of regulatory requirements to ensure that standards keep up with any changes in the field. We are happy to serve as a resource to you in this area to assist in informing future related policymaking.

Enactment of comprehensive mental health reform

Barriers to coordinated care for elderly and disabled individuals suffering from chronic mental health and substance use disorders are significantly reinforced by fragmented and uncoordinated federal mental health resources, discriminatory coverage policies that target individuals with MH/SUD, and an acute lack of research funding in the face of the immense need. For these reasons and others, APA supports enactment of bipartisan comprehensive mental health reform in this 114th Congress. APA strongly supports H.R. 2646, the Helping Families in Mental Health Crisis Act, which was recently reintroduced by Representatives Tim Murphy, PhD (R-PA) and Eddie Bernice Johnson (D-TX). H.R. 2646 prioritizes care coordination, workforce development, access to evidence-based treatments, and promotion of innovative delivery models throughout its system-wide reimagining of federal mental health delivery. APA is also looking forward to expected introduction of comprehensive mental health reform legislation in the Senate, led by Senators Chris Murphy (D-CT) and Bill Cassidy (R-LA). We urge your continued attention to these critical efforts.

Addressing the geriatric and community psychiatric workforce

Nearly one in five older Americans have one or more mental health or substance use disorders. These conditions both debilitate on their own and exacerbate other chronic medical comorbidities. For example, the presence of depressive disorders among the elderly often adversely affects and complicates the treatment of other chronic diseases¹. Furthermore, older adults with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer in the hospital on average². The treatment needs of this population greatly benefit from specialized care, yet access to a certified geriatric psychiatrist is challenged by significant workforce shortages. Since 1990, only about 2,500 psychiatrists have received subspecialty certification in geriatric psychiatry. This supply is woefully inadequate to meet the future needs of the nation to provide the highest quality of care for elderly Medicare beneficiaries with chronic mental health conditions. The landmark 2012 Institute of Medicine report titled *the Mental Health and Substance Use Workforce for Older Adults* made a number of recommendations to ameliorate this situation that are due consideration by Congress. These include recommendations on coordinating federal workforce development efforts, scholarship and loan forgiveness promotion, and enhancing data collection, among others.

These methods may be similarly employed to address the critical workforce shortage of community psychiatrists. Further federal assistance is needed to recruit, train, professionally support, and retain psychiatrists practicing in community settings who frequently face overwhelming patient loads, among other challenges.

¹ Chapman DP, Perry GS, Strine TW (2005). The vital link between chronic disease and depressive disorders. *Prev Chronic Dis*; 2(1):A14.

² U.S. Department of Health and Human Services (1999). *Older Adults and Mental Health. Mental Health: A Report of the Surgeon General*

Forthcoming expiration of the ACA's Medicare Primary Care Bonus

As you know, the Affordable Care Act created a 10 percent Medicare incentive payment to eligible physicians for specified primary care services. This Medicare reimbursement bonus is scheduled to expire at the end of 2015. The Medicare Payment Advisory Commission has recommended that this bonus payment be replaced with a per-beneficiary payment for "primary care" providers to be paid for by a reduction in all services under the fee schedule besides those that are defined as primary care under the program. Psychiatrists and other cognitive specialists provide these services to individuals with complex medical conditions, yet they would not be eligible for the payment - and their patients would not be afforded greater access to coordinated care under the MedPAC plan.

CMS recently recognized the central role psychiatrists take on for their patients in commentary within its recently released Final Rule that made modifications to the Medicare Shared Savings program:

"We agree with commenters that psychiatry and its subspecialties often provide a substantial proportion of primary care for certain patients ...psychiatry is frequently the point of first contact for persons with undiagnosed conditions and that those persons with serious mental illness or substance abuse disorders or both may prefer to receive their total care from their psychiatrist rather than from primary care physicians"³

While the MedPAC proposal has both merit and the potential to facilitate better coordinated care for Medicare beneficiaries with chronic mental illness and other comorbidities, it would disenfranchise scores of individuals, particularly those with SMI, who rely on a psychiatrist as their primary care provider. We recommend that Congress base any future coordination payment incentive on the services rendered to the patient rather than arbitrary specialty designation.

Empowering Medicare patients to play a greater role in management their health and provider engagement

If Medicare patients are to play a greater role in managing their own health, the system needs to find more ways to encourage/incentivize preventive care and compliance with treatment plans, and systems must be based on a better understanding of factors that impact health. As noted in a recent report from the National Academy of Sciences, "Despite strong evidence of the influence of social and behavioral factors on health, these factors have not been well addressed in clinical care. The increasing emphasis on population health management is focusing more attention on the social and behavioral determinants of health, but the limited availability of information on these determinants impedes efforts to delay the onset and progression of disease and improve well-being."⁴ As previously noted, the ability to collect data on the impact of these factors largely hinges on widespread adoption of meaningful electronic health records – which has been a challenge among psychiatrists and within the mental health community.

³ <http://federalregister.gov/a/2015-14005>

⁴ <http://www.nap.edu/catalog/18951/capturing-social-and-behavioral-domains-and-measures-in-electronic-health-records>

Effective prescription drug policy

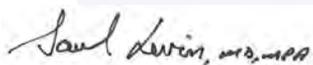
Coverage of appropriate and physician-recommended interventions for Medicare beneficiaries with chronic conditions is an essential element to promoting adherence and facilitating the treatment of the whole person - including the interaction of psychotropic medications with other medications and other medical comorbidities. Currently, Medicare Part D beneficiaries have coverage for all or substantially all medications in six protected classes of pharmaceuticals that are prescribed to treat conditions including mental illness, epilepsy, cancer, and HIV/AIDS. The protected classes policy came under attack last year when the Centers for Medicare and Medicaid Services (CMS) proposed to exclude antidepressants, antipsychotics, and immunosuppressants from their protected status. Such a revision would have had a potentially devastating effect on millions of Americans who rely on these therapies for their health and well-being. After a massive public outcry and a strong response from Congress, CMS chose not to finalize these proposed changes - but the door was left open to make such exclusions in the future. Without permanent statutory protection, the protected classes remain at risk.

S.648, The Medicare Formulary Improvement Act, introduced by Senator Chuck Grassley (R-IA), would require CMS to permanently preserve protected status for the six classes of medication. This legislation protects patients with chronic mental health and substance use conditions and ensures that seniors, people with disabilities, and Medicare-Medicaid dual enrollees would not be denied their access to life-saving medications.

Lastly, pharmacy benefit plans must not be creating obstacles in access to medications that will provide optimal care and will minimize the need for higher cost services for acute episodes of chronic diseases. The costs of drugs must be balanced against the costs of failing to provide effective treatment, and the effective use of registries would allow for this kind of assessment. Monitoring through registries or other tracking methods should be employed to assess patient progress (i.e., "treat to target"). There also needs to be effective use of specialists who can offer consultation on pharmacotherapy to a primary treating physician when improvement is not seen. Enhancing availability and adoption of state of the art health information technology is essential for optimal chronic care coordination.

APA looks forward to working with you and other Committee members on methods to promote models of evidence-based integrated mental healthcare for elderly and disabled Medicare beneficiaries suffering from chronic medical conditions. Thank you in advance for your review and consideration.

Sincerely,



Saul Levin, M.D., M.P.A.
CEO and Medical Director

CC: The Honorable Johnny Isakson
The Honorable Mark Warner