



1000 Wilson Blvd., Suite 1825
Arlington, VA 22209

October 28, 2016

Andy Slavitt, M.B.A.
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
(Submitted electronically to SIM.RFI@cms.hhs.gov)

Board of Trustees
2016-2017

Maria A. Oquendo, M.D.

President

Anita S. Everett, M.D.

President-Elect

Altha J. Stewart, M.D.

Secretary

Bruce J. Schwartz, M.D.

Treasurer

Renée L. Binder, M.D.

Paul Summergrad, M.D.

Jeffrey A. Lieberman, M.D.

Past Presidents

Jeffrey L. Geller, M.D., M.P.H.

Vivian B. Pender, M.D.

Roger Peele, M.D.

Ronald M. Burd, M.D.

R. Scott Benson, M.D.

Melinda L. Young, M.D.

Jeffrey Akaka, M.D.

Lama Bazzi, M.D.

Gail E. Robinson, M.D.

Stella Cai, M.D.

Uchenna B. Okoye, M.D., M.P.H.

Trustees

Assembly

2016-2017

Daniel J. Anzia, M.D.

Speaker

Theresa M. Miskimen, M.D.

Speaker-Elect

James R. Batterson, M.D.

Recorder

Administration

Saul Levin, M.D., M.P.A.

CEO and Medical Director

Re: Request for Information on State Innovation Model Concepts

Dear Administrator Slavitt:

The American Psychiatric Association (APA), the national medical specialty representing over 36,500 psychiatric physicians and their patients, is pleased to provide the following comments to the Centers for Medicare and Medicaid Services (CMS) in response to its Request for Information (RFI) on State Innovation Model (SIM) Concepts. Because of the prevalence of mental health and substance use disorders (MH/SUDs) and associated comorbidities, states have an important role to play in addressing the significant gaps in care for these conditions.

There is much work to be done to increase patients' access to appropriate care that will address their mental health and substance use disorders and related needs. In 2014, about 18% (43.6 million) of adult Americans and 13 to 20% of children and adolescents had a mental illness. 8% (20.2 million) of individuals 12 and older had a substance use disorder.ⁱ Yet only 40% of adults and 50.6% of children ages 8-15 with a diagnosed mental illness – and only 59% of those with a serious mental illness – received treatment.^{ii,iii} Individuals with mental illness often also have extensive non-psychiatric medical needs, which are exacerbated by mental illness, and include cardiovascular disease, diabetes, and obesity. The rate of mortality among persons with mental illness in comparison to those without is startlingly high.^{iv} A meta-analysis of worldwide mortality estimates found that the risk of mortality was 2.2 times higher for persons with mental disorders.^v Most of this early mortality is associated with chronic comorbid conditions.

In light of these significant challenges, the APA is pleased that most states that have received a SIM grant to date have implemented some care intervention to improve the delivery of behavioral health services. However, as the RFI discusses, the types of interventions utilized by states have varied, and there are opportunities for rigorous assessment of specific interventions.

As CMS considers future SIM awards, we offer comments on the following issues:

- Utilizing CMS authority/investment to further adoption of the evidence-based Collaborative Care Model;
- Ensuring robust psychiatrist input into behavioral health integration (BHI) models and other system reforms; and
- Potential focus areas for BHI model testing.

Utilizing CMS Authority/Investment to Further Adoption of the Evidence-Based Collaborative Care Model

The APA urges CMS to utilize the SIM program and its funds to promote and support adoption of models for which a robust evidence-base already exists – and in the case of MH/SUD, the Collaborative Care Model (CoCM). Over 80 randomized controlled trials have shown the CoCM to be more effective than care as usual. Meta-analyses, including a 2012 Cochrane Review, further substantiate these findings.^{vi,vii} Economic studies demonstrate that collaborative care is more cost-effective than care as usual, and several evaluations found cost-savings associated with its use.^{viii,ix} The largest randomized, controlled clinical trial to date of the CoCM - the IMPACT study involving adults 60+ across 5 states and 18 primary care clinics - found that patients in collaborative care had substantially lower overall health care costs than those receiving usual care.^x “An initial investment in collaborative care of \$522 during Year 1 resulted in net cost savings of \$3,363 over Years 1-4.”^{xi}

Under the CoCM, primary care providers treating patients with common behavioral health problems are supported by a care manager and a psychiatric consultant who help implement effective, evidence-based treatment for common behavioral health problems in the primary care setting. The widespread implementation of the evidence-based CoCM, under both fee-for-service and value-based purchasing/payment systems, could dramatically improve access to effective behavioral health care while at the same time reducing the high health care costs associated with common mental health and substance use disorders.

CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Surgeon General, and the Agency for Healthcare and Quality (AHRQ) have already recognized the CoCM as an evidence-based best practice, and CMS has proposed to cover and reimburse the CoCM under the 2017 Medicare Part B Fee Schedule.

To speed uptake of this model, CMS could make funding available under the SIM for states to:

- 1) Create programs to train primary care practices in the model (including linking them to existing TCPI efforts in this area);
- 2) Provide technical assistance to support needed practice transformation, which includes education and support in redesigning workflows, contracting, hiring of care managers, and quality metric tracking; and
- 3) Institute appropriate reimbursement pathways for care delivered in this model.

Ensuring Robust Psychiatrist Input into Behavioral Health Integration (BHI) Models and Other System Reforms

Based upon input from psychiatrists who are active in state-based behavioral health integration efforts as well as broader delivery and payment system reform, we urge CMS to increase ongoing opportunities for psychiatrists to provide input both at the federal and state level. In relation to the quality metrics that are selected to assess a reform’s success, there are concerns that there are not enough relevant measures being used to assess meaningful improvement in care delivery and health outcomes for MH/SUDs. In cases of broader, system-wide transformation efforts, such as accountable care organizations, we have heard concerns that MH/SUDs are not a central consideration of reforms. This is despite the fact that such disorders can be a major contributor to (and exacerbating factor for) morbidity and mortality, which unfortunately is particularly true for vulnerable populations.

We urge CMS to include as part of future RFPs and funding arrangements, specific questions and other appropriate features to ensure that input is obtained from psychiatrists and other behavioral health providers. This type of information should be requested on an ongoing basis and addressing MH/SUDs should be incorporated into the design of new models of care delivery. Such avenues would include public comment periods, and requiring psychiatrist representation on work-groups/task forces/committees engaged in this reform work.

Potential Focus Areas for Behavioral Health Integration Model Testing

As the RFI discusses, there are numerous approaches to addressing MH/SUDs and primary care integration. Unfortunately, most models in behavioral health integration lack the substantial evidence basis of the CoCM. More assessments of these other models are needed. We therefore support CMS making supplemental rewards, as contemplated in the RFI, to support rigorous testing of new models and approaches.

The APA is particularly interested in identifying the key elements and design features needed to ensure the effectiveness and success of models of co-location and “reverse integration,” particularly those focusing on individuals with severe mental illness (SMI). Numerous governmental and non-governmental entities have identified specific research needs, many of which would be well suited to CMS’ interest in evaluating standardized care interventions.

The Reforming States Group and Milbank Memorial Fund reviewed the evidence on integrating primary care into behavioral health settings for individuals with SMI, evaluating 12 randomized controlled trials. They concluded that:

- Care management may improve mental health symptoms and mental health-related quality of life for patients with bipolar disorder and SMI ([moderate Quality of Evidence] QOE).
- Fully integrated care and care management improves use of preventive and medical services (moderate QoE) and may improve physical health symptoms and quality of life for patients with bipolar disorder and SMI (low QoE).
- Colocating primary care in chemical dependency treatment settings without enhanced coordination and collaboration does not improve mental or physical health outcomes (moderate QoE).
- All interventions required additional staff, training, and oversight except when intervention staff was dually trained in primary care and substance misuse treatment.”

However, “comparisons across studies to determine key components of BHI interventions for SMI populations are difficult due to few studies targeting this population and a lack of consistent definition of collaborative care management.” CMS could utilize the findings of this evidence review to design a standardized multi-state assessment around delivery of integrated care for individuals with SMI.”^{xii}

The Rand Corporation evaluated the Substance Abuse and Mental Health Administration (SAMHSA) Primary and Behavioral Health Care Integration (PBHCI) Grant Program and made specific recommendations for additional research on effective models of primary care delivery in behavioral health settings:

“Conduct a prospective trial of alternative models of integrated care. There are currently several, large ongoing trials of health care innovations including integrated care models. As such, stakeholders in the field could conduct a prospective, comparative effectiveness trial to assess the comparative clinical

impact and costs associated with these models when serving similar and/or overlapping populations of adults with SMI.”^{xiii}

The Agency for Healthcare Research and Quality (AHRQ) issued a report on “Future Research Needs for the Integration of Mental Health/Substance Abuse and Primary Care” which included the following points relevant to this RFI:

“What are effective methods of integrating primary care into specialty mental health practice settings? Studies would include both mental and general health outcome(s) (e.g., obesity and depression). Among adults with serious mental illness seen in specialty mental health settings, what are effective methods of integrating primary care components such as preventive interventions and chronic disease management, into their mental health care, compared with referral to primary care?”^{xiv}

The Patient-Centered Outcomes Research Institute (PCORI) has also identified mental health and primary care integration as a priority area and has offered the following suggestions:

“Compare the effectiveness of care models that integrate mental and behavioral health care, including substance abuse treatment, into the primary care provided by community health centers and other relevant settings, with the goal of reducing disparities in care (e.g., access to mental and behavioral health services and the diagnosis and treatment of mental and behavioral health conditions) and improving health outcomes among underserved populations, including racial/ethnic minorities, low-income individuals, and rural populations.”^{xv}

Thank you in advance for your consideration of our comments. The APA looks forward to working with CMS as it develops additional SIM funding opportunities. If you should have any questions or would like to discuss our comments further, please contact Nevena Minor, APA Deputy Director of Payment Advocacy, at nminor@psych.org or (703) 907-7848.

Sincerely,



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

ⁱ Substance Abuse and Mental Health Services Administration. “Mental and Substance Use Disorders.” Available at: <http://www.samhsa.gov/disorders>. Accessed 10/21/2016.

ⁱⁱ National Institute of Mental Health. “Use of Mental Health Services and Treatment Among Adults.” Available at: <http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml>. Accessed 10/21/2016.

ⁱⁱⁱ National Institute of Mental Health. “Use of Mental Health Services and Treatment Among Children.” Available at: <http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-children.shtml>. Accessed 10/21/2016.

^{iv} Druss, B.G et al. “Mental disorders and medical comorbidity.” Robert Wood Johnson Foundation. Research Synthesis Report No. 21, February 2011. Available at: <http://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html>. Accessed 10/21/2016.

^v Walker, E.R. et al. “Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis.” *JAMA Psychiatry* 72: 334-341, 2015.

-
- ^{vi} AIMS Center (Advancing Integrated Mental Health Solutions). "Collaborative Care Evidence Base." Available at: <https://aims.uw.edu/collaborative-care/evidence-base>. Accessed 10/22/2016.
- ^{vii} Archer J et al. "Collaborative care for people with depression and anxiety." Cochrane Review. October 2012.
- ^{viii} Gilbody S et al. "Costs and Consequences of Enhanced Primary Care for Depression: Systematic Review of Randomised Economic Evaluations." The British Journal of Psychiatry. October 2006;189:297-308.
- ^{ix} Glied S et al "Review: The Net Benefits of Depression Management in Primary Care." Medical Care Research and Review. June 2010;67(3):251-274.
- ^x Unützer J et al. "Long-term Cost Effects of Collaborative Care for Late-life Depression." American Journal of Managed Care. Feb 2008;14(2):95-100.
- ^{xi} Unützer J et al. "The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes." Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013.
- ^{xii} Gerrity, M. et al. "Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness." New York, NY: Milbank Memorial Fund. 2014.
- ^{xiii} Scharf D, et al. "Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program." Santa Monica, Calif, RAND, 2014.
- ^{xiv} Carey TS, et al. "Future Research Needs for the Integration of Mental Health/Substance Abuse and Primary Care: Identification of Future Research Needs from Evidence Report/Technology Assessment No. 173." Rockville (MD): Agency for Healthcare Research and Quality. 2010.
- ^{xv} Patient-Centered Outcomes Research Institute. "List7: Listed as a PCORI Priority in a Pragmatic Clinical Studies Funding Announcement." <http://www.pcori.org/research-results/how-we-select-research-topics/generation-and-prioritization-topics-funding-5>. Accessed: 10/21/2016.