AMERICAN PSYCHIATRIC ASSOCIATION

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January 26, 2016

The Honorable Orrin Hatch
Chairman, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
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, we are pleased to offer these comments in response to the Policy Options Document issued by your Bipartisan Chronic Care Working Group. In particular, we appreciate your highlighting the importance of addressing mental health among chronically ill Medicare beneficiaries, and we look forward to working with you to advance access to treatment for these individuals.

Mental illness and substance use disorders (MH/SUDs) are widespread and place a significant economic burden on our society.[1,2,3] While significant scientific advances have been made in their understanding and treatment, these diseases overwhelmingly remain chronic conditions. Individuals with MH/SUDs often experience co-morbid medical conditions, such as heart disease, diabetes, and hypertension. Additionally, the presence of MH/SUDs may actually exacerbate such co-morbidities.[4,5] As you point out, better care coordination via integration of mental health and primary care has been proven to improve health outcomes and reduce health care costs.[6] Yet only a minority of patients receive effective behavioral health care in primary care settings, which is where the majority of individuals with MH/SUD receive their usual care.[7] We therefore recommend several specific policies for your consideration, which address these challenges, and which we previously shared with you. **These include several recommendations related to promoting the evidence-based Collaborative Care Model for Beneficiaries with Common Behavioral Health Conditions (CoCM), which meets your goals of identifying data-driven policies that increase care coordination, incentivize via payment mechanisms appropriate levels of care, improve health outcomes, and realize cost savings.**

Addressing the Need for Behavioral Health Among Chronically Ill Beneficiaries

APA recommends robust Congressional support of the evidence-based and cost-effective Collaborative Care Model (CoCM). This includes:

- **Endorsing coverage and reimbursement for the CoCM in the 2017 Medicare Physician Fee Schedule, which is currently under consideration by the Centers for Medicare and Medicaid Services (CMS);**
- **Promoting the CoCM utilization in the dual eligibles population;**
- **Designating the CoCM as a qualifying Alternative Payment Model for purposes of MACRA implementation; and**
- **Backing initiatives, such as training and technical assistance to individual physician practices, to educate primary care providers about the CoCM and eliminate barriers to its adoption.**

The Collaborative Care Model for Beneficiaries with Common Behavioral Health Conditions

The CoCM employs a team-based approach that gives patients seen in primary care settings access to behavioral health care that is both clinically and economically effective. The CoCM includes all three following elements:

1) Care coordination and care management,
2) Regular, proactive outcome monitoring and treatment to target using validated clinical rating scales/standardized outcome measures, and
3) Regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement.

The CoCM requires all of these core components to be present; however, the CoCM grants considerable flexibility in their delivery. Both small and large primary care practices and both rural and urban practices have delivered evidence-based collaborative care while incorporating all of CoCM's core functions. In the CoCM, primary care providers treating patients with common behavioral health problems are supported by a behavioral health care manager and a psychiatric consultant who help implement effective, evidence-based treatments in the primary care setting. The primary care provider (PCP) is a family or internal medicine physician, but may also be a nurse practitioner, or physician assistant. The care manager is a nurse, clinical social worker, or psychologist, who is based with the PCP and trained to deliver evidence-based care coordination, brief behavioral interventions, and support the treatments initiated by the PCP. In some implemented versions of the CoCM the care management staff also conducts structured psychotherapy like cognitive behavioral therapy. The psychiatric consultant is a psychiatrist, or nurse practitioner/physician assistant with psychiatric training, whose primary responsibilities are making treatment recommendations, as needed, including psychiatric and other medical differential diagnosis, treatment strategies regarding appropriate therapies (e.g., medication, psychotherapy), and medical management of complications associated with treatment of psychiatric disorders.[8]

We would like to note that there are numerous other approaches to integrating behavioral health in primary care. However, unlike the CoCM, these separately delivered approaches lack consistent evidence of their effectiveness and cost-effectiveness.[9]

Evidence of the CoCM's Clinical Effectiveness

Over 80 randomized controlled trials (RCT) have shown the CoCM to be more effective than care as usual. These findings were further substantiated by meta-analyses, including a 2012 Cochrane Review.[10,11] As a result, the CoCM has been recognized as an evidence-based best practice by a wide array of authorities, including CMS, the Substance Abuse and Mental Health Administration (SAMHSA), the Surgeon General, the National Business Group on Health, and the Agency for Healthcare Research and Quality. In addition to the robust research evidence for the value of collaborative care, there is also substantial practice experience with this model from the Medicaid-funded Mental Health Integration Program in Washington State, the commercially funded DIAMOND program in Minnesota, and similar programs in several other states. Large scale clinical and research initiatives on using the CoCM have been conducted:

- In diverse health care settings, including different network and staff model health systems, as well as private and public providers;

- With diverse financing mechanisms, including fee-for-service and capitation;
- With different provider practice sizes in both rural and urban locations; and
- With different populations, including both insured and uninsured/safety-net populations.

Evidence of the CoCM's Cost Effectiveness

Not only have economic studies demonstrated that collaborative care is more cost-effective than care as usual,[12,13] **but several evaluations in fact found cost-savings associated with the use of the CoCM.** The largest RCT to date of the CoCM - the IMPACT study involving adults 60+ across 5 states and 18 primary care clinics - found that patients receiving the collaborative care intervention had substantially lower overall health care costs than those receiving usual care.[14] "An initial investment in collaborative care of $522 during Year 1 resulted in net cost savings of $3,363 over Years 1-4. This corresponds to a return on investment of $841."[15] **The widespread implementation of the CoCM under both fee-for-service and value-based purchasing/payment systems could therefore dramatically improve access to effective behavioral health care while at the same time reducing the high health care costs associated with common MH/SUDs.**

Barriers to Adoption

The lack of reimbursement for components of this model is the main barrier to widespread implementation. Implementing the CoCM can also require significant practice changes, another barrier for adoption by PCPs. These changes include the need for trained staff to fill the role of care manager and registry/database capacity to support care management and outcomes tracking.

Routine Medicare and Medicaid reimbursement currently does not provide reimbursement for the roles of the care manager and the psychiatric consultant. CMS, as part of its 2016 physician fee schedule rulemaking, initiated discussion of adopting and valuing codes to reimburse for the components of the CoCM. We applaud CMS' consideration of the CoCM and are sharing our expertise with the agency to ensure adoption and appropriate valuation of the CoCM. Based on all the RCTs and large-scale practice experience that has included all major payer types (Medicare, Medicaid, and commercial insurance), we believe there is no need to further study variations in payment methodology or in establishing payment amounts for the CoCM. Extensive research and practice experience with the CoCM exists to enable the development of specific codes and the appropriate valuation of these codes, and therefore are strongly encouraging CMS to proceed in establishing payment for the evidence-based CoCM without additional demonstrations.

We urge Congress to:

- **Support CMS' plans to cover CoCM care and ensure that CMS maintains fidelity to the CoCM, which, as discussed, is THE most scientifically substantiated model for integrating behavioral and primary healthcare.**
- **Create and support mechanisms through which practices can receive technical and other assistance needed to modify their operations to implement the CoCM.**
- **Designate the CoCM as a qualifying Alternative Payment Model under MACRA, similarly how it did with the patient centered medical home, because of CoCM's ability to produce cost-savings, while improving health outcomes.**
- **Consider policies to promote adoption of the CoCM for Medicare-Medicaid dual eligibles.**

Need for Integration of Primary Care Into Specialty Mental Healthcare

APA is also supportive of several efforts to better to enhance the capacity of specialty mental healthcare settings to provide important coordinated primary health services. For example, comprehensive mental health reform legislation introduced in the Senate (S.1945, *the Mental Health Reform Act of 2015*) would establish an improved primary and behavioral integration grant program for community mental health within SAMHSA. APA also supported the passage of the Excellence in Mental Health Act demonstration program (Sec. 223 of the Protecting Access to Medicare Act of 2014), to help states establish certified community behavioral health clinics and improve integration of primary and mental healthcare services therein. APA is closely following its implementation by SAMHSA and the selected demonstration states.

Co-Pay Requirements for Accountable Care and Chronic Care Management Services

The APA supports waiving of co-pay requirements to promote the use of chronic care management services. Specifically related to the CoCM, our review with CoCM experts indicates that patient co-pays can be an impediment to the use of care management and psychiatric consultation. The consistent finding that the CoCM is cost-effective, and creates cost-savings in some settings/populations, is based on programs without cost-sharing. Minnesota's DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) program did at some sites require patient cost-sharing. DIAMOND found that cost-sharing for these collaborative care services, and the associated requirements for explicit patient consent – as the chronic care management code requires – were barriers to care.[16]

Expanding Use of Telehealth

APA strongly supports reimbursement for telemedicine services across all of Medicare (including in Accountable Care Organizations (ACOs) and Medicare Advantage Plans) and lifting the originating site requirement across the entire Medicare program.
The concept of an "originating site" is an outmoded idea and contrary to current standard of care. Telemedicine use in psychiatry increases access to services with positive clinical outcomes regardless of specific originating site. Medicare Advantage reimbursement for telemedicine services would be welcome as well. To ensure accurate reimbursement for actual rendered services there should be an emphasis on physicians integrating the telemedicine technology into their tracking of delivered services and associated charges.

Improvements to ACOs

The patient attribution methodologies utilized by ACOs require substantial revision, and APA urges that resources be dedicated to address current data limitations. Under the current methodologies, providers may be inappropriately held accountable for spending they do not control, while other providers are not held accountable for their share of costs. We strongly endorse new methods for measuring spending and assigning accountability which can: 1) identify the services and spending that can actually be controlled or influenced by the respective provider; 2) identify services which represent opportunities for lower spending and improved patient care; 3) accurately categorize which patients have greater needs for services; 4) accurately account for differential structural costs for providers, and 5) better facilitate provider comparisons with respect to both costs and outcomes.

Improving Transparency at CMMI

APA supports requiring CMMI to engage in notice and comment rulemaking for models it intends to test. In light of the impact that MH/SUDs have on co-morbid conditions, it is important for relevant groups such as the APA to be able to identify if proposed models, which focus on other disease states, fail to address the interplay between MH/SUDs and that disease.

Thank you again for the opportunity to comment. APA looks forward to working with you as you craft legislation to improve the delivery of chronic care services to our nation's elderly and disabled. If you have any questions, please contact Jeffrey P. Regan, APA Chief of Government Affairs (Acting), at jregan@psych.org or 703-907-7800.

Sincerely,

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

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