

Resource Document on Core Principle for Alternative Payment Models for Behavioral Health

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The APA's Position Statement enunciates 10 principles. These are presented below along with their supporting background information.

- The first principle declares that the predominant goals for behavioral health APMs should be defined as increasing access and improving quality of care for individuals with mental health and substance use disorders (MH/SUDs), in order to improve outcomes.

From the outset, there needs to be a fresh, new approach for developing and evaluating alternative payment models for individuals with mental health and substance use disorders (MH/SUDs). Behavioral health APMs should be required to meet the fundamental goals of improving access to care, and ensuring high standards of care, for individuals with MH/SUDs. Reining in costs is a laudable goal, but models that only do this are not meeting the needs of this population.

- The second principle notes that mental health and substance use treatment has suffered from decades of inadequate funding and reimbursement.
- The third principle emphasizes that current payments for psychiatric services do not cover the costs of providing the services and APMs must reflect the true costs of care. Therefore, APMs cannot be expected to reduce expenditures for the care of the population with these disorders.

For psychiatric services, the current rates from many payors do not cover the costs of providing the services. Healthcare organizations lose money on psychiatric services and have to cover the loss from other service lines. This creates an inappropriate business incentive which restricts access. The base payment rate of any APM must be adequate to cover the costs of providing the services. (The prospective payment system (PPS) for Certified Community Mental Health Centers is an excellent example an APM consistent with this principle.) The general rationale behind implementation of APMs does not apply to patients with mental illness. Much of the impetus for new models of care stems from data showing that the high spending in American health care does not translate to better patient outcomes. The vast majority of existing APMs address either primary care – to incentivize primary care providers to serve as gatekeeper and care coordinator to decrease unnecessary procedures and hospitalizations — or are built around very costly procedures or conditions. The primary goal is often to reduce the overall costs for the entire course of care for such patients.

The circumstances are very different for patients with mental illness, including substance use, and the psychiatrists who treat them — if those patients are even able to see a psychiatrist. Unlike the overwhelming preponderance of physical health issues, mental health issues are generally regarded to be under-treated, with persistent disparities in treatment for substance use disorders, as well as racial and ethnic disparities.

- The fourth principle states that APMs should incentivize the care of underserved populations, with the use of evidence-based treatments, efficient use of resources, and tracking of outcomes using validated measures.

In 2014, about 18 percent, or 43.6 million, of American adults had a mental illness. The percentage of children and adolescents with a mental illness was a staggering 13 to 20 percent. In 2014, 8 percent, or 20.2 million, of individuals age 12 and older had a substance use disorder.ⁱ Yet only 40 percent of adults, and only 50.6 percent of children ages 8-15, with a *diagnosed* mental illness received treatment. Furthermore, only 59 percent of those with a *serious* mental illness received treatment.ⁱⁱ

Individuals with mental illness often have extensive non-psychiatric medical needs. Depression, anxiety, substance use disorders, and other common psychiatric disorders frequently are comorbid with cardiovascular disease, diabetes, obesity, pain disorders, and other costly and potentially disabling physical conditions.ⁱⁱⁱ Indeed, the rate of mortality among persons with mental disorders in comparison to those without is startlingly high.^{iv} Many chronic medical conditions require a self-care regimen in order to manage symptoms and prevent further disease progression, which may be hampered by comorbid mental conditions. A recent study found that 68 percent of adults who have a mental disorder also suffer from a medical comorbidity.^v Furthermore, most early mortality in patients with mental disorders is associated with chronic comorbid conditions, which are exacerbated by mental illness. A meta-analysis of worldwide mortality estimates found that the risk of mortality for individuals with psychiatric disorders was 2.2 times higher than for persons without mental disorders.^{vi} A majority (67%) of deaths was attributed to natural causes such as cardiovascular disease, lung disease, and diabetes and the reduction in life expectancy ranged widely from 1.4 to 32 years. Co-occurring mental disorders in persons with medical conditions also contribute to unemployment, absence from work, and decreased productivity at work.^{vii}

Increasing patient access and quality of care for individuals with MH/SUDs can often lead to savings over the long-term, particularly through improvements in overall health. But capturing those savings requires looking at the whole health of an individual, over a period of years. Most APMs are required to demonstrate savings during a snapshot period (typically a year). The bar is often raised each year due to shifting benchmarks. CMS often places limitations on what costs can be considered in that equation, for example, only comparing savings in Part B. If behavioral health APMs are subjected to this approach, most (if not all) are doomed to failure.

- The fifth principle states that Behavioral Health APMs must be designed specifically for the care of individuals with MH/SUDs and tailored to support individual treatment options to meet the diverse needs of this heterogeneous population.

Ultimately, all the emerging payment methodologies have a central commonality – holding providers accountable for the costs of care. We agree in principle that this is a proper objective. However, it is essential that any chosen methodology be properly constructed in a manner that is fair to the accountable provider and does not provide undue incentives which may jeopardize essential clinical care appropriate to any given patient's condition. This is a complex undertaking when dealing with psychiatric patients and thoughtful caution should be a primary precept.

First, the acuity or chronicity of a patient's status for any given psychiatric diagnosis is highly heterogeneous. Moreover, treatment options and the treatment of choice and how many or which providers may be involved can be highly variable as well. This greatly complicates the task of defining an episode of care where the baseline denominator is a particular diagnosis. The idiosyncrasies of this population do not lend themselves well to the one-size-fits-all approach of most existing models.

Second, the difficulties noted above have multiple implications for calculating baseline costs for any defined episodes. For example, what is the duration of the episode and what costs should be included in the bundle.

Should it include prescription medicines? Which providers should be paid out of the bundle? How will baseline costs or payment be adjusted for quality of care and patient health status? Will costs be reconciled retrospectively or are they to be truly prospective? These calculations must take these issues into consideration if incentives to skimp on care and/or avoid high-risk patients are to be minimized. Claims data can be useful in constructing preliminary answers to these questions, but extant data must also take into consideration that reimbursement for psychiatric services has been consistently underfunded and available data probably do not reflect actual costs. This can easily produce inequities for the provider deemed accountable for the bundle and increase the risk of the negative incentives noted. In any case, how baseline costs are established and adjusted is a threshold consideration in as much as the assumption of risk by the provider is inherent in any bundled-like payment arrangement and will be determinative of how service delivery is operationalized for patients.

Third, how will the accountable provider(s) be determined and how will any services subject to the payment be apportioned? Who is responsible for the initial evaluation and treatment plan and accountable for the episode? This goes to the heart of the provider risk assumption question and also involves detailed policy deliberation. There are desirable and positive care coordination and management incentives built into these approaches. However, payment policy must take into account that the psychiatric service system has been more fragmented than not, and new approaches will require a culture change as much as optimal payment design to work toward optimizing care for patients. Phasing in any new payment model may be essential.

There are many other essential issues that require resolution regarding the design of alternative payment approaches for psychiatric services. Another concern involves whether adequate evidence supports developing new delivery models that may incentivize particular treatment modalities, and what constitutes adequate evidence. These and those noted above should be essential filters for advancing concepts to CMS. If the foregoing questions cannot be resolved, then the feasibility of any concept or idea, no matter how good in principle it appears, must be questioned. The unintended, and likely negative, consequences of poorly constructed approaches are difficult to project but will be consequential for patients and clinical outcomes.

It is also worth noting that patients with MH/SUDs can also benefit greatly from receiving support and assistance in areas that impact their health, but are not typically reimbursed by payors. For example, SAMHSA has provided grants to support health improvement interventions such as smoking cessation, weight reduction, exercise classes, cooking advice, appointment reminders, etc. These can greatly improve clinical care and patient outcomes.

- The sixth principle states that Behavioral Health APMs must be developed with substantive input from practicing psychiatrists and other mental health providers.

No behavioral health APM should be designed without involvement and input from practicing psychiatrists and other mental health providers – from the very start. As the model evolves, there must be additional opportunities for frequent input from psychiatrists and other mental health professionals who have substantial clinical experience and expertise in treating individuals experiencing various mental health and substance use disorders. It is crucial to gain input and buy-in from providers from across the country, who practice in a variety of health care settings, and treat patients from diverse ethnic and socio-economic backgrounds.

Psychiatrists should be involved from the very beginning of that process in order to avoid building upon ideas that look good in theory, but are not effective in practice. Psychiatrists have years of training in the biological, psychological, and social aspects of mental health and substance use disorders. Psychiatrists are uniquely positioned to determine appropriate medications and other treatments for individual patients, particularly those with comorbid medical conditions, severe mental illness, and multiple mental health issues. Decisions regarding diagnosis and treatment require extensive knowledge and experience regarding the pharmacological effects of

particular medications, as well as how they interact with the patient's own particular mental health and other conditions.

New behavioral health APMs can also benefit from experience that psychiatrists and other mental health clinicians have gained with existing models. For example, lessons can be learned from the Arkansas Medicaid episodes of care models for children and adolescents with ADHD (attention deficit hyperactivity disorder) and ODD (oppositional defiance disorder). Some APA members have expressed concerns that certain behavioral health models may result in decreased quality, because the main goal was cost containment. Other concerns include that existing APMs may be too narrowly drawn for treating only particular diagnoses and/or treatments, which creates disincentives for accurate diagnosis and treatment, simply to keep an individual in that model.

It is also important to consult and seek the input of professional societies representing the interests of psychiatrists and other mental health professionals. Virtually all APMs are built upon some aspect of fee-for-service and developing an APM requires substantial knowledge of current payment structures and policies. Professional societies spend significant time and resources gaining this knowledge, so their members don't have to, and also because the intricacies of existing payment policies often benefit some clinicians, while harming others.

The APA is not aware of current ideas for behavioral health APMs that are widely supported by psychiatrists and other practicing mental health professionals, although we know of recent discussions among professional societies around possible APMs for dementia care and substance use disorders. APA members have expressed concerns that private entities may be developing and marketing an array of new models of care for MH/SUDs which were designed without consulting practicing psychiatrists and other mental health professionals.

- The seventh principle declares that participation in Behavioral Health APMs should be voluntary, not mandatory.

The APA opposes any behavioral health APM mandating participation by psychiatrists or their patients, or imposing penalties or other negative consequences for their failure to participate. Psychiatrists work in a wide array of practices and settings, and many individual psychiatrists work in more than one setting. These include academic health centers, hospitals, clinics, nursing homes, and private practices. As a result, a particular APM may work for one psychiatrist or even one of their practice settings, but not others.

Psychiatrists account for the largest percentage (42%) of physicians in clinical practice that have formally opted out of Medicare.^{viii} Medicare policies need to encourage and support the ability of psychiatrists to participate in Medicare, continue to see their current Medicare patients, and accept new patients. Since 2006, less than half of the available geriatric psychiatry fellowships have been filled.^{ix}

- The eighth principle is designed to ensure that Behavioral Health APMs provide adequate reimbursement to psychiatrists and other mental health professionals.

A fundamental obstacle to creating behavioral health APMs involving psychiatrists is the general requirement that an APM must generate savings, in comparison with fee-for-service. While psychiatric care can lead to cost savings for patients overall, there is a widespread view within psychiatry that the prevailing Medicare fee-for-service rates are insufficient. This contributes to the high percentage of psychiatrists who opt of Medicare. It also poses a major obstacle for creating APMs that would require demonstrated savings based solely on the reimbursement of psychiatrists.

To achieve successful and widespread acceptance and adoption, any behavioral health APM must be built upon a framework of adequate reimbursement for psychiatrists and other health providers. Unfortunately, reimbursement for psychiatrists has simply not kept pace with the rising costs of delivering care. Many

psychiatrists in small and solo practices would like to be able to hire clinical staff and invest in electronic health record (EHR) systems, but they simply cannot afford it. As a result, many psychiatrists have left clinical practice for more lucrative opportunities, and this contributes to the shortage of psychiatrists in this country.

Even the recently issued Medicare reimbursement rates for collaborative care services may not be sufficient to cover the costs of primary care providers contracting with psychiatric consultants. While the APA strongly supports the inclusion of the Collaborative Care Model in APMs, that endorsement comes with the caveat that those models must ensure adequate reimbursement for the consulting psychiatrist's services – either by allowing separate billing for collaborative care services (under the Physician Fee Schedule) or by refraining from requiring savings generated from “ratcheting down” those rates.

- The ninth principle states that Behavioral Health APMs should take into account the lack of appropriate EHR systems for mental health care and the lack of access to CEHRT for many psychiatrists.

Under the MACRA, “Advanced” APMs must employ Certified Electronic Health Record Technology (CEHRT). In MACRA policies for the 2017 participation year, CMS has interpreted this as requiring such APMs to certify that at least half their participants use CEHRT. The APA understands that the need for greater integration and use of EHRs within health care delivery is paramount toward the goal of improving health outcomes of individuals and of the population as a whole. However, psychiatrists have struggled to meet the CEHRT requirements of the EHR Meaningful Use (MU) Incentive Program. Very few psychiatrists have been successful in meeting these standards. This may pose a significant barrier in the widespread adoption of behavioral health APMs for psychiatrists, unless allowances are made.

Many psychiatrists have been slow to adopt EHRs into their practice, particularly those who have their own small or solo practices. This due to multiple reasons, including cost, a lack of high-quality EHRs tailored to the practice of psychiatry, and concerns regarding the safety and security of highly sensitive data about individual patient's MH/SUDs. Despite the proliferation of EHR systems over the past decade, including some that purport to cater to mental health specialists, these generally do not have psychiatry-specific outcome measures integrated into their systems. Systems must custom build them into the base EHR design, at the clinician's expense. This further increases the financial burden that solo practitioners and small-group practices already shoulder when bringing an EHR online in their practice.

Some APA members, especially those practicing in solo or small group settings, have also indicated that the adoption and maintenance of a complete EHR system has resulted in decreased efficiency for their practices. Even more disturbing, some say it has shifted their focus away from the patient, and poses a serious obstacle in the therapeutic relationship central to the psychotherapeutic process. Because of this, many psychiatrists have elected not to integrate an EHR system into their practice. Another issue is that many consulting psychiatrists who care for patients in hospitals and other facility settings do not have access to the hospital EHRs for those patients, or their own practice's EHR system is not compatible with the systems for those facilities. This prevents them from using EHRs to keep comprehensive data on those patients.

- The tenth principle declares that Behavioral Health APMs should support the delivery of services via telepsychiatry.

The APA is a strong proponent of telehealth as practiced by psychiatrists, known as “telepsychiatry,” and has developed a “Telepsychiatry Toolkit” with videos and other materials to educate psychiatrists on this treatment option.^x Telepsychiatry services, particularly in rural and remote areas, can make a real difference in the ability of patients with MH/SUDs to access the care they need, both long-term for those with chronic conditions and short-term for those facing a crisis. Telepsychiatry has been employed in therapeutic settings since the 1950s. Recent advances in video technology coupled with widespread, broadband internet access have resulted in a

rapid expansion in the number of psychiatrists who regularly engage in telepsychiatry. Early and more recent research indicates that psychiatry as a medical discipline appears to be an ideal fit with videoconferencing as a treatment modality. Many psychiatric treatments can be translated to telepsychiatry. Furthermore, case studies and empirical data have revealed no known absolute exclusion criteria, nor contraindications for any specific psychiatric diagnoses, treatments, or populations. Given the current shortage of psychiatrists practicing in the United States, the use of telepsychiatry is a helpful tool that can increase access to care for an already vulnerable mental health population.^{xi}

Access to psychiatric care is fundamental to address the whole health of patients utilizing health care services. Patients with acute and chronic mental health problems are at increased risk for suicide, homicide, and accidents. The risk of suicide is especially pronounced within rural populations, which typically demonstrate higher suicide rates, particularly for men, when compared with urban populations. Telepsychiatry increases access to critical services to patients within rural, remote, and isolated settings, and has the potential to address these public health concerns.^{xii}

Medicare currently reimburses telepsychiatry services only in rural or designated underserved areas. Allowing it to be reimbursed in other areas would greatly allow expansion of those services.

ⁱ Substance Abuse and Mental Health Services Administration. "Mental and Substance Use Disorders." <http://www.samhsa.gov/disorders>.

ⁱⁱ National Institute of Mental Health. "Use of Mental Health Services and Treatment Among Adults." <http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml>. "Use of Mental Health Services and Treatment Among Children." <http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-children.shtml>.

ⁱⁱⁱ Druss, B.G., Walker, E.R. 2011. "Mental disorders and medical comorbidity." *The Synthesis Project Research Synthesis Report 21*: 1-26. <http://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html>.

^{iv} Demyttenaere, K., et al. 2004. "WHO World Mental Health Survey Consortium: Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys." *JAMA* 291: 2581-2590. Thornicroft, G. 2011. "Physical health disparities and mental illness: the scandal of premature mortality." *British Journal of Psychiatry* 199: 441-442. Wahlbeck, K., et al. 2011. "Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders." *British Journal of Psychiatry* 199: 453-458.

^v Robert Wood Johnson Foundation. 2011. "Mental disorders and medical comorbidity." www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438.

^{vi} Walker, E.R., McGee, R.E., Druss, B.G. 2015. "Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis." *JAMA Psychiatry* 72: 334-341.

^{vii} Wang, P.S., et al. 2008. "Making the Business Case for Enhanced Depression Care: The National Institute of Mental Health-Harvard Work Outcomes Research and Cost-effectiveness Study." *Journal of Occupational & Environmental Medicine* 50: 468-472. Katon, W. 2009. "The impact of depression on workplace functioning and disability costs." *American Journal of Managed Care* 15: 322-327.

^{viii} Boccuti, C. et al. December 2013. "Issue Brief: Medicare Patients' Access to Physicians: A Synthesis of the Evidence." *Kaiser Family Foundation*.

^{ix} Institute of Medicine. 2012. "The mental health and substance use workforce for older adults: In whose hands?" Washington, DC: *The National Academies Press*.

^x The APA Telepsychiatry Toolkit is available at

<https://www.psychiatry.org/psychiatrists/practice/telepsychiatry>.

^{xi} Hylar, S., Gangure, D., Batchelder, S. Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies. *CNS Spectrums* 2005; 10:403-413. De Las Cuevas, C. et al. Randomized clinical trial of telepsychiatry through videoconference versus face-to-face conventional psychiatric treatment. *Telemedicine Journal and E-Health* 2006; 12: 341-350.

^{xii} Shore, J. et al. A resident, rural telepsychiatry service: training and improving care for rural populations. *Academic Psychiatry* 2011; 35: 252-255. Yellowlees, P., et al. Using e-health to enable culturally appropriate mental healthcare in rural areas. *Telemedicine Journal and E-Health* 2008; 14:486-492. Yellowlees, P., Shore, J., Roberts, L. American Telemedicine Association: Practice guidelines for videoconferencing-based telemental health: October 2009. *Telemedicine Journal and E-Health* 2010; 16: 1074-1089.