



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

June 22, 2015

The Honorable Johnny Isakson
131 Russell Senate Office Building
United States Senate
Washington DC, 20510

The Honorable Mark Warner
475 Russell Senate Office Building
United States Senate
Washington DC, 20510

Dear Senators Isakson and Warner:

The American Psychological Association Practice Organization (APAPO) appreciates the opportunity to provide comments to the Senate Finance Committee working group on policies to improve outcomes for Medicare beneficiaries with chronic conditions. The APAPO is dedicated to advancing the practice of psychology and represents the interests of doctoral-trained psychologists, who are licensed health care professionals. The APAPO is an affiliate of the American Psychological Association (APA), the largest scientific and professional organization representing psychology in the United States. APA's membership includes more than 122,000 clinicians, researchers, educators, consultants and students.

We share the committee's concern with the need to more effectively and efficiently address the health care needs of Medicare beneficiaries with chronic conditions. In order to be successful, any such initiative must also address chronic mental health disorders, not solely chronic medical diseases. The Centers for Medicare and Medicaid Services (CMS) estimates that more than 16 percent of Medicare beneficiaries suffer from depression, which is more than suffer from heart failure, cancer, or Alzheimer's disease.ⁱ The rate of suicide for Americans 65 and older is roughly twice as high as for youth and adults under age 25.ⁱⁱ Unfortunately, only 3.9% of Medicare spending is on mental health services, less than any other private or public insurance program.ⁱⁱⁱ

The Medicare program must better address the high rate of comorbidity of mental disorders with chronic general medical conditions. An estimated 68% of adults with mental disorders have comorbid medical conditions, and 29% of adults with medical conditions have mental disorders.^{iv} Patients with a comorbid mental health disorder and medical disease are highly expensive to treat.

A comparison of treatment costs for Medicare beneficiaries with depression and a comorbid diagnosis of either diabetes and/or congestive heart failure (CHF), with treatment costs for those with only diabetes/CHF, found that those with comorbid depression had 67% higher healthcare costs.^v Across eight common medical conditions, older Medicare beneficiaries diagnosed with comorbid depressive syndrome were consistently at least twice as likely to use emergency medical services and to experience a preventable hospitalization compared with those without depression.^{vi} Behavioral health affects physical health, and optimal outcomes can only be achieved if mental health services are an integral part of the service delivery system.

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The Senate Finance Committee can take several steps to increase Medicare beneficiaries' access to effective mental health services.

Eliminate Unnecessary Requirements Impacting Patient Access to Psychologists' Services.

Psychologists provide critical care to beneficiaries in a range of Medicare settings, including hospitals, psychiatric hospitals, hospital outpatient departments, partial hospital programs, comprehensive outpatient rehabilitation facilities, rural health clinics, federally qualified health centers, and skilled nursing facilities. Psychologists are leading providers of mental, behavioral, and diagnostic care, providing more than half of all psychiatric diagnostic evaluations, roughly half of all individual and family psychotherapy, and virtually all neuropsychological testing services and health and behavioral assessments and interventions to Medicare beneficiaries.

However, psychologists are leaving Medicare due to inappropriate physician oversight requirements and steadily declining reimbursement rates. In many facility-based treatment settings, Medicare requires physician oversight and supervision of psychologists, which can cause Medicare beneficiaries to be denied access to appropriate and timely psychological care due to the lack of availability of physician supervision. Psychologists are licensed by state statute to practice independently in all 50 states and other U.S. jurisdictions. Therefore this antiquated requirement for physician supervision inappropriately and unnecessarily impedes patient access to needed mental health care. This access problem is particularly exacerbated in rural or frontier areas where there are few physicians available to oversee care.

The Medicare definition of a "physician" (section 1861(r) of the Social Security Act) has been amended several times to include non-physician providers (chiropractors, dentists, optometrists and podiatrists) so that they may provide services to the full extent of their licensure. Many insurers already define "physician" to include not only medical doctors and doctors of osteopathy but also psychologists and those other non-physicians currently in the Medicare physician definition. In fact, psychologists practice independently without physician supervision in all private sector health plans, Medicare Advantage plans, the Veterans Health Administration, and TRICARE. Including psychologists in the Medicare physician definition would allow them to provide the services for which they are trained and licensed. It would not reconstitute them as physicians or expand their scope of practice, as changes in scope of practice can only occur through changes to states' licensing laws which regulate professional practice.

To address this barrier, your Finance Committee colleague, Senator Sherrod Brown (D-OH), introduced the ***Medicare Mental Health Access Act (S. 1064)*** in the 113th Congress to improve access to the full range of psychologist services consistent with state licensure. The bill would particularly help beneficiaries in rural areas where psychiatrists are not available to provide supervision. The lack of psychiatrists to supervise treatment in all Medicare-covered settings has hindered the delivery of mental health services in rural areas. If, for example, a physician is not available to supervise partial hospital services in a rural area, then such services are not provided. Removing unnecessary physician supervision requirements will help remedy rural access to mental health services. Psychologists will be able to provide partial hospital services within their licensure without unnecessary physician oversight, while still working collaboratively with physicians according to their licensure in a given state.

An actuarial analysis of the bill determined that including psychologists in the Medicare physician definition will not significantly increase Medicare claims costs. Psychologists already provide their services in settings throughout the program, and existing requirements will remain in place to ensure that the services psychologists provide are medically necessary and appropriate. Medicare Advantage programs have not experienced cost increases by letting psychologists practice without physician supervision.

We recommend the Senate Finance Committee increase Medicare beneficiaries' access to mental health care by allowing psychologists to practice independently, by including the provisions of S. 1064 in any legislation to address chronic care the committee may consider.

Stimulate Chronic Care Management Services by Allowing Psychologist Reimbursement.

Many patients suffering from chronic diseases, such as cancer, depression, diabetes, and heart disease, would benefit greatly from chronic care management services. Chronic care management includes care coordination, transition care management, assistance with social services, and monitoring the patient's ability to adhere to the treatment plan for their disease. Care management services are especially important when a patient is transitioning from an in-patient facility back into the community. Psychologists provide many crucial care management services, and spend considerable time dealing with other healthcare providers, family members, caregivers, and social service agencies in order to assist the patient. Patients released from psychiatric facilities who do not receive care management services are at greater risk of being re-admitted.

Despite this, Medicare will not reimburse psychologists for providing chronic care management or transitional care management services to Medicare beneficiaries. The Centers for Medicare and Medicaid Services allows only physicians, nurse practitioners, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives to bill for chronic care management and transitional care management services. As a result, psychologists, who furnish the vast majority of testing and health and behavior services in Medicare, along with many of the psychotherapy services, are not being recognized for the critical work they do when treating patients who suffer from chronic diseases.

Make Psychologists Eligible for Incentives for the Adoption of Electronic Health Records.

An important element to improve health outcomes for Medicare patients with chronic conditions through integrated care is to encourage the seamless exchange of electronic health records between primary care and mental health providers. Unfortunately, despite the high prevalence of chronic, co-occurring medical/surgical conditions and mental illness, when the HITECH Act was enacted in 2009 it omitted psychologists and other mental and behavioral health providers (with the exception of psychiatrists) from receiving Medicare and Medicaid incentive payments to adopt electronic health records in their practices. Behavioral health facilities, such as community mental health centers and psychiatric hospitals, were also excluded from eligibility.

Initial investment and ongoing maintenance costs present a significant barrier to electronic health records use for mental and behavioral health providers, and as a result, very few of these providers participate in the Health Information Exchange. Consequently, Medicare primary care providers and care coordination teams struggle to (1) be informed of their patients' behavioral health disorders and medications, and (2) receive the necessary behavioral health records of their patients in a timely matter, detracting from the quality of care received by Medicare beneficiaries with mental disorders and co-occurring, chronic medical conditions.

Psychologists are the preeminent providers of behavioral health services to Medicare beneficiaries, and as such, should be made eligible for the same electronic health records use incentives made available to other providers under the HITECH Act. The inclusion of psychologists and other mental health providers will increase the likelihood that Medicare patients will receive effective, high-quality care, and should also generate savings for Medicare. Recognizing these providers as “meaningful users” under the law will promote integration of mental health services into primary care settings, reduce adverse drug to drug interactions, reduce duplicative tests, and provide necessary information to the emergency department at hospitals to triage patients more effectively.

Finance Committee member Senator Rob Portman (R-OH) sponsored ***The Behavioral Health Information Coordination Act (S. 1685)***, in the 113th Congress, to extend Medicare and Medicaid incentive payments available under the HITECH Act to psychologists and other mental and behavioral health providers and facilities, including psychiatric hospitals and community mental health centers. Senator Sheldon Whitehouse (D-RI) sponsored similar legislation in the last Congress (***The Behavioral Health Information and Technology Act, S. 1517***). We are aware that Senators Portman and Whitehouse are currently considering reintroduction of this, or similar legislation, and we recommend that the Senate Finance Committee adopt provisions similar to these bills so as to improve communication and collaboration within the health care delivery system for Medicare beneficiaries with chronic conditions.

Fully Integrate Health and Mental Health Services and Include Multiprofessional Care.

The co-location and full integration of mental health professionals as part of primary care teams are among the most effective ways to improve outcomes and reduce costs, particularly emergency department and inpatient medical costs. Integrating mental and behavioral health services into primary care settings and the patient centered medical home (PCMH) is critical to improving health outcomes for not only those with depression or other mental health disorders, but also for patients with chronic illnesses, such as diabetes, heart disease and obesity. Numerous studies indicate that mental and behavioral health diagnoses and problems dramatically inflate costs and impede outcomes for patients with chronic general medical conditions. While there is substantial value to having psychologists and other behavioral health care providers integrated into primary care settings, there are still formidable barriers to their participation driven by financial disincentives and reimbursement issues. Thirty percent of primary care patients with chronic medical conditions have comorbid mental health or substance use disorders, and only one in eight patients receives evidence-based mental health treatment.^{vii} Yet primary care clinics rarely include onsite mental health professionals.

Most individuals who receive mental health treatment get help from a primary care provider, rather than from a mental health professional.^{viii} However, an abundance of data suggests that the typical primary care intervention for patients with mental health problems falls short of the mark due in part to the limited knowledge of primary care providers about mental and behavioral health problems.^{ix} In addition, primary care providers usually treat mental disorders by writing prescriptions for psychotropic drugs, despite the fact that psychotherapy is frequently as effective as such drugs, and that there are potentially dangerous side effects associated with medication use. Consequently, it is critical that psychologists and other mental health professionals be part of an integrated health care team in settings where the greatest numbers of patients in need are located.

As part of the integrated health team, health service psychologists provide a wide range of interventions to improve patient health, including diagnosis, assessment, consultation, testing, case management, health and behavioral interventions, and psychotherapy. These services address both treatment for mental disorders (e.g., depression and anxiety) and health psychology matters (e.g., self-management of diabetes, asthma, healthy diet, and smoking cessation programs). The use of effective, evidence based psychotherapy, such as cognitive therapy and problem solving therapy, not only improves outcomes and reduces service costs, it also reduces pharmacy costs.

We are pleased that Medicare policies are in place to encourage clinical psychologists to practice in accountable care organizations (ACOs). Engaging psychologists in ACOs and other coordinated care models being formed and tested by the CMS Innovation Center should help ensure beneficiary access to appropriate mental and behavioral health services.

Enact Bipartisan Legislation to Treat and Reduce Obesity.

Obesity is a major national health concern which contributes to the risk of developing other chronic, and often costly, health conditions, including diabetes, depression and heart disease, and can negatively impact an individual's mortality. According to the Centers for Disease Control, about 34 percent of adults aged 65 and over were obese in the period of 2009 through 2012.^x Obesity is a major driver of health care expenditures. In 2010, the Congressional Budget Office reported that nearly 20 percent of the increase in U.S. health care spending (from 1987-2007) was caused by obesity.^{xi}

Senators Bill Cassidy (R-LA), Tom Carper (D-DE), Lisa Murkowski (R-AK), Martin Heinrich (D-NM), Charles Grassley (R-IA) and Chris Coons (D-DE) have recently joined together to introduce legislation, ***The Treat and Reduce Obesity Act (S. 1509)***, that will provide Medicare beneficiaries and their health care providers with meaningful tools to reduce obesity. Specifically, the Treat and Reduce Obesity Act would give CMS the authority to expand the provision of the Medicare benefit for Intensive Behavioral Therapy (IBT) for Obesity beyond primary care physicians to additional types of health care providers, including clinical psychologists, physicians who are not primary care physicians, physician assistants, nurse practitioners, clinical nurse specialists, registered dietitians or nutrition professionals. Furthermore, it would allow CMS to provide Medicare Part D coverage of FDA-approved prescription drugs for chronic weight management, as well as require the Secretary of the Department of Health and Human Services to report back to Congress on steps taken to implement the Act, and to provide Congress with recommendations for better coordination of federal government efforts on obesity.

Psychologists, as key Medicare mental and behavioral health service providers, are experts in the diagnosis, assessment and treatment of health risk behaviors and help fight obesity through behavioral interventions and counseling. In order to fully address the obesity crisis, patients must have access to the full range of evidence-based treatments, including mental and behavioral, pharmaceutical, psychosocial, nutritional and surgical interventions.

Eliminate Barriers to Providing Important Telehealth Services.

Currently, CMS has established a number of criteria that must be met for coverage and reimbursement of certain telehealth services provided to Medicare beneficiaries. The beneficiary must be located in a health professional shortage area or rural county, and must be at an eligible originating site at the time services are delivered. Originating sites are generally clinical settings,

such as a health care provider's office, hospital, rural health clinic, skilled nursing facility, or a federally qualified health center or community mental health center. CMS specifies which providers at the distant site are eligible to furnish services and receive payment, but there are no specific requirements for whether the distant site must be an office, hospital or clinic.

In addition, CMS requires as a condition of payment that the interactive audio and video telecommunications system used must permit real-time communication between the practitioner at the distant site and the beneficiary at the originating site. Asynchronous or "store and forward" technology may only be used in certain federal demonstration projects. There is a list of approved Medicare telehealth services and each year, CMS invites comments from stakeholders on proposed additions or changes to that list.

Psychologists may provide telehealth services to Medicare beneficiaries subject to the above requirements. The current list of approved psychological telehealth services include psychiatric diagnostic evaluation, individual psychotherapy, psychoanalysis and family psychotherapy with and without the patient present. Also included in the list are individual and group health and behavior assessment and intervention codes, as well as neurobehavioral status examination.

While psychologists are able to provide a number of psychological services via telehealth to Medicare beneficiaries, the current requirements are still restrictive and impede the ability of a significant percentage of older Americans to access needed care. Specifically, the geographic restriction that a Medicare beneficiary be located in either a health professional shortage area or rural county to receive telehealth services should be removed, as should the exclusion of the patient's home from the list of eligible originating sites. Patient access is a concern for those in urban, suburban and rural areas alike. Many seniors may be home-bound and/or unable to get to an eligible originating site for a variety of reasons – e.g., multiple chronic health conditions, lack of transportation resources or inability to find an eligible clinical site at which to receive a covered telehealth service.

CMS is taking steps forward by adding care coordination management services and chronic care management to its list of approved services, and it appears that CMS has considered the possibility of waiving this requirement in the future for accountable care organizations as mentioned in its recently published Final Rule on Medicare Shared Savings; Accountable Care Organizations.^{xii} Lifting geographic and eligible site restrictions would significantly improve patient access for many beneficiaries. However, it is CMS's position that it lacks the "authority to implement many of these revisions under the current statute."^{xiii}

Therefore, we encourage the Senate Finance Committee to consider removing the above-described restrictions from the enabling statute to allow changes in CMS's telehealth policies. In addition, with the rapid evolution in technology and applications used to facilitate patient health visits and transmit health data, we recommend the Committee encourage CMS to expand its definition of approved telehealth technology to allow for other modalities, such as asynchronous technology and telephone, that are compliant with relevant HIPAA and HITECH requirements and appropriate depending on the nature of the service involved. This would not only increase patient access as some Medicare beneficiaries might not have access to videoconferencing resources but would also provide clearer guidance to providers who are subject to HIPAA and HITECH requirements.

Adjust Medicare Payment Formula to End Erosion of Payments for Psychologists.

Medicare beneficiary access to needed mental health services is now jeopardized due to a steady and steep erosion in psychologist reimbursement rates. As a result, psychologists are leaving Medicare, reducing their patient loads, and refusing to take new patients. A 2013 APA Practice Organization member survey revealed that 26% of responding psychologists who were previously Medicare providers had left the program, primarily due to low reimbursement rates. Half of those psychologists surveyed left since 2008. This means that nearly 5,200 psychologists across the country are no longer providing the mental, behavioral and substance use disorder services that Medicare beneficiaries need. Congress must act to reverse this trend, since as mentioned, psychologists are the principal providers of mental health services to Medicare beneficiaries.

In 2001, Medicare paid \$102 for a 45-minute psychotherapy session (the most common service). Today, the program pays just \$84.74 for the same service, a more than 30% drop, adjusted for inflation. Rates for other psychologist services have dropped by similar amounts. Most of the decline has happened since 2007, with the advent of new methodologies for calculating providers' practice expenses. Under the payment formula, Medicare increasingly pays more for higher-cost, technology-driven services with high overhead—therefore high Practice Expense. This means that services, like psychologists' services, which are relatively low overhead and cost, are being paid at lower rates, compared to providers with increases in practice expenses year-to-year due to innovations in medical technology and equipment. However, Medicare's payment formula indexes all providers practice expenses to each other, and as a result, psychologists' practice expense-related reimbursements are repeatedly squeezed to make room for increases in practice expense payments to other providers.

We have discussed these concerns about the payment formula with CMS, and, most recently in October 2014, met with Sean Cavanaugh, Deputy Administrator to ask the agency to address this continued erosion of psychologists' fees due to the Practice Expense adjustments and the underlying payment formula. However, a legislative solution likely will be required. Congress should adjust the Medicare payment formula to ensure fairer and more appropriate reimbursement for clinical psychologists to enable them to remain in the program. A continuing departure of psychologists from the Medicare program at a time when increasing numbers of Americans are becoming Medicare beneficiaries will severely hamper beneficiary access to effective mental and behavioral health care services. We are exploring how the formula could be very slightly modified to accomplish this payment objective, and will be pleased to engage in the discussion of narrow legislative changes with you and your staff.

Conclusion

We appreciate your consideration of our suggested policy reforms to more effectively and efficiently address the health care needs of Medicare beneficiaries with chronic conditions. We look forward to working with you and your colleagues on the working group this Congress. Please call or email Doug Walter, J.D., Associate Executive Director, in the APAPO Government Relations Office at (202) 336-5889 or dwalter@apa.org should you have any questions regarding our responses or wish for further assistance.

Sincerely,



Katherine C. Nordal, Ph.D.
Executive Director for Professional Practice

ⁱ Medicare Beneficiary Prevalence for Chronic Conditions for 2013, CMS Chronic Condition Data Warehouse (CCW). Online at

https://www.ccwdata.org/cs/groups/public/documents/document/ccw_website_table_b2.pdf.

ⁱⁱ National Suicide Statistics at a Glance - Trends in Suicide Rates Among Both Sexes, by Age Group, United States, 1991-2009. Centers for Disease Control and Prevention. Online at

<http://www.cdc.gov/violenceprevention/suicide/statistics/trends02.html>.

ⁱⁱⁱ Substance Abuse and Mental Health Services Administration. Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020. HHS Publication No. SMA-14-4883. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

^{iv} The Synthesis Project, New Insights from Research Results, Policy Brief No. 21, February 2011; NHW National Healthy Worksite, <http://www.cdc.gov>.

^v Unutzer, J. et al. (2009). Healthcare costs associated with depression in medically ill fee-for-service Medicare participants. *Journal of the American Geriatrics Society*. 57, 506-510.

^{vi} Himelhoch, S. et al. (2004). Chronic medical illness, depression, and use of acute medical services among Medicare beneficiaries. *Medical Care*. 42, 512-521.

^{vii} Kathol, R. G., Butler, M., McAlpine, D. D., & Kane, R. L. (2010). Barriers to physical and mental condition integrated service delivery. *Psychosomatic Medicine*, 72(6), 511-518.

^{viii} Olfson, M., Kroenke, K., Wang, S., & Blanco, C. (2014). Trends in office-based mental health care provided by psychiatrists and primary care physicians. *The Journal of clinical psychiatry*, 75(3), 247-253.

^{ix} Mitchell, A. J., Vaze, A., & Rao, S. (2009). Clinical diagnosis of depression in primary care: a meta-analysis. *The Lancet*, 374(9690), 609-619.

^x Reference cited in S. 1509, the “Treat and Reduce Obesity Act of 2015,” 114th Congress.

^{xi} How Does Obesity in Adults Affect Spending on Health Care?, Congressional Budget Office, September 8, 2010. Online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/09-08-obesity_brief.pdf.

^{xii} 80 Fed. Reg., 32695 (2015)

^{xiii} 79 Fed. Reg., 67602 (2014)