



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

November 20, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMMI RFI
P.O. Box 8016
Baltimore, Maryland 21244-8013

Re: Center for Medicare and Medicaid Innovation New Direction Request for Information

Dear Administrator Verma:

I am writing on behalf of the American Psychological Association Practice Organization (the Practice Organization), an affiliate of the American Psychological Association (APA). APA is the professional organization representing more than 115,700 members and associates engaged in the practice, research, and teaching of psychology. The Practice Organization advocates on behalf of psychologists engaged in the practice of psychology in all settings. The Practice Organization is providing the Centers for Medicare and Medicaid Services (CMS) with comments on the Center for Medicare and Medicaid Innovation (CMMI) Request for Information (RFI) issued on September 20, 2017. We commend CMS for soliciting new models for mental and behavioral health that will enhance care integration and encourage healthcare professionals to participate in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Background

Psychologists provide Medicare beneficiaries with critical mental, behavioral, and substance use disorder services including psychotherapy, psychological and neuropsychological testing, and health and behavior assessments and interventions. Our members are among the most highly educated healthcare professionals with an average seven years of graduate school. They are the leaders in the diagnosis and assessment of mental health problems and pioneered the development of health and behavior services to assist patients struggling with physical health problems. Their work commonly involves treating patients with co-morbid conditions. Since 1970, an increasingly larger percentage of patients with mental illness are being treated by psychologists in outpatient rather than inpatient settings.

Psychologists are primary, if not the major, providers of mental, behavioral, and substance use disorder services to Medicare beneficiaries. According to Medicare's utilization database, psychologists provide 40% of the outpatient and 70% of the inpatient psychotherapy services that beneficiaries receive, and they provide most of the mental health diagnostic services. Along with licensed clinical social workers (LCSWs), psychologists provide most of the mental health benefit to those elderly and disabled persons enrolled in Medicare.

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Reimbursement rates under Medicare have been falling for years, and despite the complexity of their valuable services for beneficiaries, reimbursement for psychologists in Medicare now is woefully inadequate. Adjusted for inflation, psychologists have lost more than 37% in payment over the past 15 years for the most commonly provided mental health service, the 45-minute psychotherapy session. Declining reimbursement means a corresponding loss of Medicare beneficiary access to psychologists' services.

An internal survey of our membership reveals that psychologists' participation in Medicare is drastically declining. The survey found that 26% of responding psychologists, who were once Medicare providers, have left the program primarily due to low reimbursement rates. Half of the respondents indicate that they have left since 2008. This means over 5,000 psychologists no longer provide the mental, behavioral and substance use disorder services that Medicare beneficiaries need.

Losing psychologists from Medicare places beneficiaries in need of mental, behavioral and substance use disorder services in an increasingly dire situation, where they cannot get access to a provider of these services. Psychologists are dropping out of the program, and those who remain are more likely to limit the number of Medicare beneficiaries they see in favor of patients who privately pay or whose insurance provides more competitive reimbursement. Since most psychologists work in solo or small group practices, continuing to participate in Medicare while having their payments repeatedly cut puts their entire practice at risk. Our members say they cannot remain in Medicare or must limit the number of their Medicare patients to make a living.

Mental health access for Medicare beneficiaries living in rural areas is far worse. Although LCSWs provide many of the mental health services in rural areas they cannot substitute for psychologists as they do not have as extensive training in assessment or testing and they typically do not provide health and behavior services. Only psychologists can furnish vital psychological and neuropsychological testing services. Such services are critical when assessing patients for potential brain damage, dementia, and functionality. Imagine the plight of a stroke patient who has no access to neuropsychological testing to determine their level of cognitive functioning.

For these reasons we applaud CMS for investigating new models to encourage participation by healthcare providers in Medicare, Medicaid, and CHIP. Unless something is done to address the issues we have raised, more psychologists will decline or severely limit their participation in these federal programs. If this happens the nation's most vulnerable citizens - the elderly, disabled, and those in financial need - will lose access to vital psychological services.

Expanding access to electronic health records

In authorizing new payment models focusing on mental and behavioral health, we urge CMS to fund a CMMI demonstration project incentivizing electronic health record purchases by mental health providers, including psychologists and others excluded from receiving financial incentives under the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L. 115-5). Access to a complete health record that integrates medical and behavioral health care is essential to improving the quality of patient care, and will help reduce health care costs tied to adverse drug interactions, duplicative tests, and medical errors. The Mental and Behavioral Health model outlined in the RFI is a welcomed pathway to including reimbursement for health information technology to mental and behavioral health providers.

The Practice Organization is currently supporting bicameral and bipartisan legislation to help foster the adoption of electronic health records by psychologists and other mental and behavioral health providers. The Improving Access to Behavioral Health Information Technology Act (H.R. 3331, S.1732) authorizes CMMI to implement such a demonstration project to further integrate behavioral health and primary care approaches to improve health outcomes.

The importance of non-pharmacological treatment

We strongly encourage the agency to consider models designed with psychotherapy as the core treatment for patients suffering from mental illness. There are many reasons why non-pharmacological treatments should be the first option for older adults. Risks associated with polypharmacy (i.e., the concomitant use of multiple medications) include increased morbidity and mortality (Espino et al., 2006, Goulding 2004, Straand et al, 2006, Kennerfalk et al., 2002). Older adults are more likely to experience drug toxicity because of reduced metabolism of medications, which can lead to other health problems (e.g., lethargy, confusion, falls, delirium, and death) along with increased healthcare costs and service utilization (Arnold 2008).

In addition, many studies have been conducted on older patients' views and preferences for treatment for depression, a frequently diagnosed mental illness. When asked to choose between psychotherapy, medication, or a combination of the two, in every study patients preferred psychotherapy or a combination to medication alone. Some studies also showed that the effect of treatment varies as a function of preference, meaning those who wanted therapy did better with therapy than those who preferred a different option. Long-term care facilities are now required to reduce the use of psychotropic and antipsychotic medications.

Psychologists play a unique role in the collaboration, management, and evaluation of treatment for older adults and can help reduce the adverse consequences related to the use of medication by implementing psychologically-based interventions. For example, non-pharmacological approaches to chronic pain management reduce the risk of opioid use disorder and overdose. Nonpharmacologic therapy is one of the preferred approaches for chronic pain noted by the Centers for Disease Control in its factsheet *Guideline for Prescribing Opioids for Chronic Pain*.

Mental and behavioral health models

The following comments focus on mental and behavioral health and the role of psychologists within integrated care settings in providing pediatric well child and behavioral care, screening and care for perinatal depression in obstetric settings, and long-term care.

Pediatrics

Currently 35.6 million children are enrolled in Medicaid and CHIP.¹ There is a well-documented history of more than 50 years of collaborative work between psychology and pediatrics both in specialty and primary care.² We believe an opportunity exists to build upon the success of BHI initiatives in primary care settings to expand the accessibility of services to children for the most common Internalizing and externalizing disorders, depression and Attention Deficit Hyperactivity Disorder (ADHD).³ This would include treatment of ADHD, which is currently the second most expensive cost in an analysis of all pediatric care.⁴

In addition to treating diagnosed mental health disorders, primary care clinics provide advice and guidance on a wide range of developmental concerns. Over half of all questions posed by

parents in primary care relate to behavior and development, and often brief interventions can effectively manage difficulties and prevent further problems.⁵ Psychologists are equipped to effectively address these challenges. With an average of seven years of extensive graduate and clinical training, doctoral-level child and adolescent psychologists possess sophisticated clinical expertise in child development, behavior management, psychotherapy, and psychological assessment, as well as health and behavioral interventions. These clinical interventions can be further supported by the involvement of psychologists as educators, mentors, and leaders within the interdisciplinary primary care team. In sum, when psychologists are provided with the opportunity to bring the full array of skills and training to bear within pediatric settings, they can support medical and nursing staff in providing family centered care, and in achieving the goals of Bright Futures guidelines.⁶

Psychiatric Collaborative Care Management

Based on the Psychiatric Collaborative Care Model (CoCM) supported by the American Psychiatric Association, CMS introduced several codes (G0502, G0503, G0504, G0505, G0507) in 2017 to reimburse care collaboration services furnished to beneficiaries in primary care. While the CoCM supports an interdisciplinary team consisting of a primary care physician, a behavioral health care manager, and a consulting psychiatrist, it neglects to address the contribution of psychologists. Further, The CoCM model lacks empirical support as a framework to provide services for children.

All of studies cited in the only meta-analysis of behavioral care provided in pediatric settings include psychologists as supervisors or providers using evidence based psychological interventions with an added medication component.⁷ The often-cited Cochrane Library review of Collaborative Care clearly shows no advantage in this model for treatment of depression in adolescents. Despite psychologists' unique role in collaboration, management, and the evaluation of treatment for children and adolescents, currently psychologists can only use one of these codes (G0507).⁸

We propose, as a first step, that CMMI consider funding BHI models that demonstrate the financial and clinical benefits of utilizing psychologists in a role at the same professional level as a psychiatric consultant. Psychologists are doctoral-level, independent licensed healthcare providers like psychiatrists. Research in primary care in 2014, by the same authors of the Cochrane review of Collaborative Care, shows that the supervision of behavioral health care managers by doctoral-level professionals, either psychologists or psychiatrists, is a key component for success.⁹ Limiting psychologists' involvement to the role of behavioral health care management services in the CoCM fails to maximize utilization of the full range of skills and expertise offered by psychologists, and is ultimately more costly.¹⁰

Given the focus in child health care settings on prevention and early intervention, and linking families to the education and early intervention systems, we believe the CoCM, in its current form, is an insufficient BHI model for pediatric settings.

We assert that outcomes can be improved, and costs reduced when psychologists are reimbursed for team activities. This should include leading primary care team planning related to screening for developmental and behavioral problems, early referral to IDEA Part B & C programs as indicated for developmental delay, intervention within primary care for behavioral problems and referral for behavioral health needs requiring a high level of specialty care (Bright Futures). Training direct care staff in behavioral techniques, and supporting Quality Assurance

Performance Improvement (QAPI) projects demonstrating the impact of the intervention are also essential roles for psychologists. Ultimately, the financial disincentives that exist restrict family access to the full measure of quality and appropriate pediatric behavioral health services that psychologists can provide.

Other Integrated Care Models

In addition to the CoCM, we strongly encourage CMMI to consider adapting other well-developed integrated care models as described below.

First, the meta-analysis by Asarnow et al 2015 demonstrated that evidence based psychotherapeutic interventions delivered by psychologists and master's level supervised providers in primary care settings were more effective than the same interventions delivered in traditional mental health settings. This analysis covered a range of disorders and interventions and emphasized the positive impact of licensed mental health providers imbedded in the pediatric primary care setting. Including psychologists as core members of the primary care team is the framework for these programs.

The Primary Care Behavioral Health (PCBH) model utilizes psychologists to enhance primary care services through integrated comprehensive behavioral health roles. The PCBH model represents the behavioral component of the Patient-Centered Medical Home (PCMH), providing team-based care for all behavioral health issues. The inclusion of warm handoffs and team huddles helps reduce mental health stigma and promotes greater collaboration and cohesion among healthcare providers. The PCMH model promotes good clinical outcomes and improves the patient and provider experience.¹¹

A review by the Institute for Clinical and Economic Review (ICER) suggested that effective behavioral health integration programs include screening, team-based care with non-physicians to support and co-manage patients, shared information systems, use of evidence-based guidelines for treatment, monitoring patient responses, engagement with community services, and patient-centered care in another review, written in 2014 by the same authors of the Cochrane review usually cited as support for CoCM evaluated the effectiveness of collaborative care models for depression. Those researchers identified psychotherapy, supervision by a doctoral-level provider, and universal screenings as three key components of successful collaborative care.¹² To summarize, psychologists are effective service providers and team leaders in existing BHI models in primary care.

Obstetrics & Gynecology

Perinatal depression, the major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, is the most common medical complication during pregnancy and the post-partum period. The American College of Obstetricians and Gynecologists recommends that not only should “clinicians screens patients at least once during the perinatal period for depression and anxiety symptoms” as the early detection of perinatal depression can improve the likelihood of obtaining appropriate treatment but also includes the recommendation that “appropriate follow-up and treatment when indicated” should be provided for the best outcomes for both the mother and child.¹³

It is also expressly advised that psychotherapy is better validated than antidepressant medication for perinatal depression, and should “be considered as a first-line treatment option, especially for pregnant and breast-feeding women who are depressed.”¹⁴

Psychological interventions are safe, effective, and economical treatments for perinatal depression, but they are generally underutilized.¹⁵ In practice, a model that has worked to overcome access barriers is embedding psychologists, experts in psychotherapy, into obstetric and gynecological settings like the model described for children above. The reimbursement model that may best support this would include a bundle for services that include the psychologists providing psychotherapy to the mother. A reimbursement model could also include the ability to code services for the mother billable to the child’s Medicaid relative to perinatal depression screening and treatment.

Long-Term Care

An integrated care model, as seen in primary care, involves the highest degree of collaboration and communication among psychologists and other health care professionals on a regular basis. Psychologists are thus recognized as official members or leaders of the interdisciplinary team. Timely and regular communication is even more crucial in long-term care settings where BHI led by psychologists has achieved much success.

The Public Policy Committee of Psychologists in Long Term Care, Inc, (PLTC) and the Society of Clinical Geropsychology (SCG) of APA are also submitting comments on the RFI. In their joint letter PLTC and SCG provide detailed information on mental and behavioral health models involving psychological services for the treatment of older adults in long-term care settings. The Practice Organization values the expertise of PLTC and SCG in long-term care and supports the recommendations made in their letter.

Conclusion

Psychologist-led models for care integration have demonstrated effectiveness for treatment and have great potential for prevention, early intervention and linking families to education services. However, under the current system, psychologists are not eligible for reimbursement for a range of services for which they are professionally equipped and would contribute to the overall quality of care provided to children, pregnant women, and long-term care patients. Even within the expansion of CoCM codes that involve case management and care planning, psychologists are not positioned to share their full professional expertise.

We propose that new BHI models in long-term care include psychologists in a leadership role within interdisciplinary teams providing integrated care for children with screening, developmental and behavioral health needs, women with perinatal depression, and those needing long term care. We submit that psychologists are best equipped to supervise the behavioral health care management function, rather than serve in that role under the guidance of another professional specialty. Research shows that the supervision of care managers by doctoral level professionals is a key variable for success.¹⁶

We support the development of care models and procedure codes that more accurately describe psychologists’ work in future BHI models for the pediatric population, specifically behavioral and non-pharmacological interventions. In addition, we advocate for inclusion of training direct care staff and leadership in behavioral health care planning into reimbursement

structures, so that psychologists and other mental health professionals can furnish these needed services in pediatrics.

We thank you for the opportunity to share these comments. Please do not hesitate to contact us if we can provide further information or assistance. Any questions should be directed to Diane M. Pedulla, J.D., Director of Regulatory Affairs at dpedulla@apa.org or 202-336-5889.

Sincerely,

A handwritten signature in black ink that reads "Katherine C. Nordal PhD". The signature is written in a cursive, flowing style.

Katherine C. Nordal
Executive Director for Professional Practice

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