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November 27, 2019

The Honorable Richard E. Neal

Chairman

House Ways and Means Committee

1102 Longworth House Office Building

Washington, D.C. 20515

The Honorable Kevin Brady

Ranking Member

House Ways and Means Committee

1139 Longworth House Office Building

Washington, DC 20515

Dear Chairman Neal and Ranking Member Brady:

On behalf of the American Psychiatric Association (APA), the national medical specialty association representing over 38,500 psychiatric physicians, I want to thank you for directing the Rural and Underserved Communities Task Force, as led by Reps. Danny Davis (D-IL), Terri Sewell (D-AL), Brad Wenstrup (R-OH) and Jodey Arrington (R-TX), to focus on bipartisan legislation to improve health care outcomes within underserved communities. Per that directive, please find the APA's answers (in italic text) to your [Request for Information](#) questions (in bold text) below.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Many factors influence patient outcomes in both rural and urban underserved areas. These factors range from limited access to psychiatric services to lack of transportation, affordable housing, mental health and substance use disorder coverage, and unemployment or under employment, among other things. It is estimated that nearly 44 million adults in the United States will experience a mental illness in any given year. Left untreated or inappropriately treated, patients with mental illness often end up in the emergency room or the criminal justice system, with persistent or significant disability and a heightened risk of death.

Rates of medical illness in those with serious mental illness (SMI) exceed those of the general population in every disease category, and those with SMI experience higher standardized mortality rates compared to the general population for cardiovascular, respiratory, and infectious diseases.^{1,2} Premature death from natural causes has been estimated to contribute approximately 60% to early mortality in people with SMI,³ and

¹ Parks J, Svendsen D, Singer P, Foti ME: Morbidity and mortality in people with serious mental illness. NASMHPD. Alexandria VA 2006

² De Hert M, Correll CU, Bobes J, et al: Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry Feb 2011; 10(1):52-77

³ Eaton WW, Martins SS, Nestadt G, et al: The burden of mental disorders. Epidemiol Rev 2008; 30:1-14

a recent meta-analysis found that 67% of deaths among people with mental illness were due to natural causes.⁴ For patients with comorbid substance use disorders, infectious diseases, cancers, and accidents are particularly prevalent causes of early death.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Mental health disorders are often chronic conditions that present alongside other chronic physical health comorbidities, however, only 25 percent of patients receive appropriate and effective mental health care.⁵ We know that the effective integration of medical and behavioral healthcare services can garner a significant amount of savings⁶. When extrapolated to the nation, these models have shown impressive potential savings of up to \$67.8 billion annually.⁷ While some integrated care models are currently being piloted, the “collaborative care” model (CoCM) is supported by the greatest evidence base. Data from 80 randomized trials showed positive outcomes when testing the CoCM model for controlling costs, improving access, improving clinical outcomes, and increasing patient satisfaction in a variety of primary care settings⁸. Under the CoCM model, a Collaborative Care team is led by a primary care provider (PCP) and includes both a care manager and a psychiatric consultant working at the top of their licenses. The health care team works together with the patient to implement a care plan based on evidence-based treatment and focused on patient adherence. The focus on the patient’s improvement through adherence to the treatment plan, rather than provider focus on clinical metrics provides for more appropriate goal setting and encourages collaboration between providers. Though the Centers for Medicare and Medicaid Services has shifted some Medicare beneficiaries to this model, the adoption of CoCM models by state Medicaid programs and private insurers has not been widespread.

For patients with SMI, current fee for services reimbursement, especially in Medicaid, does not adequately reimburse for care management and many components of team-based interventions. Prospective payment models like Certified Community Behavioral Health Clinics (CCBHCs) should be supported as these structures allow a per member per month payment for important ancillary services.

⁴ Walker ER, McGee RE, Druss BG: Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA Psychiatry 2015; 72(4):334-41

⁵ Unutzer 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.

⁶ Milliman, Inc. “Potential Economic Impact of Integrated Medical-Behavioral Healthcare. Updated Projections for 2017” January 2018.

⁷ Milliman, Inc. “Potential Economic Impact of Integrated Medical-Behavioral Healthcare. Updated Projections for 2017” January 2018.

⁸ Levin, Saul, MD, MPA, FRCP-E. (2019). APA Letter to Senate HELP Committee re: Inquiry on Stabilizing Health Care Costs. [Letter]. Washington, DC: American Psychiatric Association.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

A growing body of research indicates that psychiatric care provided via telemedicine is equally as effective as in-person psychiatric care.⁹ The availability of telepsychiatry to connect psychiatrists with patients who would have otherwise not received mental health or substance use disorder (SUD) services results in improved patient outcomes, which includes shorter hospitalizations and better medication adherence. Telepsychiatry can relieve patient volume issues in areas where workforce is inadequate to match demand. Improved outcomes as a result of telepsychiatry are particularly acute among underserved populations and populations with diagnoses like autism spectrum and severe anxiety disorders. In addition, telepsychiatry can mitigate wait times, save the patient the cost of transportation and lost wages due to work absenteeism, and reduce stigma associated with seeking treatment for substance use or mental health disorders by enabling treatment in more familiar, private and comfortable settings for the patient. Despite effectiveness, policies that restrict coverage to patients who live in certain types of geographic areas and requirements for physical presence at originating sites still present significant barriers to telepsychiatry. For example, APA strongly supported the provision in HR 6, the SUPPORT for Patients and Communities Act, that waived some of Medicare's originating sites requirements for patients with SUDs and co-occurring mental health diagnosis. This waiver should be expanded to include all Medicare beneficiaries with any mental health need, regardless of co-occurring diagnosis.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —

- a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?**
- b. there is broader investment in primary care or public health?**
- c. the cause is related to a lack of flexibility in health care delivery or payment?**

The APA is a membership association representing individual psychiatrists rather than health or hospital systems, as such the association does not have specific policy on service line reduction lessons. However, the United States now has one third to one quarter the number of psychiatric beds per 100,000 population when compared with most European Union countries. The suicide epidemic, which is exacerbated by the boarding of patients needing high-level care in emergency departments, is now a major problem due in part to substantial reductions in psychiatric inpatient beds and the lack of necessary ambulatory services. Inpatient suicides are exceedingly rare in comparison to suicides after discharge because of shortened length of stay or in the community. However, citations by the Centers for Medicare and Medicaid Services (CMS) or the Joint Commission to inpatient psychiatric facilities for alleged ligature risks have had negative impacts in that they have led to reduction of beds in communities and permanent closure of facilities in some communities. Though the APA appreciates HHS's and CMS's effort to make inpatient psychiatric beds and facilities safer for patients, we have concerns with the aggressiveness with which these citations are imposed. APA encourages the Ways and Means Committee to explore legislation that would emphasize the need for assessments among surveyors to occur in a manner that is consistent and reliable across the country and promotes the highest quality of care for the greatest number of individuals. For example, we

⁹ See, e.g., Hilty DeM, Ferrer DC, Parish MB, et al. The Effectiveness of Telemental Health: A 2013 Review. *Telemed J E Health* 2013;(19):444-454.

recommend that the automatic 60-day timeframe for inpatient psychiatric facilities to adequately address potential ligature risks be extended to an automatic 90-day timeframe, instead of 60 days. If this recommendation is implemented, it is anticipated that fewer facilities will reduce capacity or close, permitting these facilities to use their resources to increase individuals' access to appropriate high-quality care.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

The APA has long been supportive of telepsychiatry to alleviate both distance challenges and workforce limitations that make accessing mental health services particularly difficult. Some states have been aggressive in their implementation of telepsychiatry by working with providers and payers to update regulations and reimbursement policies to support telehealth practices. Specific examples of telehealth policies that encourage access to psychiatric services include store-and-forward, remote patient monitoring, transmission and facility fees and updated reimbursement policies. As compiled most recently by the Center for Connected Health Policy's Fall 2019 State Telehealth Laws & Reimbursement Policies report:¹⁰

- 1. **Store-and-forward** - Fourteen states provide reimbursement for store-and-forward. Four additional jurisdictions (HI, MS, NH, and NJ) have laws requiring Medicaid reimbursement for store-and-forward.*
- 2. **Remote Patient Monitoring** - Twenty-two state Medicaid programs provide reimbursement for remote patient monitoring (RPM). As is the case for store-and-forward, two Medicaid programs (HI and NJ) have laws requiring Medicaid reimbursement for RPM.*
- 3. **Transmission/Facility Fee** - Thirty-four state Medicaid programs offer a transmission or facility fee when telehealth is used.*
- 4. **Reimbursement** - Forty states and DC currently have laws that govern private payer telehealth reimbursement policy. Although Georgia passed a private payer law, it does not become effective until Jan. 1, 2020.*

In addition, communities like San Mateo, CA have added the use of medical vans to provide psychiatric services. Psychiatrists ride a few times a week on the van to bring services to patients where they are located. Services can be provided in person or via telepsychiatry through the medical van program.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

The supply of mental health and substance use clinicians in both rural and urban areas is inadequate and provides further challenges to patient access to services. Even in less underserved communities, access to mental health services is still challenging because insurers are often non-compliant with federal Mental Health Parity law, forcing patients to pay out of pocket or to forgo services. Further, between 1955 and 2016, state and county hospitals underwent a 96 percent decline in inpatient psychiatric beds from 340 per 100,000 to 11.7 per 100,000. The severe decline in overall available psychiatric beds by 64 percent

¹⁰Public Health Institute / Center for Connected Health Policy. "State Telehealth Laws & Reimbursement Policies." Fall 2019.

since 1970 makes stabilization and treatment of patients with severe mental illness (SMI) extremely challenging. In addition, stigma surrounding mental illness and accessing help exacerbates all of the aforementioned factors that impact health outcomes in these communities.

As discussed above, data supports the implementation of Collaborative Care Models (CoCM) in part to address workforce shortages. CoCMs allow each practitioner to practice at the top of his or her license, enabling more serious mental illness to be treated by physician specialists while less severe mental health or substance use disorders to be treated by other practitioners in collaboration with physicians. CoCMs also allow seamless sharing of patient data between providers on the same team so that providers do not waste valuable time on administrative tasks like contacting referring providers or going through burdensome administrative paperwork to request patient information. In addition to reducing administrative burden, expanding provider networks to ensure that more providers take Medicaid or private insurance as detailed in the aforementioned Milliman study, can help with access¹¹.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Psychiatric and substance use needs in rural and underserved communities already exceed supply of these services. Therefore, easing the burden of utilization review processes in Medicare, Medicaid and private plans is vital by making the process more consistent, transparent, and focused only on outlier practices and those that show concern based on evidence. As with physical health care, often the longer a mental illness goes untreated, the more serious and costly it becomes. While these protocols are meant to lower direct costs to public-funded health care and for private payers, in reality, these processes only serve as obstacles to patient's health and safety. In addition, prior authorization processes, especially those without timely updated clinically appropriate, medically necessary algorithms heighten costs and administrative burden across the health care system and delay care delivery in both emergency and non-emergency situations. Additionally, given the complexity of our health care system, wait times to receive appropriate psychiatric medication as a result of utilization review processes increases frustration and time constraint burdens for patients, which can exacerbate mental health conditions.

Improving provider networks would improve patient access to timely, affordable psychiatric services. A recent [Milliman report](#) found that when patients cannot find a physician in a plan's network, they must go out of network and increase their out-of-pocket cost.¹² This creates more barriers to care than for people seeking services for physical illness. In 2017, 17 percent of behavioral office visits were to an out-of-network provider, compared to 3 percent for primary care providers and 4 percent for medical/surgical specialists. Reducing disparities in coverage and clinician payment can improve networks and affordable, access to patients.

¹¹ Milliman, Inc. "Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement." Milliman Research Report. November 2019.

¹² Milliman, Inc. "Addiction and Mental Health vs Physical Health: Widening Disparities In Network Use and Provider Reimbursement" November 2019.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

Fifty states and Washington, DC provide reimbursement for some form of live video in Medicaid fee-for-service. Mental health provision through telehealth services is the fastest and most convenient way to help patients when physical transportation is burdensome. As mentioned above, reducing the burdens to accessing psychiatric services through telepsychiatry greatly improves overall outcomes. The same telepsychiatric services necessary for general mental health well-being can be applied to address gaps in care in post-acute and long-term care situations. Though it is widely accepted that use of technology, in particular social media, can contribute to social isolation, conversely, telehealth can literally be a lifeline for patients in post-acute and long-term care settings.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

*As discussed in the 2017 edition of *Communities in Action: Pathways to Health Equality Conclusion*:¹³ further development of existing health disparity indicators to include groups beyond African American and Caucasian races is necessary to better tailor research to identify disparities. For race research, this expansion should include groups such as Hispanics and major Hispanic subgroups, Native Americans, Asians, Pacific Islanders, and mixed-race individuals. In addition, research should collect data on population groups that identify LGBTQ individuals, on individuals with disabilities, and on military veterans. Additional consideration is needed to develop research methods that oversample certain populations in order to generate stable estimates of disparities. Further, research on disparities would benefit by extending the broader definition of health by expanding metrics and indicators that capture health equity and social determinants of health. For example, broadening the definition of health to include data on exposure to abuse, violence or trauma experienced during childhood or early adult years. Data on rural location and life course could also be helpful to collect. Extending longitudinal studies to capture more quantifiable data on social determinants of health and/or mental and substance use disorders would help researchers better understand long-term impacts of disparities. Research would also benefit from studies that focus on how single structural factors can influence numerous health outcomes. Lastly, increasing investment in research grants to develop and test social determinant of health-relevant theory, measures and scientific methods would encourage investigators to undertake projects that examine structural inequities and health disparities.*

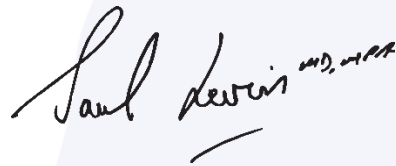
¹³ National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. *Communities in Action: Pathways to Health Equity*. Washington (DC): National Academies Press (US); 2017 Jan 11. 2, The State of Health Disparities in the United States. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK425844/>

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

A significant number of both large and small institutional, policy and programmatic efforts are needed to further strengthen patient safety and quality in health systems to improve care for our rural and underserved populations. We believe that no single policy change will have more impact on improving both physical and mental health outcomes for all populations than ensuring timely, affordable access to mental health care. This entails (1) investing in the mental health workforce, (2) making improvements to mental health coverage by ensuring that insurers are in complete compliance with the 2008 mental health parity law and (3) aligning outdated 42 CFR Part II regulations with the Health Insurance Portability and Accountability Act (HIPAA) to allow the sensible, appropriate and secure sharing of mental and physical health care data between health care providers to ensure proper care coordination. The effective integration of physical and mental health care will not only improve outcomes, it will save an estimated \$37-69 billion dollars annually. This estimate underscores the point that physical and mental health care cannot be treated in silos.

We thank you for the opportunity to submit these comments for consideration, and for your leadership and focus on these issues. Please let us know how we can aid your efforts to advance this bill. If you have any questions, please contact Michelle Greenhalgh at mgreenhalgh@psych.org / 202.459.9708.

Sincerely,

A handwritten signature in black ink that reads "Saul Levin" followed by "MD, MPA" in smaller, less legible script.

Saul Levin, MD, MPA, FRCP-E, FRCPsych
CEO and Medical Director

cc: The Honorable Lamar Alexander, Chairman, Senate HELP Committee
The Honorable Patty Murray, Ranking Member, Senate HELP Committee