Association for Behavioral Health and Wellness

Advancing benefits and services in mental health, substance use and behavior change.

June 22, 2015

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

The Honorable Ron Wyden, Ranking Member
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

Thank you for seeking feedback on chronic care reform efforts. The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to respond with our suggestions.

ABHW is the national voice for companies that manage behavioral health and wellness services. ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health to approximately 150 million people in both the public and private sectors. ABHW and its member companies use their behavioral health expertise to improve health care outcomes for individuals and families across the health care spectrum.

Below, please find ABHW's response to the questions you posed in your letter. We look forward to working with you to find solutions to ensure Americans suffering from chronic conditions, particularly mental illness and substance use disorders, receive the best possible care.

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions.

ABHW members utilize peer support services, telehealth, and community-based services to support integration and improve the lives of patients living with multiple chronic conditions.

ABHW member companies are increasingly employing Peer Support Services (PSS) and view them as a valuable component of a comprehensive approach to wellness. PSS are specialized therapeutic interactions conducted by self-identified current or former consumers of behavioral health services that are trained to offer support and assistance to others in their recovery and community-re-integration process. Peer Support is designed on the principles of consumer choice and the active involvement of persons in their recovery processes. We have seen that PSS are an effective component of behavioral health treatment and have a positive impact on consumers, purchasers, and payers. PSS are not currently eligible for reimbursement under Medicare, and we recommend a change in that policy.

Telehealth services have been proven to drive important advancements for our patients, expand access to care, improve health outcomes, reduce the inappropriate use of psychotropic medications, overcome the stigma barrier, and cut costs. Expanding access to telehealth services is a top priority for ABHW member companies and is discussed further in #5 below.

Community-based wraparound services for individuals with complex needs allow people to live in their communities. These social supports such as supported employment, supported housing, wellness plans, and transportation have been proven to help people recover and keep patients from unnecessary inpatient hospital stays. They also keep the goal of recovery at the forefront by helping to maximize function and quality of life. Medicaid waivers have helped to allow for the provision of wraparound services, but the Medicare benefit is not as flexible. We encourage the Medicare program to recognize the benefit of community-based wraparound services and allow Medicare to reimburse for these services for individuals with complex needs.

Additionally, Medicare should begin to cover all possible provider types that are currently excluded from reimbursement. Despite the high rates of mental health disorders, many Medicare beneficiaries do not have access to a mental health professional because of their remote locations and the shortage of mental health providers. Medicare currently recognizes psychiatrists, psychologists, clinical social workers, and psychiatric nurses to provide covered mental health services. In order to increase the array of providers available to Medicare beneficiaries and decrease the workforce shortage, ABHW supports Medicare's recognition of mental health counselors and marriage and family therapists. This would increase the pool of eligible mental health professionals by over 165,000 licensed practitioners and help increase access to care.

Recognizing other non-traditional services and providers may help as well. One example of an effective approach for those who speak English as a second language is the Promotoras model. In this case, lay members in the Hispanic/Latino community who receive specialized training to provide basic health education in the community serve as liaisons between their community, health professionals, and human and social service organizations. Promotoras act as advocates, educators, mentors, and translators for patients.

ABHW members are working to better integrate care in a variety of ways. Physical and behavioral health conditions have high rates of co-occurrence, with unmet behavioral health needs frequently complicating treatment for medical practitioners. The cost of not treating co-occurring physical and behavioral health conditions are significant. While working to drive forward medical and behavioral integration, a lack of system infrastructure inhibits our ability to facilitate that.

Fewer than half of behavioral health providers possess fully implemented Electronic Health Record (EHR) systems. When Congress passed the HITECH Act in 2009, it left out behavioral health providers. On average, IT spending in behavioral health organizations represents 1.8% of total operating budgets – compared with 3.5% of total operating budgets for general health care services. ABHW member companies coordinate behavioral health care with an individual's medical care and use clinical outcomes to help measure the effectiveness of the consumer's treatment. EHRs help facilitate integrated care, enhance e-prescribing, and track clinical outcomes. These benefits are hard to achieve if behavioral health providers are behind on EHR implementation. ABHW is supportive of legislation that has been introduced in Congress to extend health information technology assistance eligibility to more mental health and substance use disorder professionals and facilities.

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures.

Lower co-payments may improve outcomes for patients living with chronic diseases. ABHW members have found that patients frequently do not seek outpatient behavioral health services because of high co-payments. If a patient needs to choose between medications and outpatient services, he or she is choosing medications. These higher co-payments become a barrier that contributes to high readmission rates because people are choosing to receive only a piece of the recommended treatment (medication but not outpatient therapy). Studies show that a combination of medication and outpatient therapy leads to better patient outcomes. To remedy this situation, we suggest offering additional incentives to health plans to encourage them to provide lower co-payments, or tiered co-payments based on income levels, such that patients with small fixed incomes would have very low co-payments.

3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions.

ABHW would like to see a move from fee-for-service toward aligning payment with performance. This type of payment model will incentivize quality among providers. Bundled payment, rather than a specific fee for each intervention, would grant more flexibility to the provider and deliver whole-person focused care. This would lead to better outcomes and member satisfaction.

One ABHW member company's pay-for-performance options include a focus on primary care groups with fewer than 50 members; packaged with standard market pay-for-quality programs to bridge provider patient centered medical home (PCMH) readiness; and standardized performance measures for each market jointly selected by plan care management organizations, the quality team, and value-based staff. The company's pay-for-quality options focus on greater than 50 attributed members per practice; standardized quality measures for each market jointly selected by plan care management organizations, the quality team, and value-based staff; standardized performance measures by market; developed monthly standardized report containing performance and financial metrics for the plans; and plan-provided quarterly reports to, and engage with, providers to discuss interventions for identified gaps.

With a limited number of behavioral health practitioners, it would be beneficial to create additional incentives for providers to communicate with each other. Providers' ability to coordinate care would be enhanced by extending health information technology assistance eligibility to more mental health and substance use disorder professionals and facilities, as mentioned above in #1.

Additionally, Medicare providers are prevented from sharing 42 CFR Part 2 (Part 2) data without written reauthorization from a patient. Part 2 protects client-identifying information that would reveal a client as an alcohol or drug client, either directly or indirectly. Part 2 was created after Congress recognized that the stigma associated with substance use disorders and the fear of prosecution deterred people from entering treatment. While a laudable goal, these special protections create barriers to integration of behavioral and physical health, such as: inhibiting electronic exchange of health information, reducing the effectiveness of clinical reports to physicians, and delaying data transmission to providers. Individuals with substance use disorders will often go to different providers so that they can obtain multiple prescriptions for medications to which they are addicted; without access to a patient's record, this behavior is difficult to detect and treat. ABHW seeks the alignment of Part 2 with the HIPAA privacy rule to allow transmission of Part 2 data without written reauthorization for treatment, payment, and operations purposes.

4. The effective use, coordination, and cost of prescription drugs.

No comment.

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology.

Telehealth has the ability to reach a broad range of behavioral health consumers, including patients who reside in areas where there is a shortage of behavioral health providers; elderly patients who may have difficulty leaving their homes to travel to an appointment; military veterans; the deaf; and incarcerated populations, where the number of inmates with mental health issues is steadily growing, and prisons are failing to provide adequate mental health care.

Under section 1834(m) of the Social Security Act, Medicare pays for telehealth services when the service is furnished by an eligible practitioner; a patient is located in an originating site; and the originating site is in a rural area. Eliminating the originating site and geographic restrictions to Medicare reimbursement, increasing the list of eligible providers, addressing state regulations and licensure issues, and lessening the barriers created by the Ryan Haight Act would improve access to and quality of care for people with behavioral health needs.

The original intent of regulation regarding urban versus rural communities was based on the assumption at the time that rural areas were underserved, and therefore supporting telehealth in rural areas would help the underserved. Present reality shows that many urban areas also suffer a shortage of qualified physicians. Regarding access, it may take longer for a patient to travel to a specialist across town than for a rural resident to drive into the nearest city.

A shortage of behavioral health providers, particularly geriatric psychiatrists, limits access to mental health services. The shortage of psychiatrists and sub-specialists with expertise in geriatric populations is predicted to worsen in the near future. Making telemental services available in all settings is one way to optimize the psychiatric workforce. Expanding the list of eligible Medicare providers to include any licensed behavioral health provider practicing within the scope of his or her license would also help increase access to services. One upcoming opportunity to accomplish this goal is to add additional eligible telehealth providers in the next update of the physician fee schedule.

Regarding licensure, states need a way to mutually recognize medical licenses granted by other states, such as what is included in the interstate nursing compact. Reciprocal recognition of other state licenses will circumvent state-by-state licensing and renewal fees and lengthy delays in granting a license. We encourage Congress to direct states to collaborate to create common licensure requirements.

The Ryan Haight Act regulates anyone who delivers, distributes, or dispenses medication through the internet. It requires at least one in-person visit. The initial intent of the law has become a real barrier to administering telehealth services, as oftentimes patients are unable to visit with a provider in person because of a behavioral health provider shortage or physical difficulty traveling. Psychiatrists providing tele-services should be able to prescribe the same range of medications as face-to-face visits. Studies show that tele-prescribing is less abused than in a face-to-face setting or by phone. ABHW recommends amending the Ryan Haight Act to remove the restrictions preventing psychiatrists from prescribing medicine via telehealth services.

There is a general acceptance of telehealth today, across generations. A key change in regulation could immediately make an enormous difference in access to health care and the health of Medicare beneficiaries.

6. Strategies to increase chronic care coordination in rural and frontier areas.

As explained above, expanding access to telehealth services would increase chronic care coordination in rural and frontier areas.

Multiple counties in rural areas do not have behavioral health clinicians, including licensed clinical professional counselors (or a similar licensure dictated by individual State licensing laws) and licensed marriage and family therapists. Another way to improve access in these areas would be to see more states allow prescription services for psychologists.

7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.

Empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers requires educating patients and providers. Motivational interviewing (MI), a person-centered form of collaborative conversation for strengthening a person's own motivation and commitment to change, helps patients feel like they are a key part of the decision-making process regarding their care plan. MI can be learned quickly and continuously be improved upon. Training a broader health care provider population on the principles of MI would help to empower Medicare patients.

Peer Support Services are also successful in helping patients engage with their health care providers. Peers can accompany patients to appointments and help them advocate on their own behalf. Family supports are also empowering, as an extra set of eyes and ears for what is happening in treatment settings.

8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

Medicare needs to continue to support technological policies and programs that facilitate care coordination amongst all providers (i.e. extending health information technology assistance eligibility to more mental health and substance use disorder professionals and facilities, as mentioned above). Tools such as community-based services to help patients stay organized and focused are important as well. Community-based services discussed above assist with hands-on contact and coordination that help patients work their way through the health care system.

Requiring Mental Health First Aid training for primary care physicians and their office staffs would help them better recognize mental health issues and how to speak to their patients who have those comorbidities. This would lead to effective referrals and appropriate treatments.

Another way to more effectively utilize primary care providers and care coordination teams is to expand the use of consultations (from a psychiatrist, psychologist, etc.) to primary care providers who are the de

facto safety net for first line behavioral health services. Also, a focus on educational opportunities for primary care providers around screening and triage of behavioral health issues by primary care providers would be beneficial.

Thank you again for directing your attention toward the impact of chronic disease on the Medicare program and those it serves. We appreciate the opportunity to share our input and look forward to working together on a resolution. If you have any questions, please contact Rebecca Murow Klein at (202) 449-7658.

Sincerely,

Pamela Greenberg
President and CEO, ABHW