AMERICAN PSYCHIATRIC ASSOCIATION

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Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma,

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing 38,500 physicians specializing in psychiatry, we are concerned about the elimination of specific Medicare regulations that override existing state scope of practice laws, which could potentially result in the reduction of supervision requirements for Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs). Such a reduction could compromise the healthcare of our patients, particularly those with complex co-occurring disorders. We request instead a study about the impact of such a change and an approach that incentivizes a team-based approach, improves access to care for all patients, improves quality of care by standardizing training for APRNs and PAs nationally, and addresses inequities in reimbursement for supervision of psychiatric trainees.

APRNs and PAs are an essential part of the healthcare workforce; they may be the first and last person to interact with a patient during an episode of care and are well-equipped to play a much needed role in the health care team. However, for complex medical conditions, physician oversight is often critical to the development and implementation of a plan of care. **We would ask the Administration to consider policy alternatives that prioritize and reward team-based care.**

More than half of patients with mental illness and substance use disorders also have an underlying physical illness. For example, people with diabetes or heart disease often suffer from depression**. The complex interactions between mental and physical health conditions and the medications used to treat them require advanced medical training in order to ensure high-quality clinical care through adherence to best practices, which typically leads to highly positive health outcomes.** Psychiatrists uniquely offer the biopsychosocial training and experience to treat these complex clinical presentations. Not only is this approach clinically effective, it can also reduce costs, given that mental health and substance use related

conditions can compromise outcomes and drive costs of medical care.[1] Efforts at integrated care models are increasing, with funding streams being designed to help improve quality while containing costs. These models depend on thoughtful clinical judgment and proper management of complex conditions. A physician who provides oversight or collaborative consultation, with comprehensive knowledge of clinical needs, is essential to achieve these aims.

Although some argue that reducing supervision requirements is a method of improving patients' access to care, much better solutions to the access problem already exist. The APA is committed to improving access and quality for all Americans with mental health disorders. **One solution is implementation of team-based care through the Collaborative Care Model (CCM).** Multiple studies have validated that psychiatrists are essential to the success of the CCM – a model that has demonstrated the best evidence among integrated care models to control costs, improve access to care, and to improve clinical outcomes.[2] In the CCM, psychiatrists provide caseload consultations to care managers, who coordinate with patients and primary care providers, making their expertise essential to the model and important to improve outcomes. The CCM, which is supported by over 90 randomized controlled studies,[3] applies the principles of effective chronic disease management, including: 1) tracking treatment outcomes for all patients actively engaged in care, 2) proactively changing treatments when the patient is not at least 50 percent improved after 10-12 weeks on the current treatment regimen, 3) activating patients to participate in their own recovery, 4) using evidence-based treatments appropriate for a primary care setting, 5) identifying patients who cannot be effectively managed within primary care and tracking the outcome of referral to specialty care, and 6) promoting internal and external accountability for population-based treatment outcomes. In addition to overwhelming evidence of significantly better clinical outcomes, research shows the CCM also reduces healthcare costs[4,5] and improves patient and provider care practices, ranging from large urban practices to rural and safety-net practices.[6,7, 8,9]

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[1] Melek, S., D.T. Norris, and J. Paulus, Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman, 2014.

[2] Bower, P., et al., Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. Br J Psychiatry, 2006. **189**: p.484-93

[3] Archer, J., et al., Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev, 2012. **10**: p. CD006525.

[4] Unutzer, J. et al., Long-term cost effects of collaborative care for late-life depression. Am J Manag Care, 2008. **14**(2): p. 95-100.

[5] Unutzer, J., et al., The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. 2013.

[6] Unutzer, J., et al., Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA, 2002. **288**(22): p. 2836-45.

[7] Bauer, A.M., et al., Implementation of collaborative depression management at community-based primary care clinics: an evaluation. Psychiatr Serv, 2011. **62**(9): [/ 1047-53.

[8] Sanchez, K. and T.T. Watt, Collaborative care for the treatment of depression in primary care with a low-income, Spanish-speaking population: outcomes from a community-based program evaluation. Prim Care Companion CNS Disord, 2012. **14**(6).

[9] Unutzer, J. et al., Quality improvement with pay-for-performance incentives in integrated behavioral health care. AM J Public Health, 2012. **102**(6): p. e1-5.

**The use of telehealth has also proven effective to increase access.** Its use is rapidly growing and has a well-established evidence base, showing improved patient satisfaction, better medication compliance, fewer hospital readmissions, and reduced stigmatization of presenting at the psychiatrist's office. Telepsychiatry has also demonstrated to be particularly effective with certain diagnoses, such as autism, trauma, and severe anxiety. This allows us to reach diverse, rural populations and use the workforce more efficiently.

**We are concerned that there is inadequate reimbursement for these evidence-based approaches to care. CMS regulations should incentivize and adequately compensate for its use.**

In addition, current regulations about supervision of trainees in psychiatry prevent supervisors from fully billing for their services, a stark contrast to the rules in primary care. This prohibition interferes with the ability of hospitals and training programs to support psychiatric treatment services.

The education and training that PAs and APRNs receive is NOT equivalent to that of physicians**.** PA training involves working with physicians under their supervision. **There are currently no physician assistant schools that could legally train physician assistants to work independently from a physician.** Nurses generally must complete either a two- or three-year masters or doctoral degree program to become an APRN. While all baccalaureate nursing programs require a minimum 800 hours of patient care, advanced nursing degree programs have different patient care hour requirements with no common minimum standard. It has been estimated, for example, that nurse practitioners' training includes 500 - 720 patient care hours, and that nurse anesthetists complete approximately 2,500 hours of patient care.

In comparison, medical students spend four years focusing on the entire human body and all of its systems—cardiovascular, endocrine, digestive, organ biomedical, neuropsychiatric, and more—before undertaking three to seven years of postgraduate training to further develop and refine their ability to safely evaluate, diagnose, treat, and manage a patient's full range of medical conditions and needs. Combined, the most basic medical school and residency training total more than 10,000 hours of clinical education and supervised training experience, including basic course work as well as years of practical supervised experience with patients.

The role of APRNs and PAs on a care team remains critically important and we urge you to maintain current regulations, which may require general supervision by a physician. In addition, we encourage an approach that incentivizes an interprofessional working environment, promotes new models of care (collaborative care model, telepsychiatry), and addresses supervision inequities so that psychiatric supervisors are paid for their services, is a better way to improve access to and quality of care for all patients.

Sincerely,

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