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The Honorable Lamar Alexander, Chair
Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander:

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 your efforts to engage with stakeholders on ways to lower the cost of health care in the United States. As physicians who treat patients with mental health and substance use disorders (MH/SUDs), we share your concern on the impact rising health care costs are having on physicians and their patients. Accordingly, we recommend the following policy changes to lower or stabilize health care costs:

- Facilitating increased access to mental health and substance use disorder (MH/SUD) services;
- Encouraging the provision of MH/SUD services through innovative models of care and authorized health providers to access clinical care information;
- Eliminating unnecessary barriers to accessing MH/SUD services; and
- Discouraging the inflation of prices for prescription drugs.

Increasing Access to MH/SUD Services

Early identification and intervention, and sustained access to, MH/SUD services represents a primary means of reducing or eliminating downstream medical costs. It is estimated that nearly 44 million adults in the United States will experience a mental illness in a given year. If these disorders go untreated, or are inappropriately treated, a patient's risk of hospitalization, persistent or significant disability, or death is heightened, leading to greater costs to the broader health care and social service systems. For example, a recent study found that Medicaid patients receiving Medicare prescription drug benefits who were previously stable on their medications but had to switch medications because clinically-indicated refills were not covered or approved, experienced significantly higher adverse events (62% versus 37%),

including emergency department visits, hospitalizations, homelessness, and incarceration.¹

Parity

A key strategy to facilitate expanded access to MH/SUD services involves greater enforcement of federal parity laws, as well as increased transparency as to how insurers design their plans. As you know, APA supported the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA). However, in the decade since MHPAEA's enactment, many insurers remain out of compliance with the law, particularly in more complex matters relating to insurers' managed care practices, such as utilization review and network design. A lack of oversight from regulatory authorities and transparency by insurers allowed insurers to design these requirements in a manner that disfavors the utilization or provision of MH/SUD services.

The APA is engaged with state legislatures throughout the country to further empower regulatory authorities to address and enforce the disparities of access and coverage of MH/SUD services in the individual and small group market. The federal government also plays a significant role in ensuring that MHPAEA successfully achieves its stated goal of parity. We encourage the committee to consider legislation to provide appropriate Federal oversight to enforce the MHPAEA law. Specifically, APA supports policies that require transparency and accountability in insurers' coverage decisions, including how non-quantitative treatment limitations are designed and applied to MH / SUD relevant to physical health.

Telepsychiatry

A growing body of research indicates that psychiatric care provided via telemedicine is as effective as in-person psychiatric services.² The availability of telepsychiatry to connect psychiatrists to patients who would otherwise receive limited to no MH/SUD services can result in improved patient outcomes, including shorter hospitalizations and improved medication adherence. The positive impact of expanded access to telepsychiatry is particularly acute amongst underserved populations and individuals with certain diagnoses, including autism spectrum disorders and severe anxiety disorders. Telepsychiatry can also help mitigate the impact of stigma associated with seeking treatment for substance use disorders and addiction treatment services by enabling treatment in settings that are more private, familiar, and comfortable to the patient.

However, despite its proven effectiveness, many barriers to the provision of telepsychiatry persist, including policies that restrict coverage to patients who live in certain types of geographic areas and are physically present at specific types of originating sites. While APA supported the renewed focus on telemedicine in the recent bipartisan opioid legislation (H.R. 6, the SUPPORT for Patients and Communities Act), more work must be done to enable broader access to this evidence-based and cost-effective means of providing MH/SUD care. For example, H.R. 6 waived some of Medicare's coverage requirements

¹ Clinically Unintended Medication Switches and Inability to Prescribe Preferred Medications Under Medicare Part D. West JC, Rae DS, Mojtabai R, Rubio MS, Kreyenbuhl JA, Alter CL, Crystal S. *Journal of Psychopharmacology*; 2011, June 21.

² See, e.g., Hilty DM, Ferrer DC, Parish MB, et al. The Effectiveness of Telemental Health: A 2013 Review. *Telemed J E Health* 2013;(19):444-454.

pertaining to “originating sites” for individuals with substance use disorders and any co-occurring mental health diagnoses. This waiver should be expanded to include all Medicare beneficiaries with any mental health need, regardless of any co-occurring diagnoses.

Innovative Models of Integrated MH/SUD Care

While mental health and substance use disorders are often chronic conditions that people experience alongside other chronic medical conditions, such as heart disease and diabetes, only about 25% of patients receive effective mental health care where the majority of patients with MH/SUD receive their medical care.³ The effective integration of medical and behavioral health care services is estimated to save approximately \$26-\$48 billion annually.⁴ While different models of integrated care are being tested across the country, the “collaborative care” model (CoCM) has the greatest evidence base, demonstrating its effectiveness in over 80 randomized trials for controlling costs, improving access, improving clinical outcomes, and increasing patient satisfaction in a variety of primary care settings.

Under this model, a Collaborative Care team is led by a primary care provider (PCP) and includes a care manager and a psychiatric consultant, all of whom are empowered to work at the top of their license. The team then implements a care plan based on evidence-based measures and protocols and focuses its attention on patients not meeting their clinical goals. While APA applauded CMS’ adoption of billing codes that would enable reimbursement of the collaborative care model through Medicare, the adoption of CoCM amongst private insurers and state Medicaid programs remains inconsistent and APA recommends incentives towards more widespread adoption of CoCM. We also suggest that the federal government fund pilot projects across the country to accelerate education about and the adoption of CoCM in appropriate settings and provide additional data about the model’s impact on health care outcomes and cost savings.

Eliminating Unnecessary Barriers to Evidence-Based MH/SUD Services

Discouraging Additional Utilization Review in Medicare

In light of the Committee’s commendable goal of lowering health care costs, APA asks the Committee to resist efforts to enable or facilitate additional utilization review protocols for medications used to treat mental health and substance use disorders. While these protocols are, in theory, meant to lower direct costs to public funds and private insurers, in real-world practice these protocols only serve as a detriment to the patient’s health and safety and to heighten costs to the overall health care system, including imposing additional administrative burdens on physicians. Recently, CMS proposed rules that would allow Medicare Advantage plans to apply additional utilization management tools (e.g., indication-based prior authorization requirements and indication-based formularies) to a broader array of medications, including

³ Unützer 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.

⁴ Milliman, Inc. “Economic Impact of Integrated Medical-Behavioral Healthcare. Implications for Psychiatry.” April 2014.

antidepressants and antipsychotics. Imposing additional prior authorization requirements on life-saving medications to patients with MH/SUD could exact immense downstream personal costs from the patient, such as suicide, as well as higher monetary costs to the overall health care system, such as increased rates of hospitalization.

Drug prescribing is a complicated matter, given the nature of a drug in the classes for the treatment of psychiatric and addiction disorders. The pharmacological treatment that may be most effective depends on a variety of individualized factors such as patient's treatment history, potential side effects, co-occurring medical diagnoses, and interaction with other medications. Furthermore, many mental illnesses are chronic, lifelong conditions with both acute and stable phases, characterized by a broad array of symptoms, even among patients who have the same or similar diagnoses. Imposing arbitrary policies that delay or deny access to MH/SUD medications recommended by the patient's physician heightens the risk of worsening symptoms and further treatment to undo the damage. This also increases the burden on emergency room departments that already struggle with boarding patients in the midst of a crisis. In a survey⁵ conducted of American College of Emergency Physicians (ACEP) members, 48% of respondents indicated that psychiatric patients are boarded one or more times a day in their emergency department (ED). Over a third of respondents indicated that patients waited in an ED between 1-5 days for an inpatient bed.

Reducing Administrative Burden on Physicians

While utilization management protocols like the drug management policies described above are ostensibly meant to reduce costs, in real-world practice these protocols generally serve to increase the already high administrative burden on physicians, diverting their attention away from patient care and resulting in worse patient outcomes. According to a recent report⁶ by the American Medical Association, 92% of physicians report that "prior authorizations programs have a negative impact on patient clinical outcomes." The AMA study also estimated that "every week a medical practice completes an average of 29.1 prior authorization requirements per physician, which takes an average of 14.6 hours to process—the equivalent of nearly two business days."⁷

APA recommends the following strategies to save costs by reducing unnecessary administrative burden on providers: (1) continuous evaluation of the impact of regulations and administrative protocols on physician and patients; (2) leveraging health technology to improve usability, clinical workflows, and patient access; (3) simplification of clinical documentation requirements; and (4) facilitating the development of streamlined or uniform prior authorization requirements and, where appropriate, removing them entirely.

⁵ American College of Emergency Physicians, "ACEP Physician Poll on Psychiatric Emergencies September 28 – October 6, 2016," retrieved from: <http://newsroom.acep.org/download/psychemergencypolloct2016.pdf>.

⁶ American Medical Ass'n, Survey: Patient Clinical Outcomes Shortchanged by Prior Authorization, Mar. 19, 2018, retrieved from <https://www.ama-assn.org/press-center/press-releases/survey-patient-clinical-outcomes-shortchanged-prior-authorization>.

⁷ Id.

42 CFR Part 2 Reform

The regulations contained in 42 CFR Part 2, which pre-date HIPAA, were rightfully intended to provide heightened protections against unwarranted disclosure of SUD records. However, in modern practice these regulations now have the effect of separating SUD records from the remainder of a patient's medical records. Physicians without access to the full scope of their patient's medical records may unwittingly prescribe or recommend treatments that are adverse to their MH/SUD treatment, leading to potentially dangerous outcomes for the patient and added costs of treatment for those outcomes.

In reforming 42 CFR Part 2, APA recognizes the importance of protecting the privacy record of a patient suffering from SUD. Last year, APA supported HR 6062 that enhanced consumer protections currently applicable to Part 2, including provisions to prohibit the use of a patient's record in any criminal, civil or administrative investigation, action or proceedings. While the bill passed by an overwhelming majority in the House, APA was disappointed to see that the bill did not receive a vote by the full Senate and hopes that the Committee will support the bill upon its reintroduction.

Lowering Drug Costs

Rising drug prices, combined with high-deductible health plans, are causing many medications—even many that have been on the market for decades—to become unaffordable for many patients. According to a March 2018 report⁸ by the Senate's Homeland Security and Governmental Affairs Committee, "the prices of many of the most popular brand-name drugs increased at nearly ten times the cost of inflation from 2012 to 2017." Generic drugs, which are usually presumed to offer a lower-priced competitive alternative to bioequivalent brand name drugs, are not immune to major price increases. A study⁹ in the October issue of Health Affairs shows that the portion of generic drugs that at least doubled in price in successive years represents a small but growing share of the market: from 1% of all generic drugs in 2007 to 4.39% in 2013.

Prescription drug price increases are contributing to higher premiums charged to both employers and employees, greater outlays from public programs like Medicare and Medicaid, and greater out-of-pocket costs for patients. In many cases, payers are reacting to the higher costs of covering prescription drugs by removing beneficial drugs from their approved formularies, requiring that patients and their physicians obtain prior authorization before the medication that best treats their medical condition will be covered, or requiring that they try other drugs (a practice known as "step therapy") before the preferred medication will be authorized. Patients, particularly those with lower or fixed incomes, often respond to increasing costs of drugs by reducing the strength of their medications or by skipping doses entirely.

⁸ Retrieved from <https://www.hsgac.senate.gov/media/minority-media/breaking-brand-name-drugs-increasing-at-10x-cost-of-inflation-mccaskill-report-finds>.

⁹ Retrieved from <https://news.usc.edu/149667/do-price-spikes-on-some-generic-drugs-indicate-problems-in-the-market/>.

APA asks the Committee to take a multi-pronged approach to lowering the costs of prescription drugs, specifically by (a) enhancing transparency as to how manufacturers set the list prices of drugs; (b) fostering competition amongst name-brand and generic drug manufacturers and discouraging industry practices that inappropriately limit competition; and (c) examining the roles of regulatory agencies, payers, and pharmacy benefit managers (PBMs) in encouraging or discouraging competition, value and fair pricing of medications.

Thank you for your ongoing commitment to finding bipartisan strategies to lower the costs of healthcare in our system. Accordingly, we welcome an opportunity to further aid the Committee's efforts. If you have any questions, please contact Mike Troubh at mtroubh@psych.org / 202.559.3571.

Sincerely,

A handwritten signature in black ink that reads "Saul Levin" followed by "MD, MPA, FRCP-E" in smaller text.

Saul Levin, MD, MPA, FRCP-E
CEO and Medical Director
American Psychiatric Association

CC: The Honorable Patty Murray, Ranking Member, HELP