January 26, 2016

Senator Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Senator Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

RE: Committee Solicitation: Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch and Ranking Minority Member Wyden:

The American Association for Marriage and Family Therapy, American Counseling Association, American Mental Health Counselors Association, California Association of Marriage and Family Therapists and National Board for Certified Counselors. appreciate the opportunity to comment on the Finance Committee's Working Group Bipartisan Chronic Care Working Group Policy Options Document. Our organizations speak for two separate mental health professions, clinical mental health counselors (CMHC) and marriage and family therapists (MFT), both which earn a master's or doctoral degree in a mental health discipline and have completed two years of post-master's clinical supervision and have passed a state licensure examination for independent practice. Both professions practice in a variety of settings including hospitals, substance abuse treatment centers, employee assistance plans, community mental health centers, agencies, and private practice.

Our organizations are pleased the Working Group has recognized the important goal to "Address the Need for Behavioral Health Among Chronically Ill Beneficiaries." We strongly support this goal to more effectively and efficiently address the chronic care and mental health needs of Medicare beneficiaries. Your document notes that many Medicare beneficiaries have multiple chronic conditions, including many beneficiaries experiencing co-morbid behavioral health conditions. We note that many previous comments to the Working Group have recommended that your final product include legislation to expand the number of nonphysician providers in any team-based models as well as incorporate more community-based providers, public health resources, and social services into supporting care coordination practices and policies to avoid lapses in treatment and adherence. **Our key recommendation is to recognize the importance of expanding Medicare beneficiaries' access to needed mental health providers by including CMHCs and MFTs as Medicare recognized providers.**

The Substance Abuse and Mental Health Services Administration and the Administration on Aging have documented the extent of behavioral health problems among older adults such as alcohol or medication misuse or abuse, depression, and anxiety. Behavioral health problems can have a great impact on older adults and are associated with decreased quality of life, diminished adherence to treatment plans, poor medical condition, and overuse of medical services. Despite the impact of behavioral health problems, they often go undiagnosed and undertreated. Furthermore, Medicare providers are often poorly equipped to address behavioral health problems with co-occurring disorders, resulting from their inability to include appropriate providers in their practice arrangements, and insufficient physician time to screen, diagnose, and treat both physical and behavioral health problems. The Centers for Medicare and Medicaid Services (CMS) estimates that more than 16 percent of Medicare beneficiaries suffer from depression, which is more than suffer from heart failure, cancer, or Alzheimer's disease.[1] The rate of suicide for Americans 65 and older is roughly twice as high as for youth and adults under age 25.[2] Unfortunately, only 3.9% of Medicare spending is on mental health services, less than any other private or public insurance program.[3]

Moreover, the cost of depression is significant. Over half of Medicare beneficiaries have one of six chronic conditions that include depression. Direct medical care cost for people with chronic conditions accounted for approximately 83% of U.S. health care dollars in 2001, a per person average that is five times higher than for those without a chronic condition. The average Medicare beneficiary payment per year for someone with depression is $16,869, compared to $2,820 for someone without the six condition. Fifty-five present (55%) of Medicare beneficiaries with depression have multiple chronic condition (29% with two conditions, 26.1% with three or more).[4] Medicaid expenditures show there are significant savings that may accrue from decreasing the costs of depression. Nearly 60 percent of Medicaid spending is incurred by just five percent of the program's beneficiaries, including many with disabilities and multiple chronic conditions health needs. The Center for Health Care Strategies (CHCS) report that roughly 60 percent of Medicaid highest cost beneficiaries with disabilities were found to have co-occurring physical and behavioral health conditions.

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[1] Medicare Beneficiary Prevalence for Chronic Conditions for 2013, CMS Chronic Condition Data Warehouse. Online at https://www.ccwdata.org/cs/groups/public/documents/document/ccw_website_table_b2.pdf.

[2] National Suicide Statistics at a Glance - Trends in Suicide Rates Among Both Sexes, by Age Group, United States, 1991-2009. Centers for Disease Control and Prevention. Online at http://www.cdc.gov/violenceprevention/suicide/statistics/trends02.html.

[3] Substance Abuse and Mental Health Services Administration. Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020. HHS Publication No. SMA-14-4883. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[4] Medicare Beneficiary Prevalence for Chronic Condition for 2013, CMS Chronic Condition Data Warehouse. Online at file:///C:/Users/jfinley.D3WCXN02/Dropbox%20(AMHCA)/Jfinley/Medicare/ccw_website_table_b2%20(1).pdf

The Medicare program must better address the high rate of comorbidity of mental disorders with chronic medical conditions. An estimated 68% of adults with mental disorders have comorbid medical conditions, and 29% of adults with medical conditions have mental disorders.[5] Furthermore, patients with comorbid mental health and medical disease are highly expensive to treat with frequently diminished health outcomes.

Covered mental health professionals recognized by Medicare presently include psychiatrists, psychologists, psychiatric nurse specialists, physician assistants and clinical social workers. The single greatest statutory barrier that prevents Medicare beneficiaries from obtaining mental health and behavioral health care is the exclusion of CMHCs and MFTs from the program. These two provider groups, which represent 40 percent of the licensed behavioral health workforce, are fully qualified to deliver behavioral health services in all 50 states. Unfortunately, their services are not covered under Medicare due to their more recent recognition for independent practice in the states than the other Medicare mental health care eligible professionals. Other federal agencies now recognize these two professions for independent practice, including the National Health Service Corps, the Department of Veterans' Affairs and DoD/TRICARE. It is long past time for Medicare beneficiaries to gain access to these professions. Senators John Barrasso (R-WY) and Debbie Stabenow (D-MI) have sponsored S.1830, legislation adding CMHCs and MFTs services under the Medicare program.

MFTs and CMHCs have the education, training and practice scope equivalent to or greater than existing Medicare covered providers. This legislation does not change the mental health benefit or modify the MFT/CMHC state scope of practice, but it will allow Medicare beneficiaries who need medically necessary covered mental health services to obtain these services. In essence, our proposal only increases the pool of Medicare qualified providers that beneficiaries can choose from without changing the covered services.

Lack of Access in Rural and Underserved Areas--Approximately 77 million older adults live in 3,000 mental health professional shortage areas. Fully 50 percent of rural counties in America have no practicing psychiatrists, psychologists, or social workers. However, many of these mental health professional shortage areas have CMHCs and MFTs whose services are underutilized due to their lack of Medicare coverage. CMHCs and MFTs are often the only mental health providers in many communities, and yet they are not recognized within the Medicare program.

Medicare Cost Savings--Currently, Medicare is a very inefficient purchaser of mental health services. Inpatient psychiatric hospital utilization by elderly Medicare recipients is extraordinarily high when compared to psychiatric hospitalization rates for patients covered by

[5] The Synthesis Project, New Insights from Research Results, Policy Brief No. 21, February 2011; Robert Wood Johnson Foundation. Online at: http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf

Medicaid, VA, TRICARE, and private health insurance. Many of these expensive inpatient placements are caused by clinical depression and addiction disorders that can be treated at much lower cost when detected and treated early through the outpatient mental health services.

Integration of behavioral and physical health care is key--Accountable Care Organizations and other health care practices that provide integrated patient care can avoid unnecessary tests, provide integrated behavioral health and medical health diagnoses, and can readily prescribe psychiatric medications to support patient care. Most importantly, they report improved patient outcomes with lower costs.[6], [7] In many of these models, older adults receive screening and treatment for behavioral health problems in their primary care setting, and they receive care from both their primary care provider and a behavioral health specialist that is co-located within the primary care team. Alternatively, some specialized behavioral health clinics and centers have embedded primary care practitioners within their practices to provide integrated care to patients. Effective integrated care teams develop a comprehensive plan to address physical and behavioral health care needs, and share patient information. The behavioral health provider can support medication management prescribed by the primary care provider and can deliver brief evidence based behavioral health interventions, such as problem-solving therapy, interpersonal therapy, or brief alcohol interventions. The effectiveness of treatment is measured and tracked, and treatment is changed or intensified if a patient does not show improved clinical outcomes. Passage of S.1830 adding these two professions as recognized Medicare providers would greatly alleviate this major service deficit in the program.

In the context of reforming Medicare, it is difficult to project greater cost effectiveness at significantly reduced costs than the concepts we have discussed. The nation has a proven resource in CMHCs and MFTs who are well qualified and dedicated behavioral health specialists. Our organizations are gratified by the interest the Working Group has expressed in these issues, and we would be pleased to serve as your resource on these issues.

Sincerely yours,

American Association for Marriage and Family Therapy
American Counseling Association
American Mental Health Counselors Association
California Association of Marriage and Family Therapists
National Board for Certified Counselors

[6] Collins C, Hewson DL, et al. (2010). Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund.

[7] Integrating Behavioral Health into Primary Care. SAMHSA-HRSA Center for Integrated Health Solutions. Accessed February 27, 2013

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