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ADVOCATING FOR BEHAVIORAL HEALTH
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SUBMITTED ELECTRONICALLY: www.regulations.gov

September 6, 2016

Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: **CMS-1654-P: "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model" –** RIN 0938–AS81 (42 CFR Parts 405, 410, 411, 414, 417, 422, 423, 424, 425, and 460)

Dear Mr. Slavitt,

***NOTE*:** **Our comments focus on "Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions"**

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the proposed rule (CMS-1654-P) titled "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model" as published in the July 15, 2016, *Federal Register*.

Our comments below focus specifically on the section related to "Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions."

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. NAPHS members are behavioral healthcare provider organizations that own or manage more than 800 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks.

COMMENTS

NAPHS supports the CMS proposal to implement the codes they have developed to allow Medicare reimbursement for the Collaborative Care Model under the physician fee schedule. This is a well-tested and well-documented model that has proven its ability to improve care for individuals with mental and addictive disorders.

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Over the course of more than a decade, NAPHS member organizations and behavioral health professionals have been among those who have pilot-tested and successfully implemented this model with primary care (through such programs as The IMPACT Collaborative Care Program). The collaborative model has demonstrated that it can save lives and save money.

Interest in and support for this model have grown as a way to better reach individuals with behavioral health disorders at the right time so that they can get appropriate supports. The need is great as 43.8 million adults (or 1 in every 5 adults) had any mental illness in the past year, and 20.3 million adults (or 1 in 12 adults) had any substance use disorder, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). Early intervention – particularly within primary care – has shown to help offset costs (such as emergency department visits) that result when disorders are not treated at their earliest stages.

Given widespread workforce shortages, primary care practitioners often have limited access to comprehensive psychiatric supports and collaboration. With a system for reimbursement for Collaborative Care, the healthcare system can make better use of scarce specialty resources, while at the same time improving patient care.

The CMS proposal to – for the first time – implement a payment code under the physician fee schedule for non-face-to-face collaboration between primary care physicians and psychiatric specialists is an important first step. We support this approach and urge CMS to move forward to implement payment for the Collaborative Care Model in CY2017.

We recognize that CMS has singled out one very specific collaborative care model (as employed by the Diamond Program in Minnesota and the Washington State Mental Health Integration Program and as detailed in the literature) for inclusion in the physician fee schedule.

This is a precedent-setting move, yet only a first step. We encourage CMS to continue to review other integrated care models (both inpatient and outpatient) so that reimbursement will be widely available for an effective service for Medicare and Medicaid beneficiaries. We encourage ongoing work to remove the barriers to mental and substance abuse treatment through policies and strategies such as widespread implementation of the Collaborative Care Model, the integration of primary care with treatment for all behavioral health disorders, and implementation of ongoing coordination of care with the health system and the payment reforms that are necessary to achieve these goals.

The codes should be reviewed regularly to assure that they adequately compensate professionals for the intensity of the work. Flexibility within the codes could provide for their use as other care models evolve based on what the field learns from continued implementation of the Collaborative Care model.

SPECIFIC CMS REQUESTS FOR COMMENT

CMS has asked for specific feedback on several issues.

Consent

CMS has asked for comment on whether the Medicare beneficiary's signed consent would be required prior to using the Collaborative Care model.

NAPHS supports the CMS proposal to, "require a general beneficiary consent to consult with relevant specialists prior to initiating these services, recognizing that applicable rules continue to apply regarding privacy." We support the proposal regarding documentation of the beneficiary's consent. Physician-to-physician communication as well as communication within treatment teams happens routinely – without an extra layer of formal written consent – for other medical conditions. We recommend that general consent to confer with relevant specialists should be done prior to enrolling patients into a collaborative care management program.

Coding

We support the extensive work the American Psychiatric Association (APA) has done in reviewing the proposed values assigned to the GPPP1, GPPP2 and GPPP codes. We support their conclusion that the proposed values assigned to the codes do not adequately reflect the work of the psychiatric consultant and would result in reimbursement that would not be sufficient to sustain the care model. We agree that the work is more closely equivalent to the medical decision-making of an evaluation and management service and the crosswalk to CPT code 90836 (Psychotherapy with a relative value unit of 0.42) is not appropriate.

Care Manager Location and Supervision

We strongly recommend that the care manager be permitted to work off-site and under the general (not direct) supervision of the treating physician or other healthcare professional. We agree that it is important for the care manager to have effective working relationships with the primary care team but suggest this can be done in many different ways. Depending on the size and geographical location of the practices being served, a care manager may work with more than one practice. Research (AIMS Center of the University of Washington) supports the effectiveness of this model. Flexibility in the implementation of this important innovation is very important.

Application of the Collaborative Care Model for Other Diagnoses and Treatment Modalities

We believe that any psychiatric and/or substance use disorder is appropriate for this model. At a minimum, limitations of its use based on diagnoses would be difficult to monitor for accuracy and could create incentives for misdiagnosing.

CONCLUSION

Thank you for your consideration of our comments. We look forward to working with CMS and the Department of Health and Human Services to support Medicare beneficiaries' access to proven integrated treatment models such as Collaborative Care and to modernize payment mechanisms to allow providers to deliver these effective services.

Sincerely,

/s/

Mark Covall
President/CEO