NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
900 17th Street, NW, Suite 420, Washington, DC 20006-2507 | Ph 202/393-6700 | Fx 202/783-6041 | naphs@naphs.org | www.naphs.org

SUBMITTED ELECTRONICALLY: www.regulations.gov

September 9, 2015

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-1631-P: "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2016"

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-1631-P) titled "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2016" as published in the July 15, 2015, *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 develop codes 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.

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

-continued-

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 – create 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 CY2016.

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 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.

Within the physician fee schedule, we recommend that development of the codes – and reimbursement – for Collaborative Care be based on the following principles:

- Code creation should be driven by the usual process for development of codes and relative values for all other medical conditions. We look to the professional medical societies (including the American Medical Association and the American Psychiatric Association) for their technical expertise on code development.

- Codes should be inclusive of appropriate practitioners, including advance practice RNs (APRNs).

- While the Collaborative Care model is a well-tested and well-documented model, flexibility should be provided on who is eligible for payment based on local needs and resources.

- For the Collaborative Care model to be sustainable, the right economic supports / modeling must be provided. Too often, the Collaborative Care model is insufficiently funded. This is a team approach, and sufficient economic support must be available to fully engage a team with appropriate clinical expertise.

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 is concerned that requiring written consent in every case is an unnecessary barrier preventing access to a service that has proven value in helping primary care address mental and substance use conditions. 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.

NAPHS recommends that CMS create the codes now for the Collaborative Care Model so that it can be implemented in CY2016, rather than doing a demonstration through the CMMI. The specific Collaborative Care Model outlined by CMS (as employed by the Diamond Program in Minnesota and the Washington State Mental Health Integration Program) has a proven track record and should be implemented without further delay within the physician payment system. Waiting for results of a demonstration (which, by definition, would involve only selected sites) would limit access to what we already know – from the science base – works.

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.

Coding

We agree with the American Psychiatric Association (APA) that coding could facilitate appropriate valuation of the services furnished under the collaborative care model (CoCM), if it:

1. Explicitly incorporates the clinical approach and processes basic to the model; and
2. Accurately describes the work entailed in each of the explicit functions for each of the key providers.

There are four key providers required for the model: the primary care physician (PCP), the care manager, the psychiatric consultant, and the care manager supervisor. The roles of the care manager and psychiatric consultant are new for the treatment of behavioral health conditions in the primary care setting. Their functions and responsibilities have standard descriptions, which have been developed for the model. The role of the PCP does not substantially change.

We believe that no codes currently exist that adequately capture the scope and intensity of the CoCM model. We think separate codes need to be developed for the care management functions (can be bundled) and that a new and separate code is needed for the psychiatric consultant.

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.

Quality, Technology, Co-Pays

We agree with the American Psychiatric Association (APA) that there are quality and outcome measures that are inherent to the model and constitute the basis for quality reporting and monitoring for use with new codes. These measures can be used to enable pay-for-performance features for the model in the future.

We think that any technology requirements associated with these services will be derived from the scope of service and care delivery requirements of the codes that are developed.

We suggest that patient co-pays would be a serious impediment to utilization of the care management services. The model is a population-based approach. While the model's protocols are uniformly applied, there will be variations in the intensity of services required by an individual at any given time. This would present a serious problem in individual billing.

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