DRAFT Information – State Plan Amendment for 1115 Waiver

Introduction
PROVIDE INFORMATION ABOUT THE STATE'S EFFORTS TO INTEGRATED CARE AND/OR IMPROVE ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES THROUGH THE 1115 WAIVER AND THE GOAL OF ADOPTING THE INTEGRATED CARE MODEL.

Background
SUMMARY OF THE STATE'S 1115 WAIVER.

Demonstration Population
BASED ON CURRENT 1115 WAIVER, IDENTIFY THE POPULATION(S) THAT MAY BENEFIT FROM THE CHANGE.

Demonstration Project Description
The proposed policy changes include:

1. Adopting the Psychiatric Collaborative Care Management Codes (G0502, G0503, G0504) included in the 2017 Medicare Physician Fee Schedule to effectively integrate behavioral health and primary care.

Amendment Proposal
Behavioral health problems, such as depression, anxiety, and substance use disorders are responsible for 25 percent of all disabilities worldwide and a major driver of overall health care costs. One in five Americans experienced mental illness in the past year,[1] often with comorbid health conditions such as heart disease and diabetes. **Yet, only 25 percent of patients receive effective mental health care, including in primary care settings, where the majority of patients with MH/SUD receive their usual care.[2]** An analysis of nationwide claims data show that Medicare and Medicaid patients with these problems have healthcare costs for non-mental health illnesses that are 2-3 times higher than other beneficiaries.[3] In the United States, additional healthcare costs incurred by those with comorbid behavioral health conditions were estimated to be nearly $300 billion in 2012. This increased cost is largely attributed to use of medical services (rather than behavioral health services), creating a large opportunity for savings through more effective treatment.

Better care coordination via integration of mental health and primary care is a viable solution that has proven to improve patient access and outcomes. **Three decades of research and over 80 randomized controlled trials (RCT) have identified one model in particular – the Collaborative Care Model (CoCM) – as being effective and efficient in delivering integrated care.[4]** Studies show that effectively integrating behavioral and medical care has the potential to save between $26 - $48 billion each year.[5]

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[1] Department of Health and Human Services. "Mental Health Myths and Facts." http://www.mentalhealth.gov/basics/myths-facts/

[2] 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.

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

[4] Advancing Integrated Mental Health Solutions (AIMS) Center. "Evidence Base." https://aims.uw.edu/collaborative-care/evidence-base

[5] Milliman, Inc. "Economic Impact of Integrated Medical-Behavioral Healthcare. Implications for Psychiatry." April 2014.

Historically, fragmentation has divided the mental health system from the physical health system and posed a challenge to integration. By overcoming the barrier and effectively integrating care, improved quality, outcomes, and efficiency may be achieved to better serve people with mental health and substance use disorders.

Collaborative Care Model

In the Collaborative Care model, primary care providers (PCPs) treating patients' behavioral health problems lead a team that consists of a behavioral health care manager and a psychiatric consultant.

- **The PCP** is a primary care physician, physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) who serves as the treating physician and remains responsible for the overall treatment plan and is the billing practitioner
- **The care manager** is a social worker, psychologist or nurse with psychiatric expertise/training who works with the PCP. S/he is trained to deliver evidence-based care coordination and brief behavioral interventions, and support the treatments initiated by the PCP. In some implemented versions of the CoCM the care manager also conducts structured psychotherapy.
- **The psychiatric consultant** is a psychiatrist or PA, NP, or CNS with psychiatric training, whose primary responsibilities are making treatment recommendations through the care manager to the PCP, including developing treatment strategies (e.g., medication, evidence based therapies) and medical management of any complications associated with treatment.

The team implements a measurement-guided care plan based on evidence-based practice guidelines, and focuses attention on patients not meeting their clinical goals. Service components include the following:

- **Initial assessment** by the primary care team (billing practitioner and behavioral health care manager)
    - Initiating visit (if required, separately billed)
    - Administration of validated rating scale(s)
- **Care planning** by the primary care team, jointly with the beneficiary, with care plan revision for patients whose condition is not improving adequately.- Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments
- **Systematic follow-up using validated rating scales and the use of a registry** performed by the care manager
    - Assesses treatment adherence, tolerability, and clinical response using validated rating scales; may provide brief evidence-based psychosocial interventions such as behavioral activation or motivational interviewing
    - 70 minutes of behavioral health care manager time the first month
    - 60 minutes subsequent months
    - Add-on code for 30 additional minutes any month
- Regular case load review with psychiatric consultant – The primary care team regularly (at least weekly) reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care as needed

Key Outcomes

1. **Improved access to mental health care and satisfaction with care:** The vast majority of patients with behavioral health problems do not currently have access to care that includes

input from a psychiatrist. Research shows that effectively implemented Collaborative Care improves access and substantially improves patient and provider satisfaction.[6,7]

2. **Improved clinical outcomes:** Research shows that Collaborative Care improves clinical outcomes for behavioral health conditions, such as depression and anxiety[8], and can also improve outcomes for medical disorders like diabetes and heart disease.[9]
3. **Reduced healthcare costs:** The largest randomized control trial of Collaborative Care shows substantial reductions in all categories health care utilization and costs.[10] Over a four-year period, savings of more than $3,000/per patient in healthcare expenditures were achieved for patients who received usual care. This resulted in a $6.50 ROI for each $1.00 spent. Avoiding unnecessary inpatient and emergency room care yielded the largest savings and were generated by improving primary care capacity to identify and effectively treat patients.

Implementation

[State] plans to implement any approved provisions within at least one year after CMS approval. This will allow time to educate providers about the availability of the codes and prepare and implement operational and administrative changes at the state level.

Budget Neutrality

Evaluation Design

Public Notice Requirements

[6] Hunkeler, E.M., et al., Long term outcomes from the IMPACT randomized trial for depressed elderly patients in primary care. BMJ, 2006. **332**(7536): p. 259-63.
[7] Levine, S., et al., Physicians' satisfaction with a collaborative disease management program for late-life depression in primary care. Gen Hosp Psychiatry, 2005. **27**(6): p. 383-91.
[8] Archer, J., et al., Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev, 2012. **10**: p. CD006525.
[9] Katon, W., et al., Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial. Arch Gen Psychiatry, 2012. **69**(5): p. 506-14.
[10] 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.