AMERICAN PSYCHIATRIC ASSOCIATION

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Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically to HealthyChildrenandYouth@cms.hhs.gov

Re: Request for Information on Pediatric Alternative Payment Model Concepts

Dear Administrator Verma:

The American Psychiatric Association (APA), which represents more than 37,000 psychiatrists and their patients, is pleased to provide the following comments to the Centers for Medicare and Medicaid Services (CMS) in response to the Request for Information (RFI) on Pediatric Alternative Payment Model (APM) Concepts. This RFI seeks input on the design of a draft model concept focused on improving the health of children and youths covered by Medicaid and the Children's Health Insurance Program (CHIP), through state-driven integration of health care and health-related social services with shared accountability and cost savings. The aim of the model would be to facilitate strategies for timely and appropriate delivery of family-centered, community-based, linguistically and culturally appropriate, cost-effective, and integrated services to all children and youths covered by Medicaid and CHIP – with an emphasis on those with or at-risk for developmental, social, emotional, or behavioral health challenges, intellectual or physical developmental delays or disabilities, and/or those with complex and/or chronic health conditions (known as "high-need, high-risk beneficiaries").

I. The Pediatric Alternative Payment Model Should Address Mental Health and Substance Use Benefits and Services for Children, Adolescents, and Young Adults

CMS should place a high priority on addressing mental health and substance use disorders, including trauma in any Pediatric Alternative Payment Model. Because of the prevalence of mental health and substance use disorders (MH/SUDs) and associated co-morbidities, states play a crucial role in addressing the significant gaps in care for these conditions through the provision of essential MH/SUD benefits and services through individual state Medicaid and CHIP programs. Approximately 20 percent of adolescents and young adults in our country have a mental health or substance use disorder, and these account for a significant part of the burden of disability for this population.[1] Moreover, as of 2011, one in five Medicaid

[1] Richardson, L.P. et al. "Research in the Integration of Behavioral Health for Adolescents and Young Adults in

beneficiaries had a behavioral health diagnosis.[2] In addition, unrecognized trauma contributes to the continuation of poverty and high costs to the health care system.[3] Research show traumatized children and adolescents display changes in level of stress hormones similar to those seen in combat veterans.[4] These changes may affect the way traumatized children and adolescents respond to future stress in their lives, and may lead to poorer health outcomes later in life. Evidence shows that individuals who experience trauma, particularly in childhood, have higher rates of chronic disease and behavioral issues.[5,6,7]

In 2014, about 18 percent, or 43.6 million, of American adults had a mental illness. More importantly, the percentage of children and adolescents with a mental illness was a staggering 13 to 20 percent. In fact, in 2014, 8 percent, or 20.2 million, of individuals age 12 and older had a substance use disorder.[8] Yet only 40 percent of adults, and only 50.6 percent of children ages 8-15, with a *diagnosed* mental illness received treatment. And only 59 percent of those with a *serious* mental illness received treatment.[9] Individuals with mental illness often also have extensive non-psychiatric medical needs, which are exacerbated by mental illness, and include cardiovascular disease, diabetes, and obesity. The rate of mortality among persons with mental illness in comparison to those without is startlingly high.[10] A meta-analysis of worldwide mortality estimates found that the risk of mortality was 2.2 times higher for persons with mental disorders.[11] Most of this early mortality is associated with chronic comorbid conditions.

Primary Care Settings: A Systematic Review." *Journal of Adolescent Health* 60: 261-269, 2017.

[2] Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP. March 2016.

[3] Centers for Disease Control and Prevention (2014). Child abuse and neglect cost the United States $124 billion. Available at: http://www.cdc.gov/media/releases/2012/p0201_child_abuse.html

[4] Pecora et al. (December 10, 2003). Early Results from the Casey National Alumni Study.

[5] V.J. Felitti, R.F. Anda, D. Nordenberg, D.F. Williamson, A.M. Spitz, V. Edwards, et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine, 14, no. 4 (1998): 245-258.

[6] J. P. Shonkoff, A. S. Garner, & the Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; and Section on Developmental and Behavioral Pediatrics. "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." Pediatrics, 129, (2012b): 232–246.

[7] Findings from the Philadelphia Urban ACE Survey. Prepared by the Public Health Management Corporation. 2013. Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407836

[8] Substance Abuse and Mental Health Services Administration. "Mental and Substance Use Disorders." http://www.samhsa.gov/disorders.

[9] National Institute of Mental Health: "Use of Mental Health Services and Treatment Among Adults." http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml. "Use of Mental Health Services and Treatment Among Children." http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-children.shtml.

[10] Druss, B.G. et al. "Mental disorders and medical comorbidity." Robert Wood Johnson Foundation. Research Synthesis Report No. 21, February 2011. http://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html.

[11] Walker, E.R. et al. "Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis." *JAMA Psychiatry* 72: 334-341, 2015.

There is much work to be done to increase access to appropriate mental health care for children and adolescents, particularly in light of the traumatic effects of the ever-increasing epidemic of opioid addiction and deaths over the past decade.[12] Unfortunately, children and adolescents have been ensnared in this epidemic both as active participants, and also as a result of their relationships with parents and other family members with substance use disorders. **With respect to young adults, the APA supports and is a signatory of the comment letter submitted on behalf of the National Alliance to Advance Adolescent Health and other organizations, requesting the expansion of Medicaid and CHIP benefits to vulnerable young adults through the age of 26. We also strongly support incorporating trauma-informed approaches to care.**

In light of these significant challenges, the APA is pleased that many states have implemented some care interventions to improve the delivery of behavioral health services. However, the types of interventions utilized by states have varied, and there are many additional opportunities to improve these programs and services, particularly for children and adolescents.

II. The Evidence-Based Collaborative Care Model Should Be a Key Feature in the Pediatric Alternative Payment Model

The APA applauds CMS for supporting the Collaborative Care Model through the creation of new payment codes for Medicare claims, as well as encouraging practice transformation within your Transforming Clinical Practice Initiative networks throughout the country to integrate behavioral health into primary care, increase the integration of health care services to optimize benefits for patients, and streamline the work of health care providers. An estimated $25 to $48 billion could be saved annually through the effective integration of mental health and other medical care.[13] Furthermore, the Medicaid and CHIP Payment and Access Commission (MACPAC) has recently noted that "Medicaid enrollees with behavioral health conditions often find themselves interacting with multiple public and private agencies and receiving care from myriad providers funded from different sources. This fragmentation can impede access to care and result in inappropriate use of services, poor health status, and increased costs (Melek et al. 2014, IOM 2006, deGruy 1996)."[14]

The APA urges CMS to utilize this opportunity to promote and support the adoption of alternative payment models for which a robust evidence-base already exists, particularly the Collaborative Care Model. Over 80 randomized controlled trials have shown the Collaborative Care Model to be more effective than care as usual. Meta-analyses, including a 2012 Cochrane Review, further substantiate these

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[12] Opioids were involved in 33,091 deaths in 2015, and opioid overdoses have quadrupled since 1999. Centers for Disease Control and Prevention. Increases in Drug and Opioid Overdose Deas – United States, 2000-2014. https://www.cdc.gov/drugoverdose/data/statedeaths.html.

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

[14] Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP. March 2016.

findings.[15] [16] Economic studies demonstrate that collaborative care is more cost-effective than care as usual, and several evaluations found cost-savings associated with its use.[17] [18] The largest randomized, controlled clinical trial to date of the Collaborative Care Model – the IMPACT study involving adults ages 60 and over, across 5 states and 18 primary care clinics, found that patients in collaborative care had substantially lower overall health care costs than those receiving usual care.[19] "An initial investment in collaborative care of $522 during Year 1 resulted in net cost savings of $3,363 over Years 1-4."[20]

The Collaborative Care Model has been employed successfully in a number of settings to improve the integration of behavioral health for children and adolescents.[21] A recently published research study highlights the advantages of integrated behavioral health care for adolescents and young adults, citing two studies that the Collaborative Care Model "was associated with increased treatment engagement and significantly improved outcomes for depression among adolescents compared to usual care."[22] The model also serves as an important tool in filling the gaps caused by the significant shortage of psychiatrists in this country, which is even more severe for child and adolescent psychiatrists.

Under the Collaborative Care Model, primary care providers treating patients with common behavioral health problems are supported by a care manager and a psychiatric consultant who work together to help implement effective, evidence-based treatment for common behavioral health problems in the primary care setting. The widespread implementation of the evidence-based Collaborative Care Model, under both fee-for-service and value-based purchasing/payment systems, could dramatically improve access to effective behavioral health care while at the same time reducing the high health care costs associated with common mental health and substance use disorders.

CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Surgeon General, and the Agency for Healthcare and Quality (AHRQ) have already recognized the Collaborative Care Model

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[15] AIMS Center (Advancing Integrated Mental Health Solutions). "Collaborative Care Evidence Base." https://aims.uw.edu/collaborative-care/evidence-base.
[16] Archer, J et al. "Collaborative care for people with depression and anxiety." Cochrane Review. October 2012.
[17] Gilbody, S. et al. "Costs and Consequences of Enhanced Primary Care for Depression: Systematic Review of Randomised Economic Evaluations." *British Journal of Psychiatry*. October 2006; 189:297-308.
[18] Glied, S. et al. "Review: The Net Benefits of Depression Management in Primary Care." *Medical Care Research and Review*. June 2010;67(3):251-274.
[19] Unützer, J. et al. "Long-term Cost Effects of Collaborative Care for Late-life Depression." *American Journal of Managed Care.* Feb 2008;14(2):95-100.
[20] 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.
[21] American Psychiatric Association, Academy of Psychosomatic Medicine. "Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model. 2016. Available at: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/collaborative-care-model.
[22] Richardson, L.P. et al. "Research in the Integration of Behavioral Health for Adolescents and Young Adults in Primary Care Settings: A Systematic Review." *Journal of Adolescent Health* 60: 261-269, 2017.

as an evidence-based best practice, and CMS has implemented coverage and reimbursement for these services under the 2017 Medicare Part B Fee Schedule.

As part of development of a Pediatric Alternative Payment Model, we recommend that CMS make funding available under Medicaid and CHIP for states to:

1) Create programs to train primary care practices in the model (including linking them to existing efforts in this area under CMS' Transforming Clinical Practice Initiative);
2) Provide technical assistance to support needed practice transformation, including education and support in redesigning workflows, contracting, hiring of care managers, and quality metric tracking; and
3) Institute appropriate reimbursement pathways for care delivered in this model, including Medicaid and CHIP coverage and reimbursement under individual state plans.

III. New Models of Care for Mental Health Should Address the Onset of Psychosis in Adolescents and Young Adults

We also encourage the use of effective new models of care for reducing the onset of psychosis in adolescents and young adults. Psychotic illnesses typically first emerge in mid- to late adolescence or in early adulthood with the potential for long-term significant impairments that affects a person's ability to finish school, stay employed, and live a healthy life. However, research has shown that appropriate treatments and supports can help prevent the full on-set of a psychosis and improve the long-term outcomes for those who have experienced a first episode of psychosis by using coordinated specialty care (CSC) treatments for people who experienced a first episode psychosis. The *Recovery After an Initial Schizophrenia Episode (RAISE)* project, a large-scale research initiative by the National Institute of Mental Health (NIMH), studied CSC to understand whether CSC worked better than care typically available in communities and the best way for clinics to start using the CSC treatment programs. The model promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences.

The results show that CSC can be successfully delivered in the community and it is cost effective. Clients' symptoms improved over time as did their work, educational and social lives. Clients also had more satisfaction with the program because they received effective services and where treated with respect.[23]

Similar promising outcomes were found from the *Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP)*, a research and treatment initiative supported by the Robert Wood Johnson Foundation. The study compared two treatment options for 337 young people between the ages of 12-25 who were at risk of psychosis. The promising results show how a package of pre-emptive, evidence-

[23] National Institute of Mental Health. "Recovery After an Initial Schizophrenia Episode (RAISE)." https://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

based services can prevent young people exhibiting the earliest signs and symptoms of a psychotic disorder from converting to full-blown psychosis. The conversion rate to psychosis among those who received intervention through EDIPPP with strong family involvement averaged 6.3 percent—well below the 29 percent conversion among at-risk individuals who get infrequent or no treatment in the community. EDIPPP helped families learn to engage and support someone with severe mental illness, and helped patients succeed in school and at work. A significant number of people in the study (83-90 percent) who received the broad EDIPPP interventions could maintain or increase participation in work or school, increasing productivity.[24]

The use of these promising patient-centered, community-based approaches should be advanced and used to improve the health of children and youths covered by Medicaid and CHIP.

IV. Future Opportunities for Input

We urge CMS to continue to ensure ongoing opportunities for psychiatrists to provide input both at the federal and state level. In cases of broader, system-wide transformation efforts, such as accountable care organizations, we have heard concerns from psychiatrists who are active in state-based behavioral health integration, that MH/SUDs are not a central consideration of reforms. This is despite the fact that such disorders can be a major contributor to (and exacerbating factor for) morbidity and mortality, which unfortunately is particularly true for vulnerable populations. We also urge CMS to employ quality measures in the Pediatric Alternative Payment Model, which will assess meaningful improvement in care delivery and health outcomes for MH/SUDs. **We also urge CMS to include as part of future RFIs and funding arrangements, specific questions addressing mental health and substance use disorders.** This type of information should be requested on an ongoing basis and addressing MH/SUDs should be incorporated into the design of all new models of care delivery. Such avenues could include public comment periods as well as including representation of psychiatrists and other mental health providers in technical advisory panels and other advisory bodies engaged in this reform work.

Thank you in advance for your consideration of our comments. The APA looks forward to working with CMS as it develops a Pediatric Alternative Payment Model for Medicaid and CHIP. If you should have any questions or would like to discuss our comments further, please contact Eileen Carlson, APA Director of Reimbursement Policy, at ecarlson@psych.org or (703) 907-8590.

Sincerely,

Saul Levin, M.D., M.P.A.
CEO and Medical Director

[24] McFarlane, W.R. et al. "Clinical and Functional Outcomes After 2 Years in the Early Detection and Intervention for the Prevention of Psychosis Multisite Effectiveness Trial." *Schizophrenia Bulletin*, July 26, 2014.