AMERICAN PSYCHIATRIC ASSOCIATION

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August, 1, 2022

The Honorable Rachel L. Levine, M.D.
Assistant Secretary for Health
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: HHS Initiative to Strengthen Primary Health Care RFI

Dear Assistant Secretary Levine,

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, would like to take the opportunity to respond to the request for information regarding successful approaches and innovations that can strengthen and improve primary care. **Our comments focus on The Collaborative Care Model (CoCM), an evidence-based model that has been shown to both improve access to care and treatment outcomes, as well as reduce medical cost savings for patients receiving care for mental health and substance use disorders (SUD) in the primary care setting.[1] Implementation of this model is particularly important at this moment in time given the significant increase in the number of individuals seeking mental health and/or SUD care, and the lack of capacity within specialty care to treat everyone.**

We strongly support CMS's interest in strengthening our primary care system. The COVID 19 pandemic has severely weakened a system that has historically been under-resourced yet is the first, and possibly only, point of contact most Americans have with the healthcare system. The primary care system is being taxed further as the number of patients seeking care for mental health and SUD increases, putting in serious jeopardy practices that are struggling financially to keep their doors open. The outlook for 2023 looks even worse financially given the proposed reductions in Medicare payments due to negative adjustments to the conversion factor.

One of the more promising near-term solutions to shoring up primary care can be found in the promotion of population-focused, evidence-based, integrated care models such as the Collaborative Care Model (CoCM). CoCM has proven adept in providing prevention, early intervention, and timely treatment of mental illness and SUDs. As you know, many individuals first display symptoms of a mental health/SUD

[1] Holmes A, Chang YP. Effect of mental health collaborative care models on primary care provider outcomes: an integrative review [published online ahead of print, 2022 Mar 31]. Fam Pract. 2022;cmac026. doi:10.1093/fampra/cmac026 [AMA style]

in the primary care setting but do not receive the necessary follow-up treatment. Often, they have difficulty finding a mental health clinician or avoid seeking treatment due to the stigma that still exists. CoCM provides a strong framework to address these problems by ensuring patients can receive timely behavioral health treatment within the office of their primary care physician.

CoCM integrates behavioral health care within the primary care setting and features a primary care physician, a psychiatric consultant, and a care manager working together in a coordinated fashion. Importantly, the team members use measurement-based care to ensure that patients are improving, and treatment is adjusted when they are not. CoCM is supported by more than 90 statistically validated studies to show its effectiveness but has demonstrated a particular and significant utility in treating depression, where patients have seen a fifty percent decline in symptoms. In addition to demonstrated clinical efficacy, CoCM's population-based approach helps to alleviate the psychiatric workforce shortage by leveraging the expertise of the psychiatric consultant to provide treatment recommendations for a panel of 50-60 patients in as little as 1-2 hours per week rather than providing traditional 1:1 care over a series days.

CoCM has been shown to improve depression among racial and ethnic minorities.[2,3] Additionally, the CoCM has tremendous potential to produce significant cost savings. For example, one cost/benefit analysis demonstrated that this model has a 12:1 benefit to cost ratio for the treatment of depression in adults.[4] Furthermore, the virtual nature of CoCM enabled care to continue throughout the public health emergency.[5] Finally, primary care physicians have reported an increased sense of well-being and feel better prepared to provide care to patients with mental health and SUD. All of these feature's function to improve both mental and physical health and prevent downstream hospitalizations, or emergency room visits (not only for mental health or SUD conditions but physical health conditions as well) ultimately reducing overall-costs to our healthcare system.[6]

CoCM is currently being implemented in many large health care systems and practices, and is also reimbursed by Medicare, many private insurers, and a growing number of state Medicaid programs. Despite its strong evidence base and availability of reimbursement, uptake of the CoCM by primary care physicians and practices remains low due to a number of barriers including:

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[2] Hu J, Wu T, Damodaran S, Tabb KM, Bauer A, Huang H. The effectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: a systematic review. Psychosomatics. 2020, online first.

[3] Snowber K, Ciolino JD, Clark CT, Grobman WA, Miller ES. Associations Between Implementation of the Collaborative Care Model and Disparities in Perinatal Depression Care. Obstet Gynecol. 2022;140(2):204-211. doi:10.1097/AOG.0000000000004859

[4] Washington State Institute for Public Policy Benefit-Cost Results for Adult Mental Health. Retrieved from: https://www.wsipp.wa.gov/BenefitCost?topicId=8

[5] Carlo AD, Barnett BS, Unützer J. Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. JAMA Psychiatry. 2021;78(4):355-356. doi:10.1001/jamapsychiatry.2020.3216

[6] Melek SP, Norris DT, Paulus J, Matthews K, Weaver A, Davenport S. Milliman Research Report potential economic impact of integrated ... Milliman. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf. Published February 12, 2018. Accessed July 27, 2022.

- Up-front costs associated with implementation/practice transformation, including infrastructure/EHR/registry needs, hiring of additional staff (care manager, psychiatric consultant) as well as uncompensated costs not associated with direct patient care but none the less important to ensuring positive outcomes (i.e., development and training on workflows and caseload reviews, ongoing education, quality improvement activities).

- PCP concerns that reimbursement rates for billable services are insufficient to cover costs or incent practices to implement.

- Patient attrition due to copays/cost-sharing requirements including high-deductible plans.

- Billing challenges related to tracking of minutes over the course of a calendar month, limitations on the number of minutes billed per month (i.e. MUE billing limitations), and different time requirements in FQHCs and RHCs that result in underpaying for the time spent to provide care, creating a disincentive.

As you begin to formulate your plan to strengthen primary care, we ask that you consider ways to incentivize the adoption of the CoCM including addressing these and other barriers. Consideration should be given to:

- Funding mechanisms that provide financial and technical support for practices for the costs associated with implementation; costs not typically addressed within a fee for service payment methodology and costs that should not be borne by patients seeking care. The Collaborate in an Orderly and Cohesive Manner (COCM) Act, H.R. 5218, (supported by a diverse group of over 40 national stakeholders including members of the mental health community, every major primary care physician association, patient advocates, employers and payors) recently passed the House as part of the Restoring Hope for Mental Health and Well-Being Act, H.R. 7666, mental health and opioid abuse crisis package of legislation. The legislation allows primary care practices to be eligible for grants to provide financial assistance to implement the model as well as technical assistance to implement this evidence-bases model.

- Developing reimbursement mechanisms for CoCM to incent practices to implement the model. Recommendation 14 from a 2021 report from Rand, supported the launch of a National Care Coordination Initiative,[7] including financial support to defray capital costs incurred to implement the model (one of two highlighted) and higher reimbursement rates over a period of time to ensure practices maintain the model. The report also suggests modeling the Initiative after CMS's Transforming Clinical Practice Initiative (TCPI) through regional learning networks to provide technical assistance for those that want to implement.

[7] McBain RK., Eberhart N, Breslau J, Frank L, Burnam A, Kareddy V, and Simmons MM. How to Transform the U.S. Mental Health System: Evidence-Based Recommendations. Santa Monica, CA. RAND Corporation. 2021. https://www.rand.org/pubs/research_reports/RRA889-1.html.

- Designation of the CoCM services as preventive services by the Secretary, thus eliminating cost-sharing requirements for these services. Reports from the field cite concerns of patients about cost-sharing amounts as one of the reasons patients chose not to engage in care or continue to receive care through the model. The United States Preventive Services Task Force (USPSTF) has given the Depression Screening in Adults and in Children and Adolescents B ratings (an evidence-based service whose net benefits are moderate to substantial[8]), meeting one of four categories identified by statute as a preventive service. Screening for depression is a core function of the CoCM. In fact, the USPSTF notes in their 2016 recommendation statement that the "Community Preventive Services Task Force recommends collaborative care for the management of depressive disorders based on strong evidence of effectiveness in improving depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression. This collaboration is designed to improve the routine screening and diagnosis of depressive disorders, as well as the management of diagnosed depression."

  A recent report from Assistant Secretary for Planning and Evaluation (ASPE) reported that millions of Americans have benefited from ACA coverage and the lack of cost-sharing associated with preventive services. The report noted the value of preventive care/screening for chronic conditions to prevent or reduce impacts on long-term health. It is widely understood that depression has been linked to increasing mortality and morbidity for individuals with chronic conditions (i.e., cardiovascular disease, diabetes). Identifying and treating depression and other mental health conditions sooner could modify the trajectory of disease and save overall health care costs not to mention improve the quality of life for patients.

- Identifying ways to streamline the billing and documentation requirements associated with the CoCM codes including elimination of limitations on billing related to Medically Unlikely Edit (MUE) policies, and the adoption of CPT billing requirements regarding time by FQHCs/RHCs.

We thank you for recognizing the need to take action to support our colleagues in primary care. They are critical to ensuring the health and wellbeing of all Americans and are our partners in ensuring everyone has access to quality mental health care and substance use disorder treatment. Please contact Becky Yowell (byowell@psych.org), Director, Reimbursement Policy and Quality, if you have questions and let us know how we can be of assistance.

Sincerely,

Saul Levin, MD, MPA

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CEO and Medical Director
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[8] The Patient Protection and Affordable Care Act, Sec. 2713 (a)(1)