

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

September 8, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-1631-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2015 NPRM; (July 15, 2015)

Dear Administrator Slavitt:

On behalf of the American Academy of Child and Adolescent Psychiatry (AACAP), please accept our comments to the Centers for Medicare and Medicaid Services (CMS) pursuant to the public notice for comment [CMS-1631-P] on the proposed rule “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016” (hereafter referred to as the Proposed Rule).

AACAP is a nearly 9,000 member-strong, professional medical organization comprised of child and adolescent psychiatrists. These uniquely trained physicians promote healthy human development by their evaluation, diagnosis, and treatment of children, adolescents and their families who are affected by disorders of feeling, thinking, learning, and behavior.

AACAP appreciates your invitation to provide comments on how coding under the physician fee schedule (PFS) might facilitate appropriate valuation of the services furnished under collaborative care models for beneficiaries with common behavioral health conditions. Given the importance of this subject to our members and the children and adolescents whom we serve, AACAP has chosen to focus our comments on suggested areas and topics to make collaborative care models workable for physicians, particularly child and adolescent psychiatrists, serving patients under a variety of potential collaborative care arrangements.

Collaborative Care Models

AACAP recognizes and supports the use of and need for collaborative care models to ensure that more children and adolescents receive needed psychiatric services. The physician workforce shortages facing America are real. AACAP estimates there are

approximately 8,300 practicing child and adolescent psychiatrists (CAPs) nationwide, whereas studies indicate the capacity need is closer to 30,000 CAPs. Unfortunately, subspecialty fellowship slots are not being completely filled at the same time as the average age of a CAP has risen to 57 years old, resulting in a growing shortage that will only increase in the years to come.

With this aging workforce and limited supply, average initial wait times have grown to nearly 8 weeks—a figure that is inclusive of all forms of payment including cash and private payer insurance. This figure does not take into account individuals who did not pursue the scheduling of an appointment due to the extended initial wait time.

Recognizing the significant workforce shortage, as well as the need for collaboration, AACAP's Committee on Collaboration with Medical Professions (COCMP) convened a work group several years ago to assess and submit recommendations on collaborative care models that could address access to care for this vulnerable population. The Committee concluded that “a working relationship between CAPs and [Primary Care Providers (PCPs)] can significantly enhance mental health services across populations. Through these partnerships, CAPs can significantly influence the psychiatric care of larger numbers of children and their families through the promotion of prevention, early intervention, and treatment of childhood psychiatric illness.”¹

To this point, we join the American Medical Association (AMA) and the American Psychiatric Association (APA) in favorably acknowledging your references to randomized controlled trials that have provided evidence that collaborative health models for patients with behavioral health conditions can be successful. In appropriate contexts, models such as AIMS (described in part at <http://aims.uw.edu>), have allowed primary care offices to collaborate with a psychiatric consultant, both for individual patient concerns and for population health questions and direction. Under this model, much of this collaboration is performed non face-to-face by the psychiatrist and by the primary care physician's ancillary psychiatric personnel. AACAP would note that within the AIMS model there is a recommended care manager who would collaborate with psychiatric consultants. While laudable in arrangements in which it proves economically viable and reflective of workforce availability, not all PCPs, such as individual or small-group pediatricians or family physicians, are able to have appropriate co-located ancillary personnel on site.

When collaborating across providers, there are times when more complex patients present where the psychiatrist may need to be the coordinator of care. AACAP and its members have recognized the need to delineate treatment for children and adolescents with more complex health needs, as presented in the recommendations of our *2012 Best Principles*

¹ DeMaso, D., Martini, R., Sulik, R., Hilt, R., Marx, R., Pierce, K., Sarvet, B., Becker, E., Kendrick, J., Kerlek, A. J., and Biel, M. (2010). A guide to building collaborative mental health care partnerships in pediatric primary care. American Academy of Child and Adolescent Psychiatry. Retrieved from: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf

for *Integration of Child Psychiatry into the Pediatric Health Home*.² In such instances, when a child presents with more acute and complex psychiatric conditions, optimal care may require that the psychiatrist provides a direct assessment and evaluation as opposed to the PCP.

For CAPs, care coordination often entails speaking, working and spending time with other health care professionals, therapists, speech language providers, occupational and/or physical therapists, educators, as well as child protection services, and juvenile justice representatives. The care coordination is primarily done by the child psychiatrist, and his or her work time is often not captured and frequently left largely unreimbursed when it falls outside of a more direct physician to patient encounter. Coding changes are needed to reflect this non face-to-face work. Developing coding that appropriately values the CAP work effort is critical to not making the unreimbursed time an impediment to the required provision of care. As requested in the Proposed Rule, AACAP presents potential coding recommendations in the **Establishing Separate Payment for Collaborative Care** section of this letter for consideration.

Evidence of Behavioral Health Collaborative Care Model

Another excellent working example of care coordination to consider for children and adolescents is the non-traditional model of the Massachusetts Child Psychiatry Access Program (MCPAP). This model and other similarly constructed state programs, demonstrate the impact of the collaborative care model increasing access to services and generating potential health savings.³ In this program, the PCP can call the program and speak with a caseworker who then makes a referral to a child psychiatrist, when appropriate, while the patient is in the PCP's office. This may be a more viable option for many small practices that would not have the financial means or volume to support a care manager in their practices. With onset of lifetime mental illness occurring by age 14 in half the population, the merits of this approach are obvious: diagnosis and treatment of mental health conditions in childhood enables early interventions that could serve to promote the overall wellbeing and generate health care cost savings.^{1,4} Yet, as above, new coding mechanisms are critical to the viability and proliferation of these programs which in other states are attempting to maintain their sustainability through strained state revenue streams.

² Martini, R., Hilt, R., Marx, L., Chenven, M., Naylor, M., and Sarvet, B. (2012). Best principles for integration of child psychiatry into the pediatric health home. American Academy of Child and Adolescent Psychiatry. Retrieved from:

http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

³ Sarvet, B., Gold, J. Bostic, J., Masek, B. J., Prince, J. B., Jeffers-Terry, M., Moore, C. F., Molbert, B., and Straus, J. H. (2010). Improving access to mental health care for children: The Massachusetts Child Psychiatry Access Project. *American Academy of Pediatrics*, 126(6), 1191-1200.

⁴ National Institute for Health Care Management. Children's mental health: An overview and key considerations for health system stakeholders. (2005). Retrieved from

<http://www.nihcm.org/pdf/CMHReport-FINAL.pdf>

Establishing a Separate Payment for Collaborative Care

New payment models should be aimed at 2 general situations, both important for improving mental health care:

Augmenting the mental health care in PCP offices. This is a thrust of the AIMS model and a major part of the care delivered through MCPAP. CMS should consider starting with reimbursing the inter-professional telephone/electronic consultation codes as well as the non face-to-face prolonged service codes. In addition, CMS should consider payment for the non face-to-face time of a care manager in PCP offices, perhaps with sufficient practice expense to allow contracting with CAPs and other psychiatrists.

Augmenting the mental health care in the offices of CAPs and other mental health professionals. CAPs are currently burdened with large amounts of unreimbursed service in coordinating care with therapists, schools, other physicians, parents, and various agencies, to name a few. The complexity of the caseload is likely only to increase with the CAP workforce shortage, and better management of simpler cases in PCP offices. AACAP recognizes that CMS policy has generally been to not reimburse non face-to-face services and appreciates that CMS now appears more open to considering novel reimbursement methods. AACAP requests a signal from CMS as to the structure for coding some of the non face-to-face collaboration services important to the functioning of CAP offices. Note that unlike chronic care management services, the non face-to-face services in CAP offices are mostly by the physician, rather than clinical office staff.

Conclusion

AACAP thanks CMS for requesting comments on methods of enhancing the delivery care system and appropriately capturing the efforts of child and adolescent psychiatrist and other physicians within new models. Given the current workforce shortage in our field, the proposed changes would introduce the opportunity to leverage resources across specialties to best serve patients in providing the highest quality care.

AACAP stands ready and willing to assist in efforts to improve access, treatment, and delivery of mental health care. Please direct any questions you may have to AACAP's Director of Government Affairs & Clinical Practice, Ronald Szabat, JD, LL.M., at 202-587-9666, or by email at rszabat@aacap.org or AACAP's Assistant Director of Quality and Regulatory Affairs, Stephanie M. Demian, MPH, CPH, at (202)587-9670 or by email at sdemian@aacap.org.

Sincerely,



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President, American Academy of Child & Adolescent Psychiatry