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CMS Proposes Payment Model for Integrated Care

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A growing body of evidence suggests coordination and collaboration between primary care and behavioral health providers improves patient care and reduces costs, but the unanswered question has been how to pay for it.

Beginning a year's trial in January 2017, the Center for Medicare and Medicaid Services (CMS) has enabled providers who work in centers that have adopted a Collaborative Care Model (CoCM) developed by psychiatrists to use a new set of codes that reimburses for integrated care.

CMS published a proposal in the July 15, 2016 Federal Register that establishes a set of six new billing codes, some of which potentially apply to psychologists who work in collaborative care settings.

CMS wrote, "… In the calendar year (CY) 2016 PFS final rule with comment period, we stated that we believed the care and management for Medicare beneficiaries with behavioral health conditions may include extensive discussion, information sharing and planning between a primary care physician and a specialist."

Medicare's current reimbursement structure for behavioral health services requires face-to-face patient contact. CMS acknowledged that psychiatric care management services are not appropriately recognized or paid for under the current payment system.

CMS Acting Administrator Andrew Slavitt said in a statement on the CMS website, "If this rule is finalized, it will put our nation's money where its mouth is by continuing to recognize the importance of prevention, wellness, and mental health and chronic disease management."

In the Federal Register CMS described the CoCM that establishes a team consisting of a primary care provider and a care manager who work collaboratively with a psychiatric consultant who reviews the status of patients and makes recommendations. Two psychiatrists at the University of Washington, the late Wayne Katon, M.D., and Jürgen Unützer, M.D., M.P.H., developed the model that has been tested in more than 80 randomized, controlled trials.

Unlike other integrated care programs such as the Veterans Health Administration (VHA) model of integrated primary care, the CoCM requires oversight by a psychiatrist rather than a licensed independent mental health provider.

CMS has proposed separate payment using six new G codes, paralleling codes that the American Medical Association's Current Procedural Terminology (CPT) committee has been developing.

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The proposed code that appears to have generated the most controversy is GPPP6, used for cognition and functional assessment with standardized instruments for the patient with cognitive impairment.

According to the American Psychological Association Practice Organization (APAPO), the language of the code does not differentiate between screening and comprehensive testing to allow for accurate diagnosis and staging of dementia. Therefore the APAPO does not support the use of this code.

According to Alexander Blount, Ed.D., co-director, Center for Behavioral Health Innovation, Antioch University, New England, "By starting with the Collaborative Care Model, CMS is beginning where it must, where the best evidence for clinical improvement has been demonstrated.

"APA's portraying the CoCM as psychiatrist dominated, or as choosing medication therapies over psychotherapy, shows a poor grasp of how the CoCM plays out in practice and of the evolution that the model must undergo due to the future of the potential workforce."

Blount said this is an opportunity to give primary care practices a mechanism to get started with behavioral health integration that also emphasizes the value of teamwork.

Code GPPP7 is assessment of and care planning for patients requiring chronic care management services. Code GPPPX is for care management services for behavioral health conditions, at least 20 minutes of clinical staff time per month.

Because of the length of time involved for the usual process in which the CPT committee develops the codes followed by surveys of health care professionals to determine the codes' work values and then scrutiny of the survey results by the Relative Update Committee (RUC,) CMS decided to bypass the standard process in order to implement the new codes in 2017.

CMS wrote, "We intend for these to be temporary codes (for perhaps only one year) and will consider whether to adopt and establish values for the new CPT codes under our standard process, presumably for CY 2018."

"Patients who are appropriate candidates to participate in the psychiatric CoCM may have newly diagnosed conditions, need help in engaging in treatment, have not responded to standard care delivered in a non-psychiatric setting, or require further assessment and engagement prior to consideration of referral to a psychiatric care setting," according to CMS.

In the CoCM patients require a behavioral health care assessment, a care plan and brief intervention for an episode of care during which treatment goals are targeted and monitored. The behavioral health care manager furnishes services incident to the physician or other qualified health care professional, and the psychiatric consultant qualified to prescribe medications provides consultation to the treating provider.

Referral to specialty care can also be made when needed.

According to CMS, the manager is a member of the clinical staff with specialized training that may include a range of disciplines such as psychology, social work and nursing but who may not meet the requirements to be an independent provider under Medicare. The manager provides both face-to-face and non-face-to-face treatment, communicating with the psychiatric consultant each week.

Roles that clinical psychologists, psychiatric nurse practitioners or social workers may play in this system are not well delineated in the proposal, and the language opens the door for other behavioral health professionals such as Doctors of Behavioral Health or licensed professional counselors.

How the new payment and delivery system will impact behavioral health care in the long run remains to be seen.

CMS accepted comments until Sept. 6 with the final rule slated to be released in November.

According to the July 28 Psychiatric News online, the American Psychiatric Association received a grant from CMS through its Transforming Clinical Practice Initiative to train psychiatrists and primary