October 31, 2022

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street, #810
Boston, MA 02118

Sent by email to kevin.beagan@mass.gov and rebecca.butler@mass.gov

Re: Comments Regarding Chapter 177 of the Acts of 2022 – Collaborative Care

Dear Deputy Commissioner Beagan and General Counsel Butler:

On behalf of the Massachusetts Association for Mental Health and Health Care for All, thank you for holding listening sessions and for the opportunity to comment on various provisions of Chapter 177 of the Acts of 2022, *An Act addressing barriers to care for mental health*. Please find below responses to the questions the Division of Insurance ("Division") has asked stakeholders to respond to in developing further guidance on the requirement for health insurance carriers to cover the Psychiatric Collaborative Care model ("collaborative care").

We look forward to working with the Division to ensure effective and impactful implementation of these benefits. Please do not hesitate to contact us with any questions or to discuss our comments further. Thank you.

Sincerely,

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1. *Is the definition of "psychiatric collaborative care model" understood or does it require additional clarification?*

    a) *Is it clear what should be considered to be an "evidence-based, integrated behavioral health service delivery method"?*

The definition of the collaborative care model is well understood. The model is described in detail in resources available on the AIMS Center website at the University of Washington.[1] It has also been described in a brief prepared by the Center for Health Care Strategies, a policy design and implementation partner working to improve outcomes for people enrolled in Medicaid.[2] It is worth noting that collaborative care is a specific type of integrated behavioral healthcare and there are other models. Chapter 177 is clear that the coverage requirement pertains to the collaborative care model.

a. Are there known standards for what is to be considered an evidence-based, integrated behavioral health services delivery method?

It is also clear what is an "evidence-based, integrated behavioral health service delivery method." The integrated behavioral health service delivery method is well-established. As the Centers for Medicare and Medicaid Services (CMS) states: "The medical community now widely considers integrating behavioral health care with primary care (behavioral health integration or BHI) an effective strategy for improving outcomes for millions of Americans with mental or behavioral health conditions."[3] Among models of integrated behavioral health and primary care, collaborative care is the model with the deepest record of evidence. The AIMS Center has prepared information on collaborative care's evidence base.[4]

b. Is this method to be recognized because it has been recognized as having met certain standards by another agency or other body?

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[1] See, e.g., AIMS Center, Checklist of Collaborative Care Principles and Components, https://aims.uw.edu/resource-library/checklist-collaborative-care-principles-and-components; Applying the Integrated Care Approach: Skills for the PCP, https://aims.uw.edu/resource-library/applying-integrated-care-approach-skills-pcp.

[2] CHCS, The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes (May 2013), https://www.chcs.org/resource/the-collaborative-care-model-an-approach-for-integrating-physical-and-mental-health-care-in-medicaid-health-homes/.

[3] See Center for Medicare and Medicaid Services & the Medicare Learning Network (CMS), Behavioral Health Integration Services (Feb. 2022), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf.

[4] Evidence Base for Collaborative Care, https://aims.uw.edu/resource-library/evidence-base-collaborative-care.

The collaborative care model should be recognized as it has already been recognized as meeting standards by Medicare, which is reimbursing for this model using the three CPT codes approved for reimbursement, including in Massachusetts.[5] MassHealth began reimbursing primary care providers for collaborative care in 2021, using the three CPT codes referenced in Chapter 177 and used by Medicare.[6]

Additional detailed information regarding coding for Integrated Behavioral Health Care is available on the AIMS Center website.[7]

b) Is it clear what should be considered to be a "structured care management"?

a. *Are there known standards for what is to be considered to be "structured care management"?*
b. *Is structured care management to be recognized because it has been recognized as having met certain standards by another agency or other body?*

It is clear what is to be considered as "structured care management." Information on the Behavioral Health Care Manager is available at https://aims.uw.edu/collaborative-care/team-structure/care-manager.

We agree that allowing some flexibility in the role of the care manager is important to effectively address individual patient needs. We liked an example provided during the listening session; a care manager could connect the patient with peer support to help them stay on track in their treatment. This type of activity could be integral to providing the range of formal and informal supports that the individual needs.

2. *According to the statute, the "psychiatric collaborative care model" is to work "in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations." Are there any expectations about who would be the "psychiatric consultants" that would work with the "psychiatric collaborative care model" primary*

[5] MassHealth, Physician Bulletin 103: Integrated Behavioral Health Service Code, Description, and Billing Requirements (July 2021), https://www.mass.gov/doc/physician-bulletin-103-integrated-behavioral-health-service-code-description-and-billing-requirements-0/download ("MassHealth has already begun implementing this first phase within the MassHealth Physician Program by covering Medicare psychiatric collaborative case management (CCM) CPT codes 99492, 99493, and 99494.")

[6] MassHealth references coverage for the psychiatric collaborative care model in this bulletin regarding coverage for integrated behavioral health models more broadly: https://www.mass.gov/doc/physician-bulletin-103-integrated-behavioral-health-service-code-description-and-billing-requirements-0/download.

[7] AIMS Center, Basic Coding for Integrated Behavioral Health Care (Apr. 2021), https://aims.uw.edu/sites/default/files/Basic%20Coding%20for%20Integrated%20BH%202021_0.pdf.

care and care manager? Should the psychiatric consultant meet any licensing or training requirements?

We agree that the psychiatric consultant should be a psychiatrist who meets the same licensing and training requirements for any other psychiatrist working in Massachusetts. We do not believe there should be any additional requirements.

3. *Are health plans and providers to enter into new contracts to reflect the expectations of the "psychiatric collaborative care model"? Are there specific services expected to be provided by providers operating within the "psychiatric collaborative care model"?*

We agree that there should not be new contracts required for plans and providers to offer the collaborative care model.

4. *It is noted in section 84 of Chapter 177 that "reimbursement for the psychiatric collaborative care model shall include, but not be limited to, the following current procedural terminology billing codes established by the American Medical Association: (i) 99492; (ii) 99493; and (iii) 99494." Are these codes clearly understood by carriers and providers? Since the law indicates that reimbursement "shall include, but not be limited to" these codes, are there other codes that should be considered to reimburse for service?*

As discussed above, we believe that there is good information currently available regarding codes for collaborative care services. We also agree that the "not limited to" language in section 84 is important, as it suggests that the primary care provider may ultimately need to bill other existing codes (or other new codes that might be created in the future).

5. *For plans providing benefits through a network of providers, are all primary care and care manager providers of the "psychiatric collaborative care model," as well as the psychiatric consultants to be contracted as in-network providers for the "psychiatric collaborative care model" to be available as in-network providers under an insured's health plan?*

We appreciated the response in the listening session to this question from the American Psychiatric Association (APA) representative that the primary care practice should be a network provider, but that the psychiatrist need not be. This makes sense, particularly given the shortage of psychiatrists in the state. The primary care practice is the entity that is eligible for reimbursement under collaborative care codes, and therefore any psychiatrist they employ as part of the team delivering collaborative care, whether a practice employee or consultant, should be covered by the rate. This seems to be widely understood by the carrier representatives who participated in the listening session and would be worth reiterating in any guidance. More generally, we would suggest that the Division's guidance

support the principle that carriers shouldn't put up any additional/unnecessary burdens for providers to deliver collaborative care.

6. *The law applies as policies are issued or renewed within or without the commonwealth. Is this clear or would it be helpful to do a Q&A with examples of what this means? The law also applies to insured health plans. Would it be helpful to do a Q&A with examples of what this means? How will covered persons and providers know whether or not the law applies to them?*

Yes, it would be helpful for DOI to develop a Q&A in simple language so that people will understand what the service is, what coverage exists, what kinds of cost-sharing might be involved, and where to go or call for more information regarding this service and coverage of it. We reiterate our previous comments in this regard and are willing to work with the Division to create materials to help consumers understand this and other benefits that will be available as a result of Chapter 177.

7. *The law does not include any provisions related to cost sharing. Would it be helpful to include information within a Q&A to explain that plan deductibles, coinsurance or copayments may apply to such services?*

Yes, as discussed above, a Q&A regarding cost sharing would be important, particularly because this information is not addressed in statute.

8. *Does there need to be clarity about utilization review for care provided through the "psychiatric collaborative care model" of care? Does there need to be clarity about how to bill carriers for any care provided through the "psychiatric collaborative care model" of care?*

There should be information provided about utilization review for care provided under the collaborative care model. Although other sections of Chapter 177 reference utilization review, section 84 does not. We expect that such information would make clear that there are no time limits or other onerous or inappropriate barriers to receiving this service.

9. *What types of provider and member education may be helpful to educate providers and members about the availability of these services?*

Education should include information in appropriate health plan documents, such as the schedule of benefits, Q&As, and other documents. Plans should provide specific telephone numbers and web addresses where consumers can obtain more information. Information should also be made available to providers about how to provide and arrange coverage for this service. Information should be included on insurance cards. As with consumer-facing materials overall, options should be available for people with Limited English Proficiency to receive the appropriate information.

We also agree with others that clear information about this model is essential so that primary care providers will be encouraged to adopt the model in their practices.

10. Are there any barriers or privacy concerns that should be considered?

We appreciate the conversation in the listening session about ensuring that there is no barrier to the model due to its reliance on telehealth. We agree that use of telehealth between the PC provider and the psychiatric consultant is covered in the codes for this model and should not pose a barrier.

We agree that information would be shared among the team in this model and within the PC's practice. We appreciate that privacy concerns should be an element of any training offered to providers and administrators regarding this model.