DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

SHO # 23-001

RE: Coverage and Payment of Interprofessional Consultation in Medicaid and the Children's Health Insurance Program (CHIP)

January 5, 2023

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this letter to clarify Medicaid and CHIP policy for coverage and payment of interprofessional consultations. For purposes of this letter, interprofessional consultation is defined as a situation in which the patient's treating physician or other qualified health care practitioner (hereafter referred to as the treating practitioner) requests the opinion and/or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise (hereafter referred to as the consulting practitioner) to assist the treating practitioner with the patient's care without patient face-to-face contact with the consulting practitioner. This letter clarifies that Medicaid and CHIP coverage and payment of interprofessional consultation is permissible, even when the beneficiary is not present, as long as the consultation is for the direct benefit of the beneficiary.

This guidance supersedes CMS's previous policy that prohibited coverage and payment of interprofessional consultation as a distinct service, because the presence of the patient was required under that earlier policy guidance for specialty consultation services to be directly covered. Under the previous policy, the treating practitioner was paid an increased payment rate for a covered Medicaid service, which could have included costs for the consultation activities. The treating practitioner would then have to pay the consulting practitioner out of that payment rate through a separate arrangement between the two providers.[i] This approach was administratively complex and created barriers to specialty input on beneficiary care.

Background

Timely access to specialty providers can improve the quality of care and treatment outcomes for both physical and behavioral health. While access to specialty care has been a challenge across a range of specialties, access to specialty care for mental health and substance use disorders has been a particular challenge. In 2019 (even before the COVID-19 public health emergency), more than 55 percent of adults aged 18 or older with mental illness in the past year, and nearly 35 percent of those with serious mental illness, did not receive care.[ii] The rates are even lower for minorities. In 2019, 67 percent of Blacks and 66 percent of Hispanics aged 18 or older with any mental illness in the past year did not receive treatment.[iii] An increased need for treatment due in part to the COVID-19 pandemic, combined with a widespread shortage of behavioral

health care providers, has resulted in even greater obstacles to providing needed care. Children and adolescents have been among those at greatest risk of the behavioral and emotional health impacts of the pandemic. In 2020, the proportion of mental health-related emergency department (ED) visits among adolescents aged 12–17 years increased 31 percent compared to 2019.[iv] One year into the pandemic (February 21 through March 20, 2021), mean weekly ED visits for suspected suicide attempts were 51 percent higher than the same period in 2019 among girls of those ages and 4 percent higher among boys of those ages.[v]

Geographic distance and other barriers can also reduce access to specialty care, behavioral health care in particular, and the resulting wait times for specialists can delay diagnosis and treatment. A scarcity of behavioral health providers in most parts of the U.S. severely limits access to mental health and substance use disorder treatment, with well over one-third of Americans (more than 152 million people as of June 2022) living in mental health professional shortage areas. The number of mental health providers in these areas is only enough to meet the needs of less than 28 percent of the people who live there.[vi]

Rural areas face the most significant provider shortage challenges; more than 60 percent of nonmetropolitan counties do not have a psychiatrist and almost half of nonmetropolitan counties do not have a psychologist.[vii] As a result, primary care physicians provide half of all care for mental health disorders and prescribe more medications for depression and anxiety than psychiatrists. However, many of these providers lack the specific training in mental health conditions.[viii] Tragically, 45 percent of individuals who died by suicide have seen their primary care provider in the 30 days prior to the suicide.[ix]

In general, Medicaid enrollees have higher rates of chronic diseases than those not enrolled in Medicaid, and people with serious mental health and substance use disorders in particular have high rates of co-morbid conditions. For those enrollees with behavioral health conditions, co-occurring issues such as hypertension, heart disease, diabetes, and HIV add complexity to treating their behavioral and physical health conditions.[x] Moreover, health care costs for individuals with a behavioral health diagnosis are generally two to three times higher than for those without a behavioral health diagnosis. The bulk of these additional health care costs is attributable to services related to physical health.[xi]

Numerous studies have shown that increased integration and care coordination through collaborative care approaches, including interprofessional consultation, improve outcomes for co-morbid conditions and reduce costs among this very high cost population.[xii,xiii] Interprofessional consultation is one of the components of the Collaborative Care Model (CoCM), a team-based approach in which a treating practitioner addresses patients' mental health and substance use disorder issues while supported by a behavioral health care manager and a psychiatric consultant. More than 90 randomized controlled trials and several meta-analyses have demonstrated CoCM to be more effective than usual care for patients with depression, anxiety, and other behavioral health conditions and highly effective in treating co-morbid mental health and physical conditions such as cancer, diabetes, and HIV.[xiv] One study found a 12:1 benefit-to-cost ratio when providers used CoCM to treat depression in adults,[xv] and a number of states have significantly lowered costs and improved health outcomes in their Medicaid programs by otherwise integrating behavioral health and primary care.[xvi]

Other models that include interprofessional collaboration have also shown positive results. For example, the Missouri Community Mental Health Center (CMHC) Health Home initiative,

resulted in substantial cost savings, with a 16 percent reduction in overall costs, and significant improvements in a number of areas. This includes a 33 percent increase in independent living, a 44 percent increase in vocational activity, a 68 percent reduction in legal involvement, a 52 percent reduction in psychiatric hospitalization, and a 52 percent reduction in illegal substance use.[xvii]

Interprofessional consultations are especially important for improving access to providers who specialize in child and adolescent behavioral health. In 2016, the prevalence of children with a mental health disorder who received treatment or counseling from a mental health professional varied from approximately 30 percent to 72 percent across states.[xviii] To address these gaps, the National Network of Child Psychiatry Access Programs (NNCPAP) supports existing and emerging child psychiatry consultation programs.[xix] Evidence suggests that these programs are working. Children residing in states with statewide psychiatric telephone consultation programs were significantly more likely to receive mental health services than children residing in states without such programs.[xx] Federal investments have furthered the NNCPAP initiative. The Bipartisan Safer Communities Act (P.L. 117-159) recently reauthorized the Pediatric Mental Health Care Access (PMHCA) grant program, which is administered by the Health Resources and Services Administration, and expanded it into schools and emergency rooms.[xxi] Under the PMHCA grant program, state and regional networks of pediatric mental health care teams will provide teleconsultations, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat, and refer children and youth for mental health conditions and substance use disorders. Allowing for interprofessional consultations in Medicaid and CHIP health insurance are a core component of these state and federal initiatives to increase access to children's behavioral health services.

Additionally, telehealth can be an effective means to foster greater integration of primary care and behavioral health and other collaborative models that incorporate interprofessional consultation. Studies have found that telehealth facilitates collaboration and consultation among behavioral health care specialists and primary care and emergency department clinicians and can expand capacity for the treatment of mental health and substance use disorders.[xxii,xxiii] Telehealth may also increase retention in substance use disorder treatment, including medication-assisted treatment (MAT), especially when treatment is not otherwise available or requires lengthy travel.[xxiv] States have considerable flexibility in offering telehealth in their Medicaid programs, and in many cases, a state plan amendment is not needed to provide existing state plan services via telehealth.[xxv,xxvi]

While interprofessional consultation is key to expanding access to behavioral health services, it can also be an effective component of expanding access to specialty care for physical health conditions, particularly in rural and remote areas that may be lacking specialists. Project ECHO is one such model. Founded at the University of New Mexico in 2003 to address disparities in hepatitis C virus (HCV) treatment across the state's rural and remote communities, the model has since been adopted by universities and medical centers to address a range of health conditions, including diabetes, rheumatology, and perinatal care.[xxvii] The model is largely focused on training opportunities for practitioners and other stakeholders, but it also seeks to improve access to specialty care through interprofessional consultation.[xxviii] One study of the Project ECHO model found comparable outcomes (as measured by sustained virologic response) between patients with HCV infection who received direct specialty care and those whose primary care physician consulted with a specialist.[xxix] The U.S. Department of Veterans Affairs'(VA) highly successful implementation of the Project ECHO model, known as VA-ECHO (previously

referred to as SCAN-ECHO) has increased access to specialty care for COVID-19, HCV, liver disease, diabetes, geriatrics, sleep medicine, and multiple other conditions, with clinical benefits such as significantly improved survival in patients with liver disease and markedly decreased time to treatment in HCV patients.[xxx]

Allowing direct payments to consulting practitioners improves access to specialty care that may not otherwise be available, supports patient-centered care and holds the potential to maximize the capacity of the existing workforce. It also aligns with the Medicare policy, which has been in effect since 2019, that allows for coverage and payment for interprofessional consultations.[xxxi]

Coverage for Interprofessional Consultation in Medicaid and CHIP

To be coverable under Medicaid and CHIP, interprofessional consultation must be for the direct benefit of the beneficiary. This means the services must be directly relevant to the individual patient's diagnosis and treatment, and the consulting practitioner must have specialized expertise in the particular health concerns of the patient. Interprofessional consultation is intended to expand access to specialty care and foster interdisciplinary input on patient care. It is not intended to be a replacement for direct specialty care when such care is clinically indicated. The broad flexibility for states to utilize telehealth technology—both synchronous (audio-only, audio-visual) and asynchronous (store and forward)—to deliver covered services extends to interprofessional consultations.

Interprofessional consultation services may be covered under a variety of Medicaid state planbenefits, such as physician services, services of other licensed practitioners, and rehabilitative services. States may also wish to consider the Medicaid health home state plan option.[xxxii] Regardless of the benefit, to be covered under Medicaid or CHIP, both the treating practitioner and the consulting practitioner must be enrolled in Medicaid or CHIP. For consultations that cross state lines, consulting practitioners must be an enrolled Medicaid or CHIP provider in the state in which the beneficiary resides, though they need only be licensed/credentialed in the state in which they are practicing. Both the treating and consulting practitioner will be required to follow all state and federal privacy laws regarding the exchange of patient information.

To avoid unexpected cost sharing for interprofessional consultations, CMS encourages states to review their cost sharing requirements to maximize access to specialty care. Any Medicaid cost sharing assessed must be nominal and comply with requirements at Sections 1916 and 1916A of the Social Security Act and regulations at 42 CFR 447.50-57.

States may need to submit a state plan amendment (SPA) to enact coverage for interprofessional consultation, depending on the specific benefit in which interprofessional consultation is covered. Regardless of whether a coverage SPA is needed, states will need to submit a SPA to enact payment as discussed below.

CMS encourages states to apply this policy in CHIP in the same way it would apply to Medicaid under this guidance.

Payment for Interprofessional Consultation

States have considerable flexibility under Medicaid authorities to develop methodologies to pay for interprofessional consultation services in the Medicaid program. Section 1902(a)(30)(A) of the Act requires states to "assure that payments are consistent with efficiency, economy, and

quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Based on the guidance outlined in this letter, CMS is defining interprofessional consultation as a distinct, coverable service in the Medicaid program and in CHIP, for which payment can be made directly to the consulting provider. As noted above, interprofessional consultations may be paid for under existing mandatory and optional state plan benefits, such as physician services, services of other licensed practitioners, rehabilitative services, and health homes.

If states choose to pay for these services, they must submit a SPA to add a payment methodology for the qualifying interprofessional consultation service. States have flexibility in designing payment methodologies, and may, for example, use fee schedule rates as a payment methodology for the service. As with any SPA submission, CMS expects states to comply with all federal Medicaid and CHIP SPA requirements that are not waived or modified.[xxxiii] CMS encourages states to review and consider the billing codes and payment rates Medicare has established for interprofessional consultations when determining state payment rates for the same services.

States should be aware that as of January 2019, Medicare began paying separately for interprofessional consultation and established values for six CPT codes for these services.[xxxiv] States may also use the behavioral health integration (BHI) codes, which allow for consultation between practitioners but as part of the more comprehensive set of services comprising the Collaborative Care Model.[xxxv] As it specifically relates to the interprofessional consultation described in this letter, states are also encouraged to eliminate (or modify) prohibitions on same-day billing that may impede such consultations and the integration of behavioral and primary care.[xxxvi,xxxvii] Same-day access and "warm hand-offs" by primary care to behavioral healthcare providers can be critical for ensuring individuals follow through with their first mental health service appointments. Furthermore, prohibitions on same-day access to behavioral healthcare can be particularly burdensome for low-income individuals who often have transportation and scheduling limitations.

Documentation of Interprofessional Consultations

As an interprofessional consultation service is provided without the Medicaid or CHIP beneficiary present, states will need to develop claiming mechanisms that document that the interprofessional consultation was provided for the direct benefit of the Medicaid or CHIP beneficiary. Consistent with section 1902(a)(27) of the Act and 42 C.F.R. § 431.107 (b)(1), states must have agreements with providers for documentation to support any claims for federal financial participation (FFP) of the payments to qualified providers for qualifying interprofessional consultation services delivered to eligible Medicaid or CHIP beneficiaries. CMS does not dictate the method of documentation; however, section 2500.2 of the State Medicaid Manual indicates that, at a minimum, documentation for Medicaid claims for services must include: date of service; name of recipient; Medicaid identification number; name of provider agency or person providing the service; nature, extent, or units of service; and the place of service. If any additional documentation is necessary to establish that the consultation was provided as an adjunct to services provided to a Medicaid or CHIP beneficiary, states should explore additional state-specific documentation requirements.[xxxviii] Using documentation maintained under these requirements, states should establish an oversight and monitoring strategy to ensure these services are appropriately provided and protect against fraud, waste, abuse, and other improper payments.

Conclusion

Input from specialists with a particular expertise in the beneficiary's health conditions can be a critical component of care. Allowing direct payment to consulting practitioners expands and expedites access to specialty care and reduces the administrative burden to treating practitioners. CMS encourages states to take advantage of this flexibility in their Medicaid and CHIP programs. Please submit questions about this guidance to Kirsten Jensen, Director of the Division of Benefits and Coverage, at kirsten.jensen@cms.hhs.gov.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

[i] CMS State Medicaid Director Letter # 18—011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance", November 13, 2018. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

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[iii] Ibid.

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[vi] Bureau of Health Workforce, Health Resources and Services Administration, "Designated Health Professional Shortage Areas*"* (as of June 30, 2022). Available at: https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

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[xi] Milliman Research Report: "Potential economic impact of integrated medical-behavioral healthcare" (Jan. 2018). Available at: https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx.

[xii] Ibid.

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[xxvii] New Mexico Health Sciences Center received a Healthcare Innovation Award from the Center for Medicare and Medicaid Innovation to support an ECHO model focused on the management of complex care for patients with significant multi-morbidity, including mental health and substance abuse. For more see: https://innovation.cms.gov/innovation-models/participant/health-care-innovation-awards/university-of-new-mexico-health-sciences-center.
[xxviii] While the Medicaid state plan can support the interprofessional consultation component of Project ECHO, practitioner and stakeholder training is not coverable under state plan benefits.
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[xxxi] Centers for Medicare and Medicaid Services, Medicare Program: "Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019. 83 FR 59452, 59489. Available at: https://www.federalregister.gov/d/2018-24170/p-470.
[xxxii] The health home option at section 1945 of the Social Security Act (the Act) allows states to design health homes to provide comprehensive care coordination and integration for qualified Medicaid beneficiaries with chronic

conditions, including mental health conditions and substance use disorders. Additionally, section 1945A of the Act provides states with the option to design health homes for comprehensive care coordination for qualified children with medically complex conditions. Both of these health home options provide states a time-limited enhanced match that could help support the integration of specialty care consultation into a primary care practice. In general, states receive enhanced federal funding during the first eight quarters that a section 1945 health home option is in effect or during the first two quarters that a section 1945A health home option is in effect. States with a substance use disorder-focused health home state plan amendment under section 1945, approved after October 1, 2018, may request two additional quarters of enhanced funding, for a total of 10 fiscal year quarters.

[xxxiii] See for example, 42 C.F.R. § 440.200, et seq., Sections 1902(a)(73)(A), 1902(a)(30), 1902(a)(2) of the Act, and 42 C.F.R. § 447 Subpart B.

[xxxiv] Centers for Medicare and Medicaid Services, Medicare Program: "Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019". 83 FR 59452, 59489. Available at: https://www.federalregister.gov/d/2018-24170/p-470 .

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[xxxvi] See Roby, DH and Jones EE "Limits on Same-Day Billing in Medicaid Hinders Integration of Behavioral Health into the Medical Home Model" *Psychological Services,* Vol. 13, No. 1 (2016). Available at: https://doi.org/10.1037/ser0000044.

[xxxvii] See 21st Century Cures Act (Pub. L. 114-255) Sec. 12001.

[xxxviii] See State Medicaid Manual available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.