

2007 Santa Fe Summit on Behavioral Health



Access to Mental Health Services In Primary Care Settings: Reimbursement and Collaboration

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March 15, 2007

What I Will be Talking About Today



- ⌘ HRSA – who we are, who we serve.
- ⌘ SAMHSA/CMS/HRSA Workgroup identifying ways to reduce financing barriers to the provision of mental health services in primary care settings.
- ⌘ How a number of States, MCOs and Provider Organizations have effectively provided and been reimbursed for mental health services in primary care settings.
- ⌘ Highlighting the collaboration that is possible among Medicaid, State Mental Health Administrators, safety net providers and community mental health centers.
- ⌘ What has worked in your State that HHS needs to keep in mind as we move forward.

The Need for Mental Health Services in Primary Care Settings

- ⌘ FQHCs - 914 grantees provided 1.4 million visits for depression and other mood disorders. The third most common reason for a visit behind diabetes and hypertension. (*2004 UDS Data*)
 - ⊞ MH treatment/counseling (74%-707 FQHCs in CY2005)
 - ⊞ Substance Abuse treatment/counseling (50%-479 FQHCs for CY2005)
 - ⊞ 24-hours crisis intervention/counseling (provided by 20% of FQHCs for CY2005)
 - ⊞ See also: Druss, et. al., October 2006
- ⌘ HIV/AIDs and Mental Health - a mental health condition may be a co-morbidity in as many as 50% of patients. (*IOM, 2005*)
- ⌘ MCH and Mental Health - 1 in 10 young people suffer from mental illness severe enough to cause some level of impairment, with fewer than 20 percent receiving treatment in any given year. (*National Action Agenda for Children's Mental Health, U.S. Surgeon General, 2000*)
- ⌘ Rural Health and Mental Health - Fewer mental health providers and inpatient facilities, lower utilization of traditional mental health services due to social factors - much of the burden of mental health care provision is on primary care physicians. (*Geller and Muus, 2000*)
- ⌘ Concerns in common with Community Mental Health Center Programs – see: Colton and Manderscheid, Preventing Chronic Disease, April 2006.

Who Is HRSA



Examples of HRSA programs/activities include:

- ⌘ Providing support to over 3,800 health center sites serving approximately 14.1 million people;
- ⌘ Funding care and treatment services in 50 states and territories for an estimated 533,000 people living with HIV/AIDS;
- ⌘ Implementing comprehensive systems and services in 50 states through the Title V program to meet the many needs of children and youth with special health care needs and their families;
- ⌘ Overseeing the national system that allocates organs, tissue, and blood stem cells for transplant;
- ⌘ Working with academic health centers and other training programs to enhance the diversity and distribution of the Nation's health care workforce;
- ⌘ A partner with safety net providers: NHSC, AHECs, FQHCs, MCH, HIV/AIDS, Rural.

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CMS/HRSA/SAMHSA Workgroup



- ⌘ The New Freedom Commission on Mental Health Report recognized that financing barriers should be removed so that mental health services can be effectively delivered and reimbursed (where appropriate), in primary care settings.
- ⌘ In response to the Commissions findings and as part of a Federal Action Agenda, a workgroup consisting of representatives from CMS, HRSA and SAMHSA is addressing a number of financing issues.
- ⌘ We started by determining what was already known about financing barriers and by obtaining the input of those in the practice community, state public health, and those involved in workforce issues.

What Are The *Barriers* We Identified?

⌘ As part of this initiative, CMS/HRSA/SAMHSA did an *environmental scan* on financing barriers; we then brought together a well planned Expert Forum. Participants included:

- ⊗ A State Medicaid Director;

- ⊗ A State Mental Health Program Administrator;

- ⊗ 11 leaders in mental health service delivery including - HIV/AIDS clinics, federally qualified health centers, rural health clinics, and community mental health centers;

- ⊗ Government participants included senior staff in each of the three sponsoring agencies, CMS, HRSA, and SAMHSA.

What Were the Results From the Forum?



- ⌘ The participants identified a number of priority barriers that the three federal Agencies will be considering, including:
 - ☑ Limitations on payments for more than one visit on the same day;
 - ☑ Lack of reimbursement for components of the collaborative care model related to mental health services;
 - ☑ Absence of reimbursement for services provided by some non-physician providers and contract providers;
 - ☑ Disallowance of reimbursement when primary care providers submit bills listing a mental health diagnosis and corresponding treatment (including, but not limited to, managed care networks).

Key Points Made By Forum Participants



- ⌘ Disseminate materials on commonly used mental health billing codes (ICD-9, CPT E&M, CPT-HBAI)...while recognizing that States can and do establish their allowable billing codes.
- ⌘ Develop a project to describe specific services and reimbursement codes for collaborative care of various mental health conditions - States can turn to that source for what is known and validated by current literature and practice.
- ⌘ Work with States that want to develop contract terms that encourage MBHOs to appropriately include primary care providers in networks.
- ⌘ Improve service integration, links/referrals to specialty care settings (on-site consultation and referrals for rapid care).

What We are Doing To Address The Barriers



- ⌘ Identify what services are known to be effective in successful collaborative care models for provision of evidence-based mental health care in primary care settings (including service definitions, and reimbursement codes).
- ⌘ Documenting and articulating the components of a “care model” that effectively addresses the needs of patients.
- ⌘ Create a forum for dialogue between State Medicaid Directors, State Mental Health Directors and Safety Net Primary Care Providers to discuss changes that the Workgroup has identified as increasing access to mental health services in primary care settings.
- ⌘ Recognize States that are encouraging managed behavioral healthcare organizations (MBHOs) to appropriately include primary care providers in their networks.

Primary Care Initiatives and the Collaborative Care Model

Components of Care Models

⌘ Approaches have typically followed the clinical principles consistent with treatment of chronic disease using the Chronic Care Model:

- ⊗ Community
- ⊗ Health System
- ⊗ Self management support
- ⊗ Delivery system design
- ⊗ Decision support
- ⊗ Clinical information systems

⊗ *HRSA Bureau of Primary Health Care's Depression Collaboratives*

⌘ Examples of other *Models* include:

- ⊗ *RWJ's Depression in Primary Care Program*
- ⊗ The *Impact Model* (see Katon, et. al., *Diabetes Care*, February 2006)

⌘ As of Sept. 2006, 108 Health Centers across the Nation have participated in the Depression Collaborative.

States and Private Sector Initiatives



- ⌘ Aetna - First national insurer to integrate medical and mental health care at PC level. Enhanced PCP payment for screening patients to diagnose depression; effective referral service to specialty providers (reaching out to over 10,000 PCPs).
- ⌘ Tennessee - Cherokee Health System uses behavioral consultants embedded in primary care teams, psychiatric consults available from within the organization. Fully integrated payment for mental health and primary care under Medicaid.
- ⌘ Florida - Local Health Center coalition owns and operates a Medicaid MCO, has a contract with Magellan to provide mental health care services to approximately 140,000 patients in a pre-paid Medicaid mental health plan.
- ⌘ Oregon - Mental Health Staff on site in FQHCs/employed by FQHC (or) CMHC staff on-site in FQHC, billed to specialty mental health carve-out (Medicaid).

Moving Toward Collaboration: States, Safety Net Providers and Community Mental Health Providers



⌘ Our recent work highlights some of the working relationships occurring under Medicaid in States across the Country:

⊗ Delaware

⊗ Michigan

⊗ New Jersey

Summary



- ⌘ We are well aware of the financing barriers regarding provision of mental health services in primary care settings...we have heard similar concerns from numerous providers, Medicaid Directors and their staff, and other leaders in this field.
- ⌘ Through concerted effort across Federal Agencies, we can work together with States and provider groups, address a number of the barriers and reimbursement issues.
- ⌘ We need to learn from the experiences of States, managed care organizations and providers involved in initiatives that have successfully overcome the barriers I've discussed. We want to identify what works and share that with other interested parties.

For the Café - Your Feedback And Ideas



What works in your State and why?

What assistance would you like when considering the provision of mental health services in primary care settings or linkage/integration efforts?

Thank you!

Questions?



3/15/07

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