Behavioral Health/Primary Care Integration

Finance, Policy and Integration of Services
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This discussion paper has been prepared under the auspices of the National Council for Community Behavioral Healthcare. It is a work in progress, reflecting the participation of NCCBH staff, NCCBH consultants and external reviewers. Comments are welcomed and should be directed to the NCCBH offices at Suite 320, 12300 Twinbrook Parkway, Rockville, MD 20852 or www.nccbh.org.

Introduction

The purpose of this discussion paper on the current status of financing and policy support for behavioral health (BH) and primary care (PC) integration is to bring together multiple strands of information to support future policy change at the federal and state levels. The paper reflects recent literature and conference presentations, as well as information gathered from the experience of those implementing integration, via the use of a state assessment tool, consulting and training interactions.

In Spring of 2004, the National Council for Community Behavioral Healthcare (NCCBH) released a *State Level Policy and Financing Environmental Assessment Tool,* intended to assist agencies and provider associations in a review of state level policy and financing environments and the extent to which these environments support effective collaboration and integration of services between behavioral health (mental health [MH] and substance abuse [SA]) providers and primary care providers, especially in regard to Medicaid and "safety net" populations.

The tool assumes that "carve in" versus "carve out" methods are neutral in impact on clinical integration—what is important is how the entity that holds the BH benefits pays for and manages services—as always, the "devil is in the details".

The tool can be found on the NCCBH website at the primary care integration resource center, www.nccbh.org.

Background

Integration has been described in many ways. There can be financial, structural and/or clinical practice integration. Integration that is financial ("carve-ins", shared risk pools or other incentives) or structural (services delivered under the umbrella of the same organization or BH specialty services co-located with primary care services) does not necessarily assure clinical integration.

Clinical integration—what is experienced by the consumer in relation to the providers—is the goal. However, clinical integration is difficult to achieve without financing mechanisms, structural relationships and infrastructure that support the collaborative effort.

Cherokee Health Systems and the Washtenaw Community Health Organization are outstanding public sector examples of attending to all three aspects of integration.[1] [2] Both operate in states that have "carved-out" Medicaid mental health services, and each agency has a financing arrangement that is the only one of its kind within the state. Because their financing arrangements are unique, they will not be discussed here; a paper on the Washtenaw financing model is posted on the NCCBH website. Cherokee and Washtenaw are cited because they have been able to overcome the barriers that BH and primary care providers frequently experience in putting together a business model for collaboration.

Evidence-Based Clinical Model

Since clinical integration is the goal, a brief description of an evidence-based clinical model provides context for a discussion of finances. In the largest treatment trial for late-life depression to date, IMPACT, a team of researchers led by Dr. Jürgen Unützer followed 1,801 depressed, older adults from 18 diverse primary care clinics across the United States for two years. The 18 participating clinics were associated with eight health care organizations in Washington, California, Texas, Indiana, and North Carolina. The clinics included several Health Maintenance Organizations (HMO's), traditional fee-for-service clinics, an Independent Provider Association (IPA), an inner-city public health clinic and a Veteran's Administration clinic. The key components of IMPACT include:

A Depression Care manager

May be a nurse, social worker or psychologist and can be supported by a medical assistant. The care manager:

- Educates the patient about depression
- Supports antidepressant therapy prescribed by the patient's primary care provider
- Coaches patients in behavioral activation and pleasant events scheduling
- Offers a brief (6-8 sessions) course of counseling, such as Problem-Solving Treatment in Primary Care
- Monitors depression symptoms for treatment response
- Completes a relapse prevention plan with patients

A designated psychiatrist

- Consults on the care of patients who do not respond to treatments as expected.

Collaborative care

- Patient, care manager and primary care provider work together to develop a treatment plan (medications and/or brief, evidence-based psychotherapy)
- Care manager and primary care provider consult with psychiatrist to change treatment plan if patient does not improve

Stepped care

- Measurement of depressive symptoms at the start of treatment and regularly thereafter. The PHQ-9 is recommended; however there are other effective measurement tools.
- Adjustment of treatment according to an evidence-based algorithm. Aim for a 50% reduction in symptoms within 10-12 weeks. If patient is not significantly improved at 10-12 weeks after the start of a treatment plan, the plan should be changed. The change can be an increase in medication dosage, change to a different medication, addition of psychotherapy or a combination of medication and psychotherapy. [3]

The IMPACT research sites represented a variety of insurance coverage and payment environments, ranging from integrated systems such as Kaiser or the VA to safety net clinics. Sustainability of the IMPACT model has been a challenge to many settings outside of integrated care systems.

In a recent publication, Bachman et al observed "One of the significant challenges in providing depression care management services in an ongoing, consistent way is finding reliable mechanisms to reimburse them and compensate the staff that provides them. As with other chronic illness care management programs, care managers often expend a substantial portion of their clinical effort in activities that are typically not billable or reimbursed. As a result, the use of care management services for the treatment of depression in primary care settings has not yet become a common practice."[4] There is still much to be done to remove the financial and structural barriers that impede delivery of evidence-based care such as the IMPACT model.

Overview of Financial Barriers

There are many complexities associated with financial and structural barriers. For example, there has been considerable discussion about whether BH should be "carved-in" or "carved-out" when states or other purchasers make purchasing decisions. Some "carve-out" models have been customized to support clinical integration efforts, while some "carve-in" models have had the effect of reducing overall levels of BH spending and services, especially for the population with serious mental illness.

Depression in Primary Care: Linking Clinical and System Strategies is a five-year, Robert Wood Johnson Foundation (RWJF) funded, national program begun in 2000 with the goal of increasing the use of effective models for treating depression in primary care settings. Importantly, the RWJF program charged the eight demonstration sites (four Medicaid, four commercial) with addressing financial and structural issues as well as implementing clinical models. The program has recently published a series of papers in a special issue of *Administration and Policy in Mental Health and Mental Health Services Research*, some of which speak directly to the financial and policy barriers in the system.

> The clinical interventions that have been so successful in controlled research environments have proved difficult to sustain in the rough and tumble of daily practice. Existing financial and organizational arrangements are thought to impede incorporation of evidence-based depression care into routine practice. Common problems include the inability of PCPs to bill for depression treatment (in the context of behavioral health care carve-out programs) and the absence of payment mechanisms for key elements of the collaborative care model such as care management and psychiatric consultation services. Also, since appropriate care of people with depression typically involves more time than the average case, PCPs reimbursed on a capitated basis or rewarded for the number of patients seen may opt to refer patients to specialty care that could be treated successfully in primary care. Fragmentation in financing and delivery of care due to managed behavioral health carve-out contracts, multiple health plan contracts, and separate prescription drug budgets contribute to and reinforce tendencies to avoid attending to cases of depression using evidence-based practice...
>
> While these...demonstration programs pursued similar clinical innovations consistent with the collaborative care model, they adopted strikingly different approaches to altering the economic and organizational environment surrounding the primary care treatment of depression. Variation in the economic and organizational strategies across sites reflects both contextual differences in local delivery systems, as well as distinct judgments about which organizations should take responsibility for spearheading and financing quality improvement. Developing an economic and organizational strategy also proved to be significantly more difficult to conceptualize and implement compared with changes in clinical practice.[5]

In January 2005, the National Association of State Mental Health Program Directors (NASMHPD) issued *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities.* Many of the observations regarding financing and policy made in that technical paper continue to be true and will be referenced. The discussion that follows identifies barriers specific to major funding sources.

Uninsured

A major barrier is whether the consumer has insurance coverage (e.g., Medicare, Medicaid or commercial) or is indigent and/or uninsured. For the Community Health Centers (CHCs, some of which are Federally Qualified Health Centers [FQHCs]) serving safety net populations, there have been increasing numbers of uninsured in their service populations (between 1999-2004, the percent of uninsured in CHCs grew three times as fast as the percent of uninsured nationally).[6]

During a similar period (between 1998 and 2003), as the total number of CHCs grew 22%, the proportion of CHCs providing onsite BH (mental health and/or substance abuse) services rose from 60.4% to 73.5% and the number of persons treated with a primary BH diagnosis more than tripled, from 210,000 to 800,000 (based on the uninsured growth rate noted above, we can assume many were uninsured). The 26.5% of CHCs with no onsite BH services were likely to have smaller patient populations, higher proportions of uninsured clients, and be sited in rural or more vulnerable communities with fewer specialty providers, emergency and inpatient services.[7]

Unlike CHCs, Community Mental Health Centers (CMHCs) have no national requirement to serve the uninsured population, lacking the equivalent of the 330 funding received by CHCs and the special reimbursement relationship with Medicaid. A mandate to serve the uninsured, and financing to support it, has been a matter of state policy, with a great deal of variation among the states. Many states have shifted their mental health general fund financing to Medicaid match, leaving few to no funds for the indigent uninsured population, even if these individuals have serious mental illness. This policy environment has created strain on the relationships between CHCs and CMHCs, at a time when collaboration in provision of integrated care to safety net populations is needed.

Decreases in or discontinuation of state non-Medicaid funding to CMHCs has led to increased demand for CHC services. In some communities, CHCs now manage psychotropic medications for the uninsured population; they are managing not just SSRIs for depression but second-generation anti-psychotic medications as well.

Medicare

Medicare both leads the way and presents some of the structural barriers that the parity movement has tried to address. Medicare led the way in adopting new CPT codes to support collaborative care; intermediaries around the country are paying on these codes. Some intermediaries are also using these codes in their commercial plans, so there has been some initial success in obtaining payment for services that are focused on behavioral health issues, provided under a medical, not psychiatric, diagnosis.

TABLE 1: CPT Codes for Behavioral Health Services Related to Medical Conditions

CPT Code	Service Description
96150	Behavior assessment, clinical interview, behavior observations, psycho-physiological monitoring: face to face, 15 minute intervals
96151	Re-assessment
96152	Behavioral intervention; face to face, 15 minute intervals
96153	Group intervention (2 or more patients)
96154	Family intervention with patient present
96155	Family interventions without patient present

It is well recognized that the use of current behavioral codes may be problematic in documenting care delivered to patients with primary medical illnesses, who may have behavioral complaints related solely to their medical illness. New Health and Behavior Assessment and Intervention CPT Codes 96150-96155 were adopted by

> Medicare over two years ago in order to address this issue. These codes are intended for use by certain healthcare providers...when BH services are provided in relationship to a physical (not behavioral) diagnosis...if adopted by payors. For physicians, it may be preferable to utilize an E & M code for care delivered to these patients as it more appropriately describes the type of care delivered.[8]

For Medicare covered individuals seen principally for mental health diagnoses in primary care (e.g., major depression), the most significant barrier is the differential co-pay requirement for a mental health visit (50%) as contrasted with a primary care visit (20%). This, along with the barriers referenced by Barry and Frank above, can result in depression care being coded and billed under some other healthcare related code.

TABLE 2: Medicare Payment for Mental Health Services Summary

	Community Mental Health Center (CMHC) Site	Primary Care Site
MH Services Secondary to Primary Care Diagnosis	Not applicable	CPT Code Series 96150 - 96155
MH Services as Primary	90804-29 Series, 90853-57 Series, 90646-69 Series, 99140-5 codes*	90804-29 Series, 90853-57 Series, 90646-69 Series, 99140-5 codes *

* These codes will result in a higher co-pay per visit (50%) as contrasted with the primary care visit (20%).

Medicaid

The most complex situation vis-à-vis integration is that of the Medicaid system. CMHCs and CHCs in each state must engage in a conversation with the State Medicaid Agency (SMA) and the State Mental Health Authority (SMHA), to develop policy direction that addresses the need for greater access to BH services for the Medicaid population, without disadvantaging any of the populations that are now served by the public mental health system.

At the end of October 2003, the Health Resources and Services Administration (HRSA) issued Program Information Notice (PIN) 2004-05 regarding Medicaid Reimbursement for Behavioral Health Services. PIN 2004-05 followed on a September 2003 letter from the Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services (CMS). These documents were generated because Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) had informed HRSA that they had "difficulty receiving reimbursement from State Medicaid Agencies for the provision of behavioral health services".

The behavioral health services in question include those provided by a physician, physician assistant, nurse practitioner, clinical psychologist, or clinical social worker. The CMS letter and PIN 2004-05 state that Medicaid agencies "are required to reimburse FQHCs and RHCs for behavioral health services provided by those practitioners named above whether or not those services are included in the State Medicaid plan" and clarifies that, "in order for FQHCs and RHCs to be reimbursed..., FQHC/RHC providers must be practicing within the scope of their practice under the state law".

To understand this directive, it is important to remember federal law in regard to FQHCs, which specifically identifies the disciplines noted above. (In some states, Medicaid will not reimburse FQHCs for BH services provided by Licensed Marriage and Family Therapists (LMFTs), even if the same state will pay for Medicaid BH services delivered by licensed LMFTs in CMHCs.)

Another aspect of federal law is difference in financing policy:

> CHCs have a special relationship with Medicaid. In fee-for-service states, they are paid a differential rate for services; in managed care states, they are paid a prospective payment intended to address costs above payments made by managed care plans. While not fully cost reimbursement, it is a more generous payment system. For example, in one state, when a psychiatrist sees a patient at a university clinic (psychiatric medication service 90862) the clinic is reimbursed $12.50 via fee-for-service (FFS) Medicaid; the same visit at a community mental health center would be reimbursed $39.92; at the CHC, that visit with a psychiatrist would be reimbursed at $80-88 (variable due to quarterly recalculated cost basis). [10]

It is also important to keep the affected populations in mind when considering the implications of these Medicaid financing directives.

> The [NASMHPD] report integrates two conceptual models that assist in thinking about population-based and systemic responses. The first, *The Four Quadrant Clinical Integration Model*, is a population-based planning tool developed under the auspices of the National Council for Community Behavioral Healthcare (NCCBH). Each quadrant considers the Behavioral Health (SA and MH) and physical health risk and complexity of the population subset and suggests the major system elements that would be utilized to meet the needs of the individuals within that subset of the population. The quadrants can be briefly described as:
>
> I. The population with low to moderate risk/complexity for both behavioral and physical health issues.
>
> II. The population with high behavioral health risk/complexity and low to moderate physical health risk/complexity.
>
> III. The population with low to moderate behavioral health risk/complexity and high physical health risk/complexity.
>
> IV. The population with high risk and complexity in regard to both behavioral and physical health. [11]

What might PIN 2004-05 mean for the Medicaid population? Categorically eligible Medicaid beneficiaries (e.g., TANF, aged/blind/disabled) may or may not be able to easily gain access to public mental health services, depending on definitions of target populations and medical necessity, which vary from state to state.

NASMHPD
Integrating Behavioral Health and Primary Care Services

At the federal level, there is fragmentation and lack of coordinated knowledge transfer as BH/PC Integration initiatives expand. Many of the disconnections regarding financing begin at the federal level and require coordination and problem solving among federal agencies. Medicaid state plans also need to be updated to support integration practice changes...

The application of the Balanced Budget Act (BBA) rules in Medicaid managed care states (e.g., the repeal of the upper payment limit; review of encounter data for rate setting and disallowance of flexible services and prevention oriented expenditures; close examination of the state plan against the encounter data; and, questions regarding case management services) makes integration efforts more difficult to implement...

Federal and state categorical funding for specific target populations also make it difficult to adequately support BH services in primary care. A related issue is the state level regulatory and paperwork requirements that accompany most SMHA program efforts. Primary care based services require brief assessment, intervention and documentation. SMHA providers wanting to work with CHC partners are disadvantaged if they must complete lengthy assessments and paperwork in order to access SMHA funding for persons seen in a primary care setting. There is a concern that current federal and state policies make it impossible for SMHA providers to be responsive to community needs, creating an environment in which they may not be able to survive to serve the population of persons with SMI/SED. [9]

In states with public mental health systems that focus on populations with serious mental illness (SMI) and serious emotional disturbance (SED) [the populations in Quadrants II and IV], PIN 2004-05 creates an opportunity for other Medicaid populations [the populations in Quadrants I and III] to obtain BH services through a CHC, consistent with the HRSA initiative focused on reducing health disparities and creating behavioral health capacity in CHCs. This helps assure that safety net populations are served.

But, what does this mean in terms of financing and the BH services now provided to Quadrant II and IV populations? The answer, of course, will vary from state to state because of the differing Medicaid models among the states.

For states that are paying fee-for-service (FFS) for outpatient Medicaid mental health services, this will generate new billings and costs for the Medicaid system, but should not affect Community Mental Health Centers (CMHCs) and their target populations in Quadrants II and IV.

However, for FFS states that require public mental health providers to make the local match (from state and/or locally designated funds) to the FFS federal share, this will require problem solving:

- Will the state pay CHCs the full FFS at the matched rate, using other state funds to match?
- Will state and/or local funds now used for CMHC match be reallocated to cover billings generated by CHCs?
- What will happen to current CMHC service levels/consumers if this occurs?

For states that have managed care systems for Medicaid mental health benefits, there are a different set of questions:

- Will CHCs be added to the networks of providers?
- Where there are regional sub-capitation arrangements, how would the relationship with CHCs be structured?
- If the CHCs are brought in under the auspices of the managed care system, will they have to play by the same medical necessity/target population /documentation rules as the CMHCs, defeating the purpose of serving a broader Medicaid population in a primary care setting?
- Or, will the CHC Medicaid prospective payment cover these services outside of the managed care system and rules?
- Would this affect the payments to the managed care system and Quadrant II and IV target populations?

Other questions regarding financing identified in the NASMHPD paper include:

- Is BH consultation in a PC setting a medical or MH service? (Proponents of embedded BH consultants in PC settings believe this should be defined as a medical service.)
- How do PCPs get reimbursed for visits when a DSM diagnosis is detected and coded?
- Why is there a prohibition on same day services from a PCP and a BH provider? (Some state Medicaid programs will not process a claim for BH service provided on the same day as primary care service within the same provider organization, which undermines the concept of a "warm hand-off" from the PCP to the BH provider.)

- How will the system resolve issues of BH program licensure, documentation and data submission, clinician licensure, credentialing and supervision for BH services provided in primary care settings?
- Which entity (Health Plan or BH Plan) bears financial responsibility when BH is carved out? [12]

Analysis of data on Medicaid enrollees in Washington and Colorado suggests a hypothesis that requires further research. It may be that funding for BH services to the Quadrant I and III populations is not in the "base/capitation" of either the SMHA or the SMA/Medicaid health plans. Mental health services have not historically been delivered to the Medicaid Quadrant I and III populations. Yet, based on the data regarding prevalence of BH diagnoses in the Medicaid population as well as the impact of providing BH services on Medicaid healthcare costs, significant medical cost offsets may be found in the Medicaid population, which would warrant the investment in expanded BH service capacity. [13]

This variability of financing models for public sector BH requires every community partnership between a CHC and a CMHC to assess their specific state and local financing and policy environment in order to determine whether there is a business model that will best support their integration activities.

TABLE 3: Medicaid Payment for Mental Health Services Summary

	Community Mental Health Center (CMHC) Sites	**Primary Care Sites**
FFS MH Benefit	Services billable to Medicaid Agency and/or Medicaid Health Plans per agreements between the parties and State Medicaid Agency	Services billable based on HRSA PIN 2004-05 to State Medicaid Agencies, where an agreement has been put in place. Code Series 96150 – 96155, 90804-29 Series, 90853-57 Series, 90646-69 Series, 99140-5 codes
Capitated MH Benefit	Services based on waiver requirements, modalities in State Medicaid Plan, rates as established by actuarial review, oversight by EQRO process	Most unclear situation; based on state, regional, and/or local decision making.

TABLE 4: Mental Health Financing for Population Groups: NCCBH Four Quadrant Model

Quadrant II – Low Physical Health , High Behavioral Health	**Quadrant IV – High Physical Health, High Behavioral Health**
Payment Tools: • MH Medicaid FFS • MH Medicaid Capitation • State General Funds for MH • Medicare and private insurance	Payment Tools: • MH Medicaid FFS • MH Medicaid Capitation • State General Funds for MH • Medicare and private insurance
Quadrant I – Low Physical Health, Low Behavioral Health	**Quadrant III – High Physical Health, Low Behavioral Health**
Payment Tools: • E&M Code for Physicians • "Incident to" for MH staff, care manager (some payors) • If FQHC, PIN 2004-05 if implemented, Medicaid FFS • CPT Code Series 96150 – 96155	Payment Tools: • E&M Code for Physicians • "Incident to" for MH staff, care manager (some payors) • If FQHC, PIN 2004-05 if implemented, Medicaid FFS • CPT Code Series 96150 – 96155

Learning from Pilot Sites

Depression in Primary Care: Linking Clinical and System Strategies, Robert Wood Johnson Foundation Sites

Of the eight sites in the RWJF project, four were Medicaid sites. This discussion focuses on two of those sites, Colorado and Oregon.

In ***Colorado,*** the RWJF Medicaid demonstration site developed its approach from a perspective that was unusual in several ways. At the time that the site became engaged in the RWJF project, it was already a participant in the MacArthur Foundation's Re-Engineering Systems in Primary Care Treatment of Depression (RESPECT) Initiative. In the RESPECT Initiative, Colorado Access worked with affiliated primary care clinics to use the PH Q-9 to screen for depression and used MH clinicians trained as care managers, along with a supervising psychiatrist, to provide stepped care in collaboration with the PCP. Unlike most Medicaid health plans, it was also involved in the public mental health system.

Colorado Access presented data at the 2006 RWJF project conference after the publication of the paper excerpted below. The data represents 370 Medicaid patients, 81% female and 64% eligible under the Aged/Blind/Disabled aid code.[14] The Colorado site has achieved the following results, which are also displayed graphically below.

- Savings of $170 per enrollee per month
- 12.9% reduction in costs in high-cost, high risk patients
- $2040/year per patient
- 370 patients x $2040 = $754,800 annual medical cost savings

> Colorado Access is a non-profit Medicaid health plan that was formed in 1994 by a number of the state's safety net providers. Colorado Access has several product lines including a fully capitated Medicaid physical health HMO...and a behavioral health plan...which holds the carved out Medicaid mental health contract in Denver County. The fact that Colorado Access holds risk for both behavioral and physical health costs for some Medicaid recipients has provided it with unique insights into the clinical, economic, and systems issues involved in implementing a program to improve the treatment of depression in primary care...
>
> The company's interest in improving integration was fueled by the difficulties its partner providers experienced in dealing with the mental health issues in regions where Colorado Access did not hold the behavioral health contract and by the health plan's ability to analyze the prevalence and cost of mental health disorders within its covered population in the regions where it did.
>
> In 2000, an analysis of Colorado Access' claim data for Medicaid recipients who had both mental and physical health [coverage] showed that 40% of adult HMO members had received a mental health diagnosis on a claim form but only 33% of this group had any evidence of having been seen by a mental health specialist...Depression, anxiety and substance abuse were very common in the general medical population and resulted in higher costs across the board...
>
> ...[the] demonstration grant encouraged Colorado Access to focus on developing an economically sustainable model for depression care management...to be sustainable, Colorado Access had to realign its resources and build this new

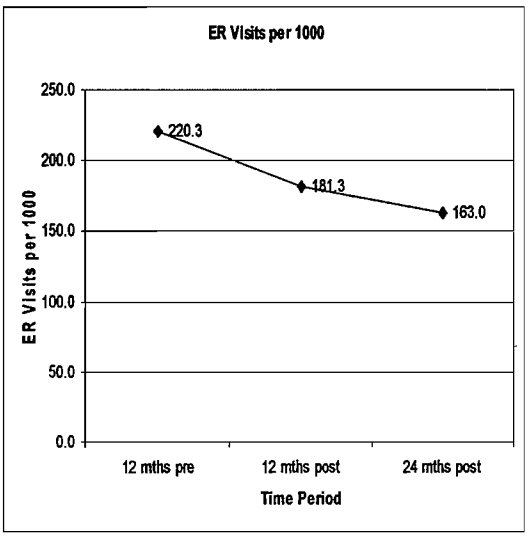
program into existing health plan operations...[the] physical health HMO...as opposed to its behavioral carve-out..., took the lead in implementing the depression care management program...focusing on these members [with diabetes, CHF, asthma/COPD and those at risk for high future costs as evidenced by Kronick scores $\geq 90^{th}$ percentile] with co-occurring depression, the existing care management staff could be trained to do depression screening and follow up as part of patient assessment and care planning activities with only incremental increases in costs...

Diagnoses	N	%
Total	**370**	**100%**
Coronary Artery Disease	370	100%
Dysthymia	190	51%
Diabetes	152	41%
Bipolar	123	33%
Asthma	97	26%
Chronic Obstructive Pulmonary Disease	81	22%
Anxiety/Panic	40	11%
Congestive Heart Failure	40	11%
Psychosis	33	9%
Schizophrenia	18	5%

From the PCP perspective, Colorado Access' care management program was offering help with mental health, psychosocial, and coordination of care issues in some of their most difficult patients...the PCPs had been frustrated about lack of access to and coordination with mental health specialty care. The Colorado Access care management model supported them in treating depression, gave them telephone access to the health plan's psychiatrist, and improved access to and communication with mental health specialists. PCPs had also been frustrated by the Medicaid fee-for-service reimbursement schedule that would not reimburse them for office visits billed with a mental health diagnosis despite the reality that they were left treating the majority of depressed patients. Colorado Access agreed to pay the PCPs for office visits billed under mental diagnoses which made the providers feel better about delivering these services. To date this has not noticeably increased the cost to the plan of PCP services, but has increased the likelihood of obtaining a diagnosis of depression on a claim form...

Patients who need to see a mental health specialist can obtain mental health consultation and treatment through the historical payment mechanisms. The care management program aims to maximize the effectiveness of primary care treatment of depression, thereby ensuring that referrals are made to those most in need of specialty care...

[Subsequently], Colorado Access revised its risk stratification process to identify its top 1000 patients based on a combination of past medical costs and Kronick scores. This list is refreshed on a monthly basis and these patients are then rank ordered and put into a queue to be assessed for possible enrollment in intensive care management. This adjustment supports the economic sustainability of the model by making it more likely that the intervention is focused on potentially high–cost members.[15]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200.0
150.0
100.0
50.0
0.0
ER Visits per 1000
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181.3
163.0
12 mths pre
12 mths post
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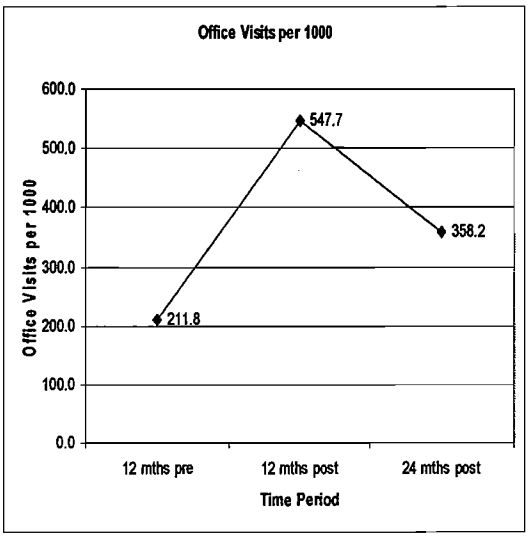
Time Period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500.0
400.0
300.0
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Office Visits per 1000
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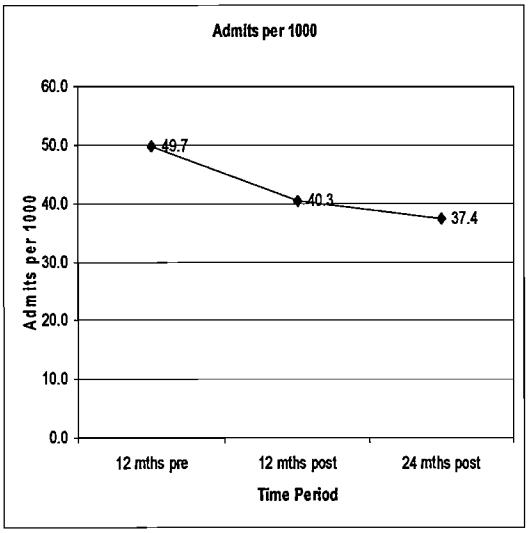
211.8
12 mths pre
12 mths post
24 mths post
Time Period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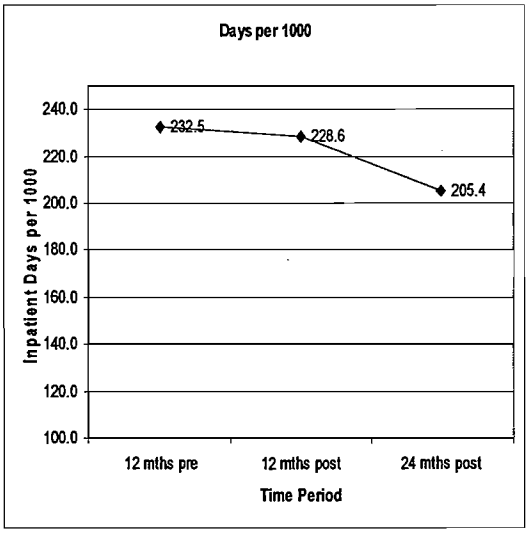
24 mths post
Time Period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220.0
200.0
180.0
160.0
140.0
120.0
100.0
Inpatient Days per 1000
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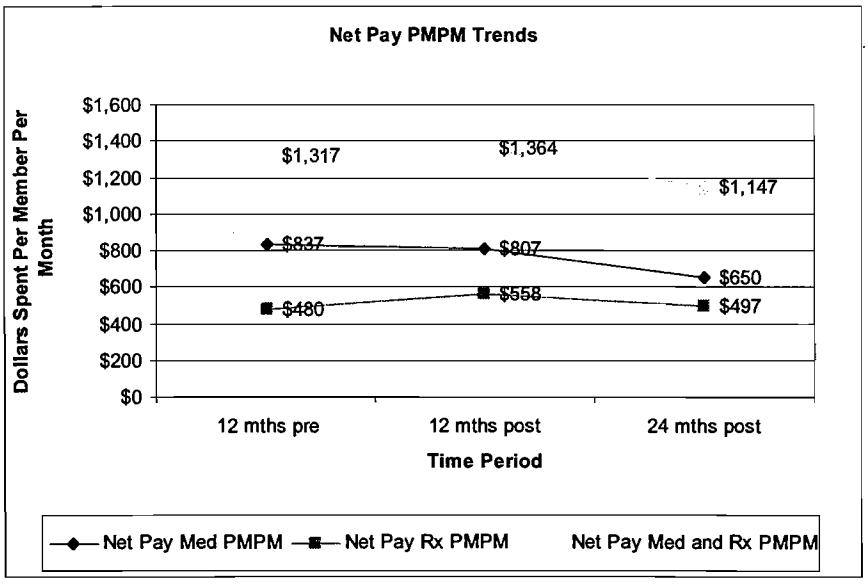
228.6
205.4
12 mths pre
12 mths post
24 mths post
Time Period


Net Pay PMPM Trends
Dollars Spent Per Member Per Month
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
$1,317
$1,364
$1,147
$837
$807
$650
$480
$558
$497
12 mths pre
12 mths post
24 mths post
Time Period
Net Pay Med PMPM
Net Pay Rx PMPM
Net Pay Med and Rx PMPM

In ***Oregon***, the RWJF Medicaid demonstration site grappled with the payment and documentation requirements of the Medicaid specialty BH system and studied two models.

> In the one model, behavioral health specialists were employed by federally qualified healthcare (FQHC) primary care clinics (i.e., the "ownership" model). Under Centers for Medicare and Medicaid rules, FQHC-designated clinics can generate revenue by billing a patient's insurer, as well as through supplemental state "Prospective Payments" up to the average cost of a clinic visit. State prospective payments are in addition to receipts received from the insurer and provide significant support for FQHC clinics. If services are within the scope of an FQHC clinic, as determined by the Health Resources and Services Agency, as are behavioral health services, they are eligible for this supplemental reimbursement.
>
> In the second economic model, at the non-FQHC Legacy Health Clinics, behavioral health specialists were "loaned" to the clinics by a community mental health center that employed these staff and billed Medicaid for their services (i.e., the "borrowed" model). Since there was no FQHC mechanism for Legacy to supplement fee-for-service revenue from these services, these Clinics were dependent on the behavioral health network to provide services and bear the costs...the "borrowed " model seems to create more barriers than solutions. As utilization priorities and funding sources shift in the specialty behavioral health centers, which own the "borrowed" staff, financial and personnel tensions arise as money remains scarce, despite many "in-kind" costs incurred by the primary care clinics.[16]

Other CMHC and CHC Partner Sites

In the course of consulting and training on integration, there has been the opportunity to see how CMHC and CHC partners have developed variations on the theme of the business models tried in Oregon. Yet another variation on business models is the "rental" model, a model in which the CHC purchases the services from a CMHC in the same way that a CHC might purchase lab or other ancillary services. In this model, the CMHC BH staff chart and bill under the auspices of the CHC either "incident to" physician services, for specific BH codes at the enhanced FFS rate, or as part of the Prospective Payment calculation.

TABLE 5: Business Models for CHCs and CMHCs

	In CHC as Primary Healthcare Provider	In FQHC/RHC as BH Practitioner (PIN 2004-05 option)	As CMHC BH Practitioner Providing Services Located in CHC
Diagnosis	Physical	Psychiatric * or Physical	Psychiatric *
Authority	PCP (incident to)	BH Practitioner or PCP	BH Practitioner
Billing under	PCP bundled services 99201-5, 11-15 series 99078 educational services-group 99401-4, 11-12 prevention interventions 0108 & 0109 for diabetes	MH benefit * 90804-29 series, individual 90853,57 group 90846-49 family 99150-5 codes as come on line Or, Health benefit 96000 series	MH benefit * 90804-29 series, individual 90853,57 group 90846-49 family 99150-5 codes as come on line
Documentation	In CHC medical chart	In CHC medical chart	CMHC records
Liability	CHC / BHP	CHC/ BHP	CMHC / BHP
Payments to	CHC	CHC	CMHC *Based on Dyer, NCCBH Conference 03*

Additionally, the CMHC BH staff have the advantage of being connected to BH clinical supervision, psychiatric back-up and the referral process at their home CMHC. In some sites experimenting with this model, psychopharmacology training for PCPs and telephone or in-person psychiatric consultation hours are a part of the package that is being purchased. It has been said that the service contract or "rental" model cannot be implemented in FQHCs that are covered by the Federal Tort Claims Act for malpractice; however, the "rental" agreement with a CMHC can be put in place as long as the CMHC provides the malpractice coverage for the "rented" staff (and includes this in costing the service). The table above summarizes these differing business models.

State Medicaid Pilots

State Medicaid pilots have emerged in the last few years, several using the NCCBH Four Quadrant Clinical Integration Model as the basis for their planning. The North Carolina and Massachusetts pilots were recently presented at the NCCBH Annual Training Conference (April, 2006).

North Carolina is supporting four pilot sites with grant funding for two years, with substantive evaluation applying standardized measures, to drive Medicaid policy and reimbursement changes. There is a commitment to look at Medicaid billing codes and rates based on the outcomes.[17]

Partners

- Community Care of North Carolina and Network (State Medicaid Agency and local networks)
- Local Management Entities (Regional BH Authorities)

Project Goals

- Collaboration and partnership between Community Care of North Carolina Network and Local Management Entities
- Improve access to primary and behavioral health care
- Increase communication between the PCP and behavioral health provider
- Determine cost-effectiveness of psychiatric telephone consultation with the PCPs
- Integrate care of depression at the PCP office
- Optimally use the Four Quadrant Model
- Be sustained and replicable
- Demonstrate effectiveness of consultation/communication

One of the pilot sites, located in Western North Carolina, is building on a history of previous foundation-funded integration efforts in Buncombe County as well as an ambitious project located in the Mountain Area Health Education Center that provides training, protocol development and other integration supports to a number of primary care sites. The Buncombe County site, located in a safety net public health department clinic, has just completed an analysis of cost and services that supports the findings from Colorado, even though the implementation models and target populations differed.[18]

Cost and Service Use

- N=1598 (26% Medicaid)
- Rolling enrollment 2000-2004
- Uncontrolled - simple changes in costs over time (12 months pre-program vs. 12 months post-entering program)
- Controlled - changes in costs over time, controlling for certain factors & adjusting for standard error

- 2005 Medicaid rates applied to all coded services

Decrease in Health Care Costs (controlled)

- Overall Health Care Costs: reduction of $66 per user/patient per month
- Mental Health Care Costs: reduction of $295 per user/patient per month
- In-patient Health Care Costs: reduction of $1455 per user/patient per month
- Cost of program was $340,000 or $17 per patient per month

Analysis of High Users

- Heavy users of health care services separated out for analysis
- Comparison of those who used services in both time periods (pre and post) showed overall health care costs decreased by $435 per user per month

Cost Effectiveness

PHQ-9

- A single point drop "costs" $29
- A 5 point change on PHQ-9 equals clinically significant change
- It costs $145 to make a patient better

SF-12

- A single point increase in mental health functioning "costs" $19
- The average SF-12 score increased by almost 9.5 points
- It costs $179 to produce this improved functioning

Massachusetts has recently initiated its pilot program and has selected six sites. Using logic models, demonstration sites submitted their proposals identifying the populations to be served, their needs for integrated services, current barriers to integration, program activities, and outcomes.[19] [20] [21]

Partners

- DMH Commissioner
- Massachusetts Health, Office of Acute and Ambulatory Care
- Massachusetts League of Community Health Centers
- Mental Health and Substance Abuse Corporation of Massachusetts
- Massachusetts Behavioral Health Partnership (MBHP)
- University of Massachusetts Medical School, Center for Health Policy Research (CHPR)

Strategic Alliances

- Strategic alliance between community health and mental health and substance abuse centers in Massachusetts
  - Built upon affiliations that already existed in some portions of the state to improve the coordination of behavioral health and primary care services.
  - Mental Health and Substance Abuse Corporation of Massachusetts and the Massachusetts League of Community Health Centers created unique partnership
- The project is one of Massachusetts Behavioral Health Partnership (Medicaid MCO for Behavioral Health carve-out) performance incentive projects for FY 2006

Barriers Identified

- Financing Models
- In Massachusetts, state mental health funding for Outpatient care to the uninsured is gone

    - Behavioral Health providers have no access to the Uncompensated Care Pool
    - Significantly higher volume of uninsured patients in CHCs than Behavioral Health clinics
- Cultural Differences
    - For example, 50 minute "hour" of Behavioral Health clinic
- Clinic Licensure Regulations
    - Outreach restriction (20 operational hrs/week & 40 staff hrs/week)
    - Record keeping requirements

Guiding Principles and Core Goals

- Improve coordination between behavioral health and primary care providers
- Apply consistent use of clinical standards in the identification and treatment of BH disorders
- Use evidence based practices
- Embed principles of recovery in all aspects of care
- Provide services locally
- Use data driven decision support
- Use quality improvement principles
- Emphasize service excellence

Regulatory Issues

- Waiver from the Department of Public Health (DPH): use of common waiting rooms for co-located facilities
- DPH regulation recently streamlined the process for care plans being reviewed by multi-disciplinary teams
- Develop electronic information sharing capacity: HIPAA compliance

Contracting

- Reimburse the CMHCs for services provided to CHC patients from the Free Care Pool.

Financial

- Develop a reimbursement rate to pay for physician-to-psychiatrist/psychologist consultation via phone or e-mail.
- Develop a new case rate for enhanced case management services (e.g. depression care manager services provided at CHC locations).

Commercial Pilots

In a November 2, 2005 press release, ***Aetna*** announced a new program, Aetna Depression Management, the first national program to integrate medical and behavioral health care at the primary care physician (PCP) office and provide incentives for screening and assessment as patients first enter the health care system.

Aetna Depression Management will be a pilot program in ***Pennsylvania, New Jersey, Maryland, Virginia,*** the ***District of Columbia, Oklahoma*** and ***Texas***. The program:

- Provides a turnkey depression treatment program for PCPs based on the clinically proven Three Component Model (3CM™) program. The model uses an empirically validated, standardized depression screening tool and outcome measurement tools. 3CM was designed and funded by the MacArthur Initiative on Depression and developed through programs run by Dartmouth College and Duke University. The three components include:

1. a prepared practice working with
2. a care manager and
3. a behavioral health specialist. The care manager helps guide and facilitate a patient's adherence to the prescribed treatment.

- Gives the doctors access to a network of psychiatrists who are on call throughout the day to answer questions about treatment that may be needed outside the PCP office. In addition, Aetna case managers track and follow up with patients.
- Redesigns Aetna's mental health benefit policy to reimburse PCPs for screening and assessing patients for depression.
- Includes a Web-based Continuing Medical Education program for PCPs and brings training and heightened sensitivity and educational materials to the doctors who first see patients, available at www.aetnadepressionmanagement.com.
- Provides training for office staff of participating PCPs who also work and interact with the patients.
- Distributes member-targeted communications materials for use by the PCPs. [22]

TABLE 6: Site Financing Summary

Site	Clinical Model	Business Model	Target Population	Financing Strategy
Colorado Access	Care managers with psychiatric back up, based at health plan, telephonic and in-person services	Health plan employs the care managers and psychiatrist	High cost and risk enrollees with co-morbidities, identified through claims data	Health plan pays, recovers costs from reductions in inpatient, ER utilization, and overall PMPM
Oregon	MH staff onsite in FQHCs, employed by FQHCs	MH staff employed and become part of FQHC cost structure, services billed to Medicaid health plan	Depressed patients in primary care	Build the cost into the FQHC Medicaid prospective payment
	Second model was CMHC staff on site in FQHCs	CMHC staff placed on site in FQHCs, services billed to Specialty MH Medicaid carve out.	Depressed patients in primary care	Specialty MH system rules and processes created barriers
North Carolina (Buncombe County site)	MH staff onsite in public health safety net primary care clinic	MH staff employed by clinic, partnership with regional MH authority supports referrals for specialty MH services. To date, has relied on multiple grants, billings, recently released cost savings results to seek additional support.	Depression, anxiety, ADHD identified in primary care	State pilot testing payment for psychiatric consultation and care management, possible future Medicaid codes.
Massachusetts (Holyoke site)	Depression care manager on site in FQHC, PHQ-9 screening, psychiatric consultation to PCPs	CMHC and FQHC partnership, referrals to specialty MH, psychiatric consults, use of Community Support case managers	Depression	Some Medicaid plans will pay for care management, some plans will pay for case managers, no funding for psychiatric consults. State pilot

Site	Clinical Model	Business Model	Target Population	Financing Strategy
				seeks to identify and address barriers.
Aetna	Screening in primary care practices. Care managers, access to psychiatric back up provided by health plan.	Primary care practices screen with existing staff, care managers and psychiatric consults provided by health plan	Depression	Commercial insurance will pay PCPs for depression screening and assessment, and provide care management and psychiatric consultation.
Tennessee: Cherokee Health	Behavioral consultant embedded in primary care teams. Psychiatric consults available from within the agency.	A single organization that is both a CMHC and FQHC (not all primary care sites are FQHCs, however)	All diagnoses	Fully integrated financially through global budgets for MH and primary care as well as billing all other payors
Michigan: Washtenaw County	CMHC staff placed on site in primary care clinics, psychiatric consultation	CMHC with University based and private primary care clinics	All diagnoses, focus on individuals with SMI covered by the Medicaid MH waiver as well as indigent patients covered by local funds	Fully integrated Medicaid capitation for both MH and primary care, in partnership with University of Michigan

A recap of the efforts of various sites would not be complete without acknowledging the commitment of sites around the country that continue to patch together funding because they believe in the efficacy of the integration approach—for example, in Washington State there is CMHC/FQHC partnership where the MH clinicians placed by the CMHC in the FQHC sites are financed by an annual golf tournament—hardly a sustainable model.

Conclusion

The Aetna project provides financial support for the same service components proven in the IMPACT trials, identified in the RWJF project and being tested in the state Medicaid pilot sites:

- ***Screening***
- ***Care management***
- ***Psychiatric consultation (principally by telephone)***

These are close to the same components identified in the report of the *President's New Freedom Commission on Mental Health,* which asserted that there must be a relationship between MH and general health. ***These service components are currently missing from public and private sector billing codes and financing policy.***

New Freedom Commission Report

Goal 5 - Excellent Mental Health Care Is Delivered and Research Is Accelerated

The Commission recommends that Medicare, Medicaid, the Department of Veterans Affairs, and other Federal and State-sponsored health insurance programs and private insurers identify and consider payment for core components of evidence-based collaborative care, including:

- Case management,
- Disease management,
- Supervision of case managers, and
- Consultations to primary care providers by qualified mental health specialists that do not involve face-to-face contact with clients.

Colorado Access and Aetna have addressed the care management and psychiatric consultation components and costs by locating them within the health plan structure. However, IMPACT places the screening and care management components on-site,

close to the PCP, as do Cherokee, Washtenaw, and most of the state Medicaid pilots now underway. The lack of reimbursement for these key components is an ongoing barrier for most on-site settings, including IMPACT programs that are not within integrated systems.

As this summary indicates, current CPT codes are frequently unreimbursed, new CPT codes are needed for key components, incentives are at cross-purposes, and business models are difficult to develop in support of mutually agreed upon clinical models. In the public and private sector pilot sites we see an effort to support these key components that have proven to be effective in the stepped care model.

The challenge, for federal, state and private payors, will be to align financial/policy incentives to support clinical integration, which research demonstrates is effective in achieving positive outcomes.

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