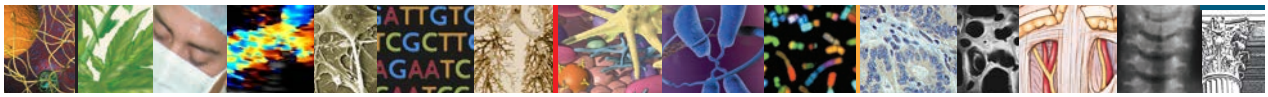

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Perspective

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Medicare Payment for Behavioral Health Integration

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Integrating behavioral health care with primary care is now widely considered an effective strategy for improving outcomes for the many millions of Americans with mental or behavioral health conditions. Uptake of behavioral health integration (BHI) has remained limited, however, largely because BHI has not been paid for separately, which has left primary care clinicians without a clear business model for incorporating these services into their practice.[1] But on January 1, 2017, the Centers for Medicare and Medicaid Services (CMS) will begin paying clinicians separately for the BHI services they provide to Medicare beneficiaries.

Four new codes were created for the 2017 Medicare Physician Fee Schedule to allow payment to health care providers for furnishing BHI services.[2] Three of these codes describe services furnished using the Psychiatric Collaborative Care Model (CoCM), an approach to BHI that has been shown to be effective in several dozen randomized, controlled trials. CoCM enhances "usual" primary care by adding two key services: care management support for patients receiving behavioral health treatment, and regular psychiatric interspecialty consultation for the primary care team, particularly regarding patients whose conditions are not improving.

For example, under CoCM, if a 72-year-old man with hypertension and diabetes presents to his primary care clinician feeling sad and anxious, the primary care team (primary care clinician and behavioral health care manager) would conduct an initial clinical assessment using validated rating scales. If the patient has a behavioral health condition (e.g., depression) and is amenable to treatment, the primary care team and the patient would jointly develop an initial care plan, which might include pharmacotherapy, psychotherapy, or other indicated treatments. The care manager would follow up with the patient proactively and systematically (using a registry) to assess treatment adherence, tolerability, and clinical response (again using validated rating scales) and might provide brief evidence-based psychosocial interventions such as behavioral activation (which focuses on helping people with mood disorders to engage in beneficial activities

and behaviors) or motivational interviewing. In addition, the primary care team would regularly review the patient's care plan and status with the psychiatric consultant and would maintain or adjust treatment, including referral to behavioral health specialty care as needed.

Using these three new codes, the primary care clinician can bill Medicare for each month in which a threshold amount of time is spent delivering CoCM services (for the first month, approximately $140 for 70 minutes per beneficiary; for subsequent months, approximately $125 for 60 minutes per beneficiary; and for all months, approximately $65 for each additional 30 minutes per beneficiary). The behavioral health care manager must have formal education or specialized training in behavioral health (which could include a range of disciplines — e.g., social work, nursing, or psychology), a continuous relationship with the beneficiary, and a collaborative, integrated relationship with the care team (but need not be a member of the primary care clinician's clinical staff). Care management services can be provided face to face or remotely — including outside usual clinic hours, as needed — but the care manager must be available to meet with the beneficiary face to face.

The psychiatric consultant must be a medical professional with psychiatric training and — given the prevalence and potential complexity of pharmacotherapy — be qualified to prescribe the full range of medications, and so might be a psychiatrist or a psychiatric nurse practitioner or physician assistant. This consultant must have a continuous relationship with the primary care practice (although he or she will typically be located elsewhere) and be able to help facilitate behavioral health specialty referral when indicated.

Since CoCM is not the only approach to BHI in use today, Medicare will also begin making separate payments using a fourth new code for services furnished according to other BHI models (approximately $48 for at least 20 minutes of services per beneficiary per month). This code can be used to report services provided under other BHI care models that include systematic assessment and monitoring using validated clinical rating scales (where applicable), behavioral health care planning (with care plan revision for patients whose condition is not improving), facilitation and coordination of behavioral health treatment, and a continuous relationship with a designated member of the care team. Services billed under this code may be provided directly by the primary care clinician and do not necessarily have to be furnished by a designated behavioral health care manager or involve a psychiatric consultant (although they may). CMS will be looking to the field in the coming years to further define the services furnished and billed using this code and to identify the resources involved in order to appropriately value the service.

Widespread implementation of CoCM and other effective BHI services could substantially improve outcomes for millions of Medicare beneficiaries and produce savings for the Medicare program.

Medicare's new payments for BHI will have their most immediate impact on clinicians already furnishing these services, who will now be paid more appropriately and accurately. But the biggest potential effect will be increasing the number of Medicare beneficiaries with access to effective BHI services. By one estimate, only about 10% of patients with depression (and less than 1% in some minority populations) receive guideline-concordant treatment under the status quo.[3] Through systematic care management and more efficient use of behavioral health specialty providers, effective BHI produces more person-centered, coordinated, evidence-based care. It also helps build behavioral health competency in the primary care workforce.

Studies have shown that CoCM improves the quality of care and patients' satisfaction with it, mental and physical health outcomes, and functioning in people with common behavioral health conditions, particularly — but not only — mood or anxiety disorders.[4] Evidence also indicates that it can reduce total health care expenditures over time and can reduce racial and ethnic disparities in quality of care and clinical outcomes. Therefore, widespread implementation of CoCM and other effective BHI services could substantially improve outcomes for millions of Medicare beneficiaries, as well as produce savings for the Medicare program.

In addition, these payments

may lead other payers to add or expand their BHI payments. Even in the era of alternative payment models that reward value — rather than volume — of services, greater access to and volume of effective behavioral health services would actually be a positive outcome, with net benefits for patients, health care providers, and payers. Plus, since most alternative payment models are built on a fee-for-service foundation, BHI payments may help payers more accurately value these services within alternative payment models.

Although we see Medicare's new payments for BHI as a major step forward, additional issues must be addressed in order to further improve the care of people with behavioral health conditions. For instance, though CoCM indirectly increases access to psychiatrists and psychiatric nurse practitioners and physician assistants (through consultation by the primary care team), it does not address other barriers to access for patients who need (or prefer) direct care from behavioral health specialty providers — such as low rates of psychiatrist participation in insurance.[5] Also, the primary care and behavioral health workforces must be equipped with the skills and tools needed to furnish BHI services. Although implementation resources are publicly available, some clinicians may benefit from technical assistance or additional training.

Medicare's new policy of paying separately for BHI builds on recent efforts by CMS to improve payment accuracy for primary care, care management, and person-centered services. These efforts include the addition of separate payment for transitional care management and chronic care management in past years and, in 2017, for complex chronic care management as well as assessment and care planning for beneficiaries with cognitive impairment. CMS looks forward to continued input and feedback from clinicians, beneficiaries, and other stakeholders as we work together to achieve better care, smarter spending, and healthier people.

The views expressed in this article are those of the authors and do not necessarily represent the views or policy of the Centers for Medicare and Medicaid Services or the National Institute of Mental Health.

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Economic Effects of Medicaid Expansion in Michigan

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Under the Affordable Care Act, 31 U.S. states have opted to expand Medicaid coverage to nonelderly adults with annual incomes up to 138% of the federal poverty level (approximately $16,400 for a single adult in 2016). The federal government currently pays the full cost of Medicaid expansion in these states. The federal share decreases to 95% in 2017 and to 90% in 2020, with participating states required to cover the remaining 5% and then 10% of the expansion costs. In some states, the anticipated costs for this newly insured population have been an obstacle to expansion.[1]

Michigan's Medicaid expansion, the Healthy Michigan Plan, has enrolled approximately 600,000 low-income adults. The total cost in fiscal year 2016 was about $3.6 billion, financed almost entirely by the federal government. When the state legislature approved the expansion in 2013, it required that the state achieve other savings and revenue to offset its share of expansion costs beginning in 2017[2] — or Michigan would end the expansion.

An important factor that may