Barriers to Providing & Utilizing Mental Health & Substance Abuse Services under Medicare

Task Force on MH & SA, Older Adults Working Group
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What will be covered:

1. Historical perspective re mental health care under Medicare
2. Current Medicare reimbursement rates
3. Barriers to being a mental health provider under Medicare
4. Intrinsic and extrinsic barriers by older adults to receive mental health tx
5. Trends/future directions to reduce or lower barriers

Medicare facts

- Medicare is the largest insurance plan
- Longevity: began 50 years ago (1965)
- Becoming a provider is relatively easy; e.g., can become a provider immediately after licensure, but application may be complicated.
- Sets the gold standard in the industry
- Benchmark for all commercial carriers, workers' compensation, & forensic applications.

Historical Perspective for Mental Health

- **OBRA (1987) included psychologists as independent providers but services were restricted to settings such as CMHCS.**

OBRA ’87 included the Nursing Home Reform Act requiring nursing homes to address psychosocial needs and behavioral problems of residents.

Historical Perspective for Mental Health

- From 1966 to 1988 Medicare paid no more than $250 per year for out-patient treatment of psychiatric disorders.

- 1988 Reimbursement for psychiatric treatment increased to $450 per year.

1990: A banner year for Mental Health (25 years later)!

- Because of OBRA 1989, in January 1990 the dollar cap on out-patient psychiatric services was eliminated.

- Effective July 1990 direct payment to clinical psychologists and social workers was made available in most settings.

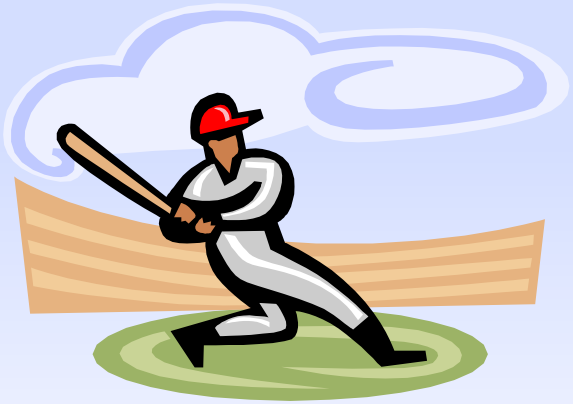
Medicare history

January 1991 clinical psychology services furnished to hospital patients were no longer bundled, allowing direct payment under Medicare Part B.

Historical perspective

Inclusion of psychology/social work as providers in Medicare catapulted behavioral health to Major League status in health care.

But the work value for mental health services was not yet determined!



Historical Perspective for Mental Health

1993: Psychology services were studied separately from psychiatric services for their "work value" through the RBRVS study conducted by Harvard economist, Dr. William Hsiao.

Medicare fact: Reimbursement rates are based upon a conversion factor plus:

1. Relative value units (RVUs)

2. Expense of malpractice insurance

3. Overhead costs

Formula for MC fees: Resource-Based Relative Value Scale

Work value for clinical procedures are based upon:

1. Technical skills and physical effort
2. Mental effort and judgment
3. Stress associated with risk to the patient or others.

RVUs are evaluated periodically with info posted in the Federal Register in mid November.

Forces impacting Medicare reimbursement

- National economic and political factors.
- Feedback from providers and specialty groups.
- Periodic examination of work values change the reimbursement of clinical services.

Congress allocates a pot of money to pay for estimated MC services.

Medicare reimbursement facts

Congress mandates budget neutrality:

- When the value of one services goes up, others decrease in monetary value to maintain the budget.
- The Relative Update Committee (RUC) advises CMS re RVUs of each

service on a periodic basis.

2015 Medicare reimbursement rates for mental health services

	CGS Ohio * Total includes 20% pd by pt Total allowed	Palmetto NC* Total includes 20% pd by pt Total allowed	OH AETNA MEDICARE Cp = co-pay Ins + Cp = Total	OH ANTHEM MEDICARE * Actual claims submitted. Co-pays differ by policy Ins + Cp = Total	OH HUMANA * Same rate as CGS MC Deductibles vary. Co-pays range from 4%-40% Total allowed
90791	130.17	129.61	80 + 25cp = 105	91.48 + 15 c-p = 106.48	130.17
90834	84.23	83.88	55 + 25 cp = 80	28.79 + 40 c-p = 68.79	84.23
90837	126.54	125.93	55 + 25 cp = 80	125.91 no cp	126.54
90839	132.20	131.61			132.20
90840	63.27	62.97			63.27
90853	25.54	25.43	18 + 25 cp = 43		25.54
96116	92.18	91.65	55 + 25 cp = 80	71.91 + 18.34 cp = 90.25	92.18
96118	96.03	95.90	55 + 25 cp= 80	76.44 no cp	96.03
96119	76.88	77.46	55 + 25 cp = 80		76.88

*Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, incur a **2 percent reduction** in Medicare payment.

The claims payment adjustment shall be applied to all claims **after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. From** www.cms.gov/apps/physician-feeschedule/ **1/5/2016**

Medicare Reimbursement for mental health services in NC: Comparisons of 2015 to 2016

CPT CODE	2015 Rate	2016 Rate	Difference
90791	128.96	129.28	+.33 or +.25%
90792	144.32	143.62	-.70 or -.5%
90832	62.99	63.11	+.12 or +.2%
90834	83.47	83.91	+.44 or +.5%
90837	125.31	125.84	+.53 or +.4%
90839	130.95	131.49	+.54 or +.4%
96116	91.65	91.38	-.27 or -.3%
96118	95.90	96.22	+.32 or +.3%
96150	21.53	21.46	-.07 or -.3%
96151	20.47	20.41	-.06 or +.3%
96152	19.48	19.70	+.22 or +.1%

Medicare facts

- Medical Review Policy
  - National Policy Sets Overall Model
  - Local Coverage Determination (LCD) Sets Local/Regional Policy (Palmetto is Medicare carrier in NC)
    - More restrictive than national policy (e.g., "incident to" policies differ by LCD)
    - Overrides national policy
    - Changes frequently

Physician Quality Reporting System (PQRS): Most powerful trend yet in shaping clinical practice patterns.

PQRS is part of a broad initiative in Medicare brought about by both the government and private payers aimed at advancing quality and efficiency in health care.

It began in 2007 as a financially incentivized, voluntary program open to physicians and to eligible professionals (in 2008) who successfully report quality measures linked to clinical services.

Origins of PQRS—2006

- The Institute of Medicine (IOM)called for variable physician payments based on quality, rather than financially rewarding only quantity of services.
- *PQRS is window to P-4-P (pay for performance)*
- A major trigger for trend for P-4-P is the growth in Medicare and its projected effect on U.S. economy over a 40 year span.

(In report to Congress by health economist,
Jim Hahn, December 2006)

Psychologists and Social workers became involved in PQRS through the first Expert Work Group 2007

- Paula Hartman-Stein, Ph.D. Chair
- Craig Piso, Ph.D. Participant
- Mirean Coleman, MSW Participant

Plus: Staff of Quality Insights of PA (QIP)

- Mental health providers became eligible for a financial bonus in 2008.

Financial consequences of PQRS

- In 2015 the 1st non-compliance "payment adjustment" (aka penalty) occurred.
- Eligible Professionals who did not participate in 2013 PQRS were subject to a payment adjustment of -1.5% of their Medicare Physician Fee Schedule allowed charges in 2015 REGARDLESS OF THEIR PARTICIPATION IN 2014 AND 2015.
- For not participating in 2014 a 2.0% reduction will be applied to patients seen in 2016.

2016 PQRS measures for mental health using claims-based reporting

- Domain: Patient safety
  - Current meds
  - Elder abuse screen & follow up
- Domain: Community/pop health
  - Tobacco screen & intervention
  - Depression Screen & follow up
  - BMI screen & follow up
- Domain: Communication & Care Coordination
  - Pain Assessment & follow-up

Barrier for providers: Audit anxiety

- Most MC providers will be audited.
- Private payers audit too.
- Insurers use anti-fraud software for "pattern recognition".
- 7/1/11: Predictive statistical modeling system contract to identify high risk claims awarded to Northrop Grumman Corporation

Audits examine "Medical Necessity"

A service "that a prudent provider of practice would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is in accordance with medical practice, clinically appropriate in terms of type, frequency, site, and duration, and not primarily for the convenience of the patient or provider."

Personal communication with James Georgoulakis (2006)

Audit anxiety

- Audits can result in demands for payback
- Penalties of $12,500 per claim plus triple damages
- Loss of Medicare provider status
- Fines under civil law
- Incarceration under criminal law

Typically Not Meeting Criteria for Medical Necessity by mental health providers

- Screening/fishing expeditions (now required in PQRS)
- Regularly scheduled/interval based evaluations
- Repeated evaluations without documented and valid specific purpose

Why become a Medicare provider?

1. Most OAs use their Medicare benefits
2. 10,000 people a day turn 65!
3. Refusal to accept MC patients can result in a discrimination lawsuit.
4. Physician Compare website advertises your participation.
5. Learning MC rules helps to pass audits of other third party payers.

Barriers for mental health providers

Based on an informal poll of psychologists (not in a ranked order):

1. **Privatization of Medicare** (i.e., Medicare Advantage Plans)
   - Lower fees
   - Pre-authorizations, restrictions
   - Paperwork, paperwork
2. **Audit anxieties**, not sure how to document medical necessity.

Barriers for mental health providers

3. **PQRS**: lack of knowledge/understanding of reasons to participate, relevance of the measures, extra time/work, not seeing how it relates to mental health, seeing it as intrusive, overly complex for small practices; resentment about Registry reporting costs.

4. **Complexity & communication issues**: "Complicated claims, difficulty accessing info, and lack of helpfulness when there is a problem such as a claim rejection." Difficulty keeping up with Medicare rules, changes. Complaints about Mental Health changes embedded within med/surg info.

Barriers for mental health providers

5. Restrictions by regional carriers re "incident to" services
6. Restrictions re which disciplines can be Medicare providers
7. Lack of training/competence in gero field.

Barriers for mental health providers

8. Lack of training/reduced comfort re how to work in integrated primary care settings, e.g., relatively few inter-professional educational opportunities

Barriers for Older Adults to receive mental health services

Intrinsic and extrinsic barriers

1. Belief about inability to find a therapist who understands their problems
2. Insurance & payment concerns
3. Help seeking attitudes
4. Belief that depressive sx are normal
5. Concerns about therapist's qualification

Barriers for Older Adults

6. Lack of knowledge and fear of psychotherapy
7. Transportation concerns
8. Physician referral issues
9. Stigma
10. Ageism (belief therapist would see tx as a waste of time due to pt's age)

Pepin, Segal & Coolidge, 2009

Trends & future directions

- Integration of MH in primary care: Example: http://www.apa.org/health/psychologists-integrated-care.aspx

- Telehealth: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

Trends & future directions

- Bring the care to the patient through existing services; e.g., Healthy IDEAS; co-locating services in senior centers
- Encourage dissemination of wellness clubs in the community; e.g., Elder Club in Asheville's Jewish Family Services; MEMO Club™ in Kent, OH
- Sponsor educational programs for the community within LTC settings, churches, senior centers, etc

Wellness Clubs for Older Adults

Venues such as senior centers or behavioral health practices can fill the gap for some older adults by providing high quality programs that stimulate thinking, support memory skills, brighten mood and foster friendships.

Provider barrier solutions

- Encourage PQRS and Medicare compliance training seminars in conjunction with regional Medicare carrier.

- Develop inter-professional geriatric training opportunities in Federally Qualified Health Centers (possible?)

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