

Mental Health Services in RHCs

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Muskie School of Public Service

Maine Rural Health Research Center



Learning Objectives

- Describe Rural Health Clinics (RHCs) offering mental health (MH) services
- Understand barriers to delivery of MH services by RHCs
- Explore clinical, administrative, and financial issues related to MH services
- Provide information that can be used by RHCs to develop MH services

History

- P.L. 95-210 established the Rural Health Clinic Program in 1977
- Goal: Increase primary care access for rural Medicare & Medicaid patients
- Subsequent legislation added MH services provided by doctoral-level psychologists and clinical social workers as part of the RHC benefit

Coverage Issues

- MH services provided by physicians, mid-level, doctoral-level psychologists, and clinical social workers are part of the RHC benefit
- MH services, as part of the RHC benefit, are covered under the cost-based per-visit rate paid to RHCs
- All other billing standards that apply to the reimbursement of MH services by Medicare apply
- Medicaid and commercial insurance reimbursement policies vary by state and carrier

Medicare Outpatient Payment Limitation

- Expenses incurred in connection with mental, psychoneurotic, and personality disorders subject to 62.5% payment limitation (Phasing out by 2014)
- Charges for diagnostic services (90801) not subject to limitation
- Beneficiary responsible for 37.5% of the all-inclusive rate for applicable services as well as co-insurance and any unmet deductible based on the remaining 62.5% of reasonable charges

Billing Issues

- Medicare MH services subject to outpatient payment limitations are billed under revenue code 0900
- Medicare MH services **not** subject to outpatient MH treatment limitations are bundled into line items using revenue code 052x
- Other carriers must use proper CPT codes
 - Psychiatric codes, health and behavioral assessment

Coding Issues

- Become familiar with all coding systems
- Diagnostic codes
 - DSM-IV – Diagnostic and Statistical Manual of Mental Disorders, 4th ed.
 - ICD-9
- Procedure codes – driven by services and patient need
 - Psychiatric codes
 - Evaluation and management codes
 - Health and behavioral assessment codes

Data and Methodology

- 2005-2006 Medicare Hospital Cost Reports
- 2005-2006 Independent RHC Cost Reports
- Rural Urban Commuting Area Codes, Zip Code Approximation File
- CMS Provider of Services File
- Interviews with RHC administrators and staff

Independent RHCs with MH Services

- Slightly less than 6% (62 out of 1,177)
- Located in 19 states with California (17), Illinois (9), and Missouri (16) having the greatest number
- 28 employ psychologists (mean 0.4 FTE, range 0.01-1.06) with mean visits per year of 583
- 48 employ clinical social workers (mean 0.55 FTE, range of 0.2-2.0) with mean visits per year of 670

Provider-Based With MH Services

- 2% (28 out of 1,349) of provider-based RHCS
- Located in 8 states with California (7), Indiana (3), New Hampshire (3), Missouri (16), and Washington (4) having the greatest number
- 7 employ psychologists (mean 0.36 FTE, range 0.02-0.74) with mean visits per year of 290
- 23 employ clinical social workers (mean 0.74 FTE, range of 0.28-2.34) with mean visits per year of 871

Overview of RHC MH Services

- Length of time providing MH services
 - 4 to 6 years was common, some as long as 11-12 years
- MH service developed in response to identified local needs, usually by an internal “champion”
- Recognition that primary care problems are often rooted in MH issues
- 38% report that MH services are not profitable

Challenges and Staffing Patterns

- Challenges to developing MH service
 - Enrolling providers in Medicare, Medicaid, commercial insurances, managed care
 - Hiring the right type of MH clinicians
- Staffing patterns
 - Low end, part-time clinician, on-site 1 day per week
 - High end, 5 FTE providers (10 contractors), psychiatrist on-site 2 days per week

Compensation and Access

- Compensation methodologies
 - Various methods including independent contractors, flat salary, hourly rate, percentage of fees generated
- Access
 - Most do not limit access to MH services to existing patients and accept new patients
 - Waiting times for new patient and follow-up appointments did not seem to be excessive
 - MH providers generally see patients from all age groups

MH Screening Process

- MH screening process varied across RHCs
- Many based referrals to MH services on PCP assessment but did not routinely screen all patients
- Use of formal screening tools not as common as expected
- Relatively few screened all patients, those that did used a formal screening tool such as the PHQ-9

Diagnoses and External Referrals

- Common diagnoses
 - Depression, ADHD/ADD, anxiety are most common
 - Others include substance abuse, adjustment disorders, family crisis, post-traumatic stress, bipolar disorders, and schizophrenia
- Referral to specialized MH services
 - Frequently a problem
 - Children's services and psychiatric consults are difficult
 - Long waiting lists are an issue

Reimbursement Challenges

- Collecting Medicare co-pays and deductibles
- Medicaid managed care and limitations on the number of allowable visits
- Commercial insurer limitations on MH benefits, use of managed care and limited provider panels
- Most cover MH services under charity care policies
- One RHC obtained a separate state MH license to obtain better Medicaid reimbursement

Quality Management

- Most have an internal process with MH providers participating in regular quality management meetings
- Primary care and MH staff providers work closely together to review cases
- Surprisingly, the need to arrange for MH-specific supervision was not raised as an issue. This might have been different if MH clinicians were interviewed.

Integration Activities

- More accurately described as co-located services rather than fully integrated
- Good cooperation between providers
- Most maintain separate patient records
- Separate treatment space is not uncommon
- Most commonly integrated activities are scheduling and billing, which are handled by the same staff as primary care services

Conclusions

- Comparatively few RHCs provide MH services
 - No systematic effort to encourage them to do so
- Services evolve based on local needs
- Internal champion is key
- Little practical information available to assist RHCs in developing services
- RHC program lacks policy leverage to encourage more to offer service

Recommendations

- Develop resources and tools to encourage RHCs to develop MH services
- Develop RHC mental health toolkit
- Include MH services as one of the tests of an essential community provider for RHCs at risk of losing their designation due to changes in their shortage area designation or rurality

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