Improving Community Based Mental Health Services for Elders in Massachusetts

Reimbursement Mechanisms for Mental Health Services: Barriers and Opportunities

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I. Executive Summary

Background

This report reviews the financial and reimbursement mechanisms that facilitate or serve as barriers to the delivery of community-based mental health services to elders in Massachusetts. The report is one deliverable of a comprehensive study of elder mental health currently underway as part of a collaboration between the Executive Office of Elder Affairs and the University of Massachusetts Medical School/Commonwealth Medicine.

Methodology

Two methods of investigation were employed for this report. The first method was a review of coverage and reimbursement mechanisms of three payers of elder mental health services in the Commonwealth of Massachusetts: Medicare, Massachusetts Medicaid (“MassHealth”), and Blue Cross Blue Shield of Massachusetts’ HMO Blue (“HMO Blue”).

The second method utilized qualitative interviews with a sample of 16 key informants (all mental health service providers) across a wide range of settings to obtain providers’ perceptions of barriers and opportunities for the financing of mental health services for elders. Interviews were conducted with clinical, management and financial staff from a variety of professional disciplines that deliver health care in home health, primary care, community mental health and community health centers, skilled nursing facilities, assisted living, acute care and psychiatric hospitals.

Coverage and Reimbursement Review

The review of Medicare, MassHealth and HMO Blue coverage and reimbursement mechanisms for community mental health services provided comparative information regarding service settings; details about mental health benefits coverage and limitations; methods for reimbursing for mental health services; and reimbursement limits and cost sharing for the three main providers of mental health benefits in the Commonwealth. Barriers and opportunities within existing coverage and reimbursement policies provide context for analysis of the provider interviews.

Mental Health Provider Interviews

Key themes that emerged from the interviews included issues with regard to access, reimbursement and administration. Access issues included workforce barriers; challenges in providing geriatric mental health care in home-based settings; lack of parity of outpatient mental health services with other benefits; and barriers regarding primary care physician offices where elders receive much of their health care. Reimbursement issues identified by interviewees included: low reimbursement rates for Medicare with regard to mental health; the impact of this low rate on service quality; and
frustrations with services that are not reimbursed at all in certain settings or for certain providers. Administrative barriers identified included: complex and confusing billing policies, problems with provider networks, and prior authorization issues.

**Conclusion and Recommendations**

The three payers reviewed in this report provide a range of mental health services but barriers to access, reimbursement and administration of benefits impede delivery of mental health care to elders. Several key ways to improve the current system are identified:

- increase reimbursement for mental health services provided to individuals dually eligible for Medicare and MassHealth
- allow for parity of coverage and reimbursement between medical and mental health benefits
- broaden reimbursement to more types of qualified mental health practitioners (e.g., social workers)
- improve coordination of care by providing reimbursable telephone consultation services so that primary care physicians have greater access to geriatric psychiatric expertise
- reduce transportation barriers to elders seeking mental health services
- develop better administrative and billing practices that are more consistent between payers and more clearly communicated to various components of the service delivery system.
II. Introduction

The Executive Office of Elder Affairs, in collaboration with the University of Massachusetts Medical School/Commonwealth Medicine is engaged in a comprehensive effort to improve the delivery of community-based mental health services to elders in the Commonwealth. The resulting research project, which extends through June 2009, consists of four components which investigate the following research areas:

1) Prevalence of mental health conditions (including substance abuse) and physical co-morbidities in the MA elder population;

2) Types of health services received by this population, and the settings in which these services are delivered;

3) Effective practices and promising models for delivering community-based mental health services to older adults; and

4) Financing and reimbursement mechanisms for mental health services for older adults.

This report addresses Component 4 of the project. Focusing on the three major payers for mental health service delivery in the Commonwealth, it reviews the financial and reimbursement mechanisms at the state and federal level for these three payers that facilitate or serve as barriers to mental health treatment for older adults. The report also presents findings from qualitative interviews with key informants regarding their experiences with these financing mechanisms. Findings from this paper are expected to help inform the Massachusetts Executive Office of Elder Affairs as it seeks to improve mental health services for older adults in the Commonwealth.
III. Background

The well documented explosion in the number and proportion of people aged 65 and over in the United States is expected to continue well into the 21st century, increasing from 20 million individuals in 1970 to an estimated 69.4 million people aged 65 and over in the year 2030 (Day, 1996; Hobbs & Damon, 1996). An increase in the number of older people with mental illness is also expected; over the next 25 years the number of older adults with major mental disorders is expected to more than double, from 7 million to 15 million older adults (Jeste et al., 1999). Currently more than one in four older adults has a significant mental disorder (Jeste et al., 1999). Among the most common mental health problems in older adults are depression, anxiety disorders and dementia (Narrow et al., 2002). Mental disorders in older persons are often accompanied by significant disability and impairment in functioning, decreased quality of life, increased caregiver stress, higher mortality and poor health outcomes (U.S. Department of Health and Human Services, 1999). Older adults with mental health problems also have higher utilization and costs for health care services (Luber, 2001).

Mental health insurance benefits have traditionally been more restricted and heavily managed than other medical benefits and most insurance plans have not covered providers’ costs for such essential services as screening and care management (Unutzer et al., 2006). Historically, Medicare and other insurers have reimbursed providers of mental health services at lower rates than for coverage of somatic illnesses (Harris et al., 2006), creating an overwhelming financial barrier for many older adults seeking treatment for mental health conditions.

Probably the largest single financial barrier is the lack of parity for payment of mental health benefits under Medicare; while treatment for physical health conditions is covered at 80%, mental health treatment is only covered at 50%. The Medicare Payment Advisory Council (MedPac) recommended to Congress in 2002 that the outpatient mental health coinsurance be made equal to Medicare’s coinsurance for other outpatient services. MedPac’s analysis showed that the high coinsurance was a financial and access barrier to care (MedPac, 2002). The Substance Abuse and Mental Health Services Administration reports that approximately 14% of Medicare beneficiaries have no supplemental insurance and pay out-of-pocket for the Medicare mental health benefit coinsurance and deductibles (U.S. Department of Health Human Services, 2005).

Recent legislative efforts may improve mental health parity at the national level, at least for commercial group plans. Pending legislation would prohibit group health plans from imposing treatment or financial limitations on mental health benefits that are different from those applied to medical/surgical services. A mental health parity bill passed the U.S. Senate in September 2007 (S. 558, 2008). In March 2008, an even more expansive parity bill passed the House of Representatives (H.R. 1424, 2008). Efforts are underway in the current session of Congress to reconcile the two bills, with advocacy groups pushing hard for this legislation (Bazelon Center for Mental Health Law, 2008; Mental Health Liaison Group, 2008).
In addition to coverage limitations and lack of parity, there is a shortage of geriatric psychiatrists and other geriatric mental health professionals available to handle the growing older population with mental health needs (Jeste et al., 1999). Nationally, in 1999, there were 2,425 board-certified geriatric psychiatrists in the US with a need of 5000 projected. In 2007, there were only 1,596 board-certified geriatric psychiatrists, as many did not recertify their specialty (Association of Directors of Geriatric Academic Programs, 2007). In Massachusetts, in 2007, out of the 2552 psychiatrists registered with the Massachusetts Board of Registration in Medicine, only 110 had identified geriatrics and psychiatry as a specialty (Massachusetts Board of Registration in Medicine, 2007). The shortage applies to psychiatric nurses as well. The Massachusetts Board of Registration in Nursing reported that there are approximately 1000 licensed advanced practice psychiatric nurses in the Commonwealth out of a total of 112,000 registered nurses (Massachusetts Board of Registration in Nursing, personal communication, 2007). This workforce shortage, while not a direct result of financing mechanisms, has a big effect on adequate access to mental health services for older adults.

Further limiting access to qualified mental health professionals, Medicare does not cover mental health counseling by licensed social workers. This has been an advocacy issue for the National Association of Social Workers (NASW) for a number of years. Medicare’s rationale is that this is covered in the Medicare rate; however, the position of NASW has been that minimal social work services are covered in the rate but ongoing mental health counseling is not. Attempts to change the policy have been included in Medicare reform legislation over a number of the years. Most recently it was included in the Children’s Health and Medicare Protection Act of 2007 (H.R. 976, 2007) which was vetoed by the President.

The goal of this paper is to identify the financial barriers to mental health treatment that are present in current state and federal policies and to offer recommendations regarding ways to improve the insurance reimbursement and payment mechanisms for older adults with mental health conditions.
IV. Methodology

Two research methods were used in this study to investigate the financial and reimbursement mechanisms that facilitate or serve as barriers to the delivery of community mental health services for Massachusetts elders.

The first method was a comprehensive policy review of Medicare, MassHealth and one large private insurer’s reimbursement policies to identify coverage gaps and options for mental health services for elders. The review included analysis of co-payments and deductibles, clinical criteria and limitations, identification of health care personnel covered, and pharmacy requirements for the 3 payers named above.

The Medicare policy review focused on the fee-for-service mental health benefit that is available under Medicare Part B. The review of MassHealth coverage and reimbursement policies also focused on the fee-for-service benefit because MassHealth’s mandatory managed care program does not allow individuals age 65 or older to enroll. Therefore, elders on MassHealth receive any mental health benefits through the fee-for-service system. HMO Blue (provided by Blue Cross Blue Shield of Massachusetts) was selected as the private insurer for this review because of the high utilization of mental health services by its older members; in the first quarter of 2007, HMO Blue reported the most inpatient mental health discharges per 1000 members over the age of 65 (Office of Consumer Affairs and Business Regulation, 2007).

The second method for this study employed qualitative interviews with a sample of Massachusetts providers in a variety of service settings to discover providers’ experiences regarding regulatory, operational and administrative barriers and solutions to the financing of mental health services for older adults. A total of sixteen interviews were conducted with clinical, management and financial staff for mental health providers that deliver care in home health, primary care, community mental health and community health centers, skilled nursing facilities, assisted living, acute care and psychiatric hospitals. The disciplines of the persons interviewed included psychiatrist, primary care physician, psychiatric nurse, clinical social worker, physician assistant, and administrator.

An Interview Guide for the qualitative interviews was developed by the project team which consisted of members from the Center for Health Care Financing, the Center for Health Policy and Research, the Division of Geriatric Medicine, the Division of Family and Community Medicine and the Central Massachusetts Area Health Education Center. Based on the central research question for this component of the study, the Interview Guide consisted of 14 questions organized around the themes identified in the literature as key to the financing of mental health services. These themes were: access to benefits, reimbursement mechanisms, and administrative issues. A copy of the Interview Guide is provided as Appendix A.
The project team developed a list of potential interviewees who would represent a cross-section of mental health providers in the state of Massachusetts. The interviews were intended to provide qualitative data regarding the experiences of providers who dealt regularly with the barriers and opportunities inherent in the current mental health financing system. The convenience sample was chosen through recommendations from project team members as well as from the recommendations of geriatric mental health specialists at UMass Medical School and other geriatric service providers. The list included geriatricians, primary care providers, and community-based mental health professionals in Massachusetts. A de-identified list of the 16 interviewees is provided as Appendix B.

Interviews each lasted about 60 minutes and were conducted either in person or by telephone. Interviews were tape-recorded and transcribed for the qualitative analysis. We used an established approach developed for qualitative analysis (LaPelle, 2004). This process involves using content and thematic analyses to extract emergent categories of responses, and to identify and count the frequency of instances of categorically-consistent responses and recurring themes within domains established by the interview guide questions.

Study limitations

The qualitative, exploratory nature of our interviews with key informants made a convenience sample an appropriate sampling methodology, but this does limit the generalizability of the findings from the interviews. The views of the 16 key informants are not meant to be representative of all providers across the state. We relied on published documentation from the Centers for Medicare and Medicaid Services MassHealth, and Blue Cross Blue Shield of Massachusetts to summarize financing and reimbursement mechanisms. No attempt was made to correct any inaccuracies or incomplete information contained in these publications.
V. Coverage and Reimbursement Review: Medicare, MassHealth and HMO Blue

This section of the report provides a review of the major payment mechanisms through which mental health services are provided for the Massachusetts elder population: Medicare, MassHealth and Blue Cross Blue Shield’s HMO Blue. The purpose of this review is twofold: 1) to outline the current payment and reimbursement mechanisms through which mental health services are provided to elders in community settings; and 2) to determine opportunities that might be leveraged or barriers that might be removed in order to improve access and coverage for mental health services to elders in Massachusetts.

Key information for each of the three insurance payers is displayed in the four tables on the following pages. The objective of these tables is to outline the benefits for which elders are eligible in community settings and the reimbursement mechanisms through which these are financed, in order to compare across the three payers.

Table 1 details the community settings in which mental health services are covered for the three payers studied in this report, and lists the types of practitioners eligible for direct payment for mental health services in these community settings. We do not discuss information about services provided in institutional settings (e.g., nursing facilities) because that is not the focus of our study. All three payers (Medicare Part B, MassHealth and HMO Blue) cover outpatient mental health services in the physician’s office, outpatient hospitals, community health centers (CHCs) and community mental health centers (CMHCs). Medicare and MassHealth also cover mental health services provided in the individual’s home, but HMO Blue does not.

With regard to the specific settings where practitioners can provide services, this varies across the three payers. Physicians and clinical psychologists can provide services in all outpatient settings. Licensed clinical social workers (LCSWs) can provide services in all outpatient settings under Medicare and HMO Blue, but under MassHealth, LCSWs can only provide services in outpatient hospitals, MHCs and CMHCs. MassHealth and Medicare home health benefits cover psychiatric nursing under skilled nursing. Both payers have specific eligibility requirements in order for an elder to be approved for home health services. Medicare beneficiaries must meet Medicare’s homebound requirement in order to meet the eligibility requirement.

Table 2 specifies the mental health benefits covered and coverage limitations for the three providers studied in this report. All three payers cover diagnostic interviews, psychotherapy (individual, family and group), electro-convulsive therapy and neuropsychiatric testing. MassHealth also covers adult day health, home visits, after-hours telephone service and psychiatric day treatment. Medicare and HMO Blue cover medication management, while MassHealth does not. All three payers list benefit limitations that vary quite specifically by provider type. HMO Blue limits members to 24 visits per calendar year for outpatient benefits, although the provider may request additional visits.
Table 3 details the methods of reimbursement to providers for mental health services in community settings. For independent practitioners, all three payers have a fee schedule based on the type of practitioner (e.g., Medicare pays 100% for a psychiatrist/psychologist, and 75% for a clinical social worker.) Medicare has an all inclusive rate per covered visit for community health centers, while MassHealth rates are based on the maximum allowable fee listed in the DHCFP fee schedule. HMO Blue reimburses providers based on a contractual rate depending on the licensure of the servicing provider.

Table 4 lists reimbursement limits and cost sharing for the three providers. Under Medicare, beneficiaries are liable for 50% of the fee for mental health services, a widely criticized feature of Medicare that, as noted above, is currently the subject of federal parity legislation. MassHealth has very specific limits on each service and setting. HMO Blue requires co-payments that range from $10 - $25 depending on the plan. HMO Blue covers a wide variety of outpatient mental health services. The services are required under the Massachusetts Mental Health Parity Act, which stipulates that mental health benefits be on a par with the medical benefit. None of the payers reimburses for evaluation and management (E/M) services; psychologists and social workers cannot bill for codes with an E/M component (American Psychological Association, 2007). MassHealth is the only one of the three payers that has no member cost sharing for mental health services.
### Table 1

**Mental Health Services: Settings and Practitioners Covered**

<table>
<thead>
<tr>
<th>Setting/Practitioner</th>
<th>Medicare Part B¹</th>
<th>MassHealth²</th>
<th>HMO Blue³</th>
</tr>
</thead>
</table>
| **Outpatient services are covered in the following settings** | • Office  
• Patient’s home  
• Group home  
• Urgent care  
• Outpatient hospital  
• Custodial care facility (nursing home)  
• Independent clinic  
• Community mental health center  
• Community health center  
• Comprehensive outpatient rehabilitation facility (CORF) | • Office  
• Outpatient hospital  
• Nursing Facility  
• Mental health center  
• Community health center  
• Patient’s home | • Office  
• Group practice  
• Residential facility (nursing home, assisted living)  
• Outpatient hospital  
• Community mental health center  
• Community health center |

| **Practitioner Disciplines in Community Settings** | Practitioners eligible to receive direct payment and provide services in all outpatient settings:  
• Physicians (Psychiatrists)  
• Clinical psychologists  
• Clinical social workers  
• Clinical nurse specialists  
• Nurse practitioners  
• Physician assistants. | Practitioners eligible to directly receive reimbursement for mental health services include:  
• Physicians (Psychiatrists)  
• Clinical psychologists  
• Psychiatric nurse  
• Mental health counselor | Practitioners that are eligible to receive direct payment for and are eligible to provide services in all outpatient settings:  
• Psychiatrists  
• Psychologists  
• Licensed independent clinical social workers  
• Certified clinical specialists in psychiatric and mental health nursing, and  
• Licensed mental health counselors. |

¹ Unless otherwise cited, the information for Medicare in the tables may be referenced to: Centers for Medicare & Medicaid Services. Medicare Part B: Mental Health Services. Washington: NHIC Corp. Publication, October 2006.

² Unless otherwise cited, information for MassHealth may be referenced to: MassHealth Provider Regulations, 130 CMR 405,410,415,429,434,450.

³ Unless otherwise cited, information for HMO Blue may be referenced to: Blue Cross Blue Shield of Massachusetts, Facility Blue Book – 2007.
### Table 2

**Mental Health Benefits Covered and Coverage Limitations**

<table>
<thead>
<tr>
<th>Benefits/Limitations</th>
<th>Medicare Part B</th>
<th>MassHealth</th>
<th>HMO Blue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits Covered</strong></td>
<td>• Psychiatric diagnostic interview, psychotherapy, family and group psychotherapy, psychoanalysis, medication management, electroconvulsive therapy, central nervous system assessment/tests, health and behavior assessment and intervention.</td>
<td>• Diagnostic services, long and short-term therapy, individual, family, couple, and group therapy, medication review, case and family consultation, crisis intervention/emergency services, electroconvulsive therapy, hospital inpatient visit, and after hours telephone service.(^4)</td>
<td>• Psychiatric diagnostic interview, psychotherapy, family and group psychotherapy, medication management, electroconvulsive therapy, neuron-psychiatric testing, and behavioral health assessment.</td>
</tr>
<tr>
<td></td>
<td>• In addition the following services may be provided in outpatient hospital, mental health clinic, and community health center under certain circumstances:</td>
<td></td>
<td>• The member receives 24 visits per calendar year for the initial outpatient benefit.</td>
</tr>
<tr>
<td></td>
<td>• Psychological testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Psychiatric day treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Home visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adult day health program</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Outreach services to nursing facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benefit Limitations</strong></td>
<td>• Non-covered services include environmental intervention for medical management, geriatric day care programs, marriage counseling, and telephone consultations.</td>
<td>• Some limitations include: vocational rehab services, sheltered workshops, educational services, recreational services, street worker services, life enrichment services, non-medical services, research and experimental treatment, and referrals.</td>
<td>• 24 visits per year for biologically based mental illness.</td>
</tr>
<tr>
<td></td>
<td>• Complex patient evaluation must be done prior to therapy services. There should be one primary professional guiding each case and treatment plan for patients.</td>
<td>• Additional limits vary by setting and provider type.</td>
<td>• 8 visits per year for non-biologically based mental illness.</td>
</tr>
<tr>
<td></td>
<td>• Additional limits vary by setting and provider type.</td>
<td></td>
<td>• The provider may request additional visits.</td>
</tr>
</tbody>
</table>

## Table 3

### Mental Health Provider Reimbursement

<table>
<thead>
<tr>
<th>Method</th>
<th>Medicare Part B</th>
<th>MassHealth</th>
<th>HMO Blue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Practitioner</td>
<td>Based on physician fee schedule.</td>
<td>Based on the rates listed in the Division of Health Care Finance and Policy (DHCFP) fee schedule.</td>
<td>Based on a fee schedule for each practitioner</td>
</tr>
</tbody>
</table>
| Method                        | • 100% - Psychiatrist/psychologist  
• 85% - Physician assistant, nurse practitioner, and clinical nurse specialist.  
• 75% - Clinical social workers. | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a hospital specific episodic rate, called a payment amount per episode (PAPE). | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a contract negotiated discount amount. |
| Outpatient Hospital            | Professional charges are reimbursed as above.  
Facility charge is reimbursed under Medicare's Outpatient PPS.  
Payments are set by using ambulatory payment classifications which are HCPCS grouped by cost and clinical similarity.  
The rate is adjusted for area wages and geographic differences in prices.\(^5\) | Based on the rates listed in the Division of Health Care Finance and Policy (DHCFP) fee schedule. | Based on a fee schedule for each practitioner                                               |
| Reimbursement Method          | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a hospital specific episodic rate, called a payment amount per episode (PAPE). | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a contract negotiated discount amount. | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a contract negotiated discount amount. |
| Community Health Center       | An all inclusive rate per covered visit, called an encounter payment.  
The services are subject to maximum payment limit cap.  
On an annual basis, community health centers submit a cost report and costs are reconciled with payments.\(^6\) | The rates are the lowest of either the usual and customary fee, the actual charge submitted, or the maximum allowable fee listed in the DHCFP fee schedule. | Based on a contractual rate that pertains to the licensure of the servicing provider. |
| Reimbursement Method          | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a hospital specific episodic rate, called a payment amount per episode (PAPE). | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a contract negotiated discount amount. | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a contract negotiated discount amount. |
| Community Mental Health        | Based on physician fee schedule.                                                                   | The rates are the lowest of either the usual and customary fee, the actual charge submitted, or the maximum allowable fee listed in the DHCFP fee schedule. | Based on a contractual rate that pertains to the licensure of the servicing provider. |
| Center Reimbursement Method   | • 100% - Psychiatrist/psychologist  
• 85% - Physician assistant, nurse practitioner, and clinical nurse specialist.  
• 75% - Clinical social workers. | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a hospital specific episodic rate, called a payment amount per episode (PAPE). | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a contract negotiated discount amount. |
|                               |                                                                                                      | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a hospital specific episodic rate, called a payment amount per episode (PAPE). | • Professional charges are reimbursed as above.  
• The hospital facility reimbursement is a contract negotiated discount amount. |

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\(^5\) Medpac, Outpatient Hospital Services Payment System Payment Basics, September 2006.

### Table 4

#### Reimbursement Limits and Cost Sharing

<table>
<thead>
<tr>
<th>Limits/Cost Sharing</th>
<th>Medicare Part B</th>
<th>MassHealth</th>
<th>HMO Blue</th>
</tr>
</thead>
</table>
| **Reimbursement Limits** | • All providers receive 50% of the allowed amount on the fee schedule and must collect the remaining from the beneficiary.  
• Clinical psychologists and clinical social workers may not bill for CPT psychotherapy codes that include medical evaluation and management (E/M) services.  
• Clinical psychiatrists or clinical social workers may not bill for medication management. | • Specific limits on each service and setting are established. | • BCBSMA does not reimburse for therapy and diagnostic codes that have an evaluation and management (E/M) component for behavioral health providers. These codes have a higher rate of reimbursement than the codes representing the same service without the E/M component. |
| **Member Cost Sharing** | • When calculated, the member cost sharing amount is 50% of the allowed amount.  
• Medicare Part B deductible applies (Except when services are provided at the FQHC.) | • There is no member cost sharing for mental health services provided to MassHealth members. | • Co-payments range from $10-$25 depending on the HMO Blue plan. |

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VI. Findings from Mental Health Provider Interviews

Presented in this section are findings from interviews with a sample of 16 mental health providers in Massachusetts. Interviews were conducted in order to find out the experience of key informants with the payment mechanisms in the above review. Respondents included clinical, management and financial operations staff at different professional levels and across a variety of mental health provider settings. As noted above, we organized the questions in the Interview Guide around the general domains of access to benefits, reimbursement mechanisms and administrative issues. The interview findings discussed in the section are grouped by these three major topics as well. Within each topic, we have noted the specific themes that emerged from our analysis of the interviews.

A. Access Issues

The ability of patients and their health care providers to quickly and knowledgeably gain access to mental health services when needed was a key theme running through all of the interviews. The major barriers to access that emerged from the interviews are noted below.

1. Workforce barriers
   
   a. Shortage of mental health professionals

   The workforce shortage in geriatrics and geriatric psychiatry and its impact (as noted above in the Background section) were acknowledged by all 16 of the interviewees. The lack of an adequate geriatric workforce was characterized by one respondent as a “looming emergency” due to aging of the baby boom generation. All the respondents also pointed to the low reimbursement rate for mental health services as a primary reason for this workforce shortage. As one respondent noted:

   “Physicians need to refer patients to geriatric psychiatrists when the mental health issues go beyond their expertise. . . and there are not enough professionals who specialize in geriatric mental health. . . ”

   b. Lack of specialized training

   Several interviewees cited lack of workforce training in geriatric mental health as another barrier to access. Interviewees noted that physicians specializing in geriatrics receive some formal training in geriatric psychiatry because of the needs of the population that they serve, but the training is not adequate.
2. Home-based mental health services barriers

Several respondents noted that many elders served by community-based services have significant functional limitations that limit their ability to leave their homes to seek mental health treatment when they need it. Major themes that emerged regarding home health service barriers were:

   a. *Travel time for home visits by physicians is a barrier*

Several interviewees acknowledged that in-home visits by geriatric psychiatrists were essential in some cases, but noted the problem that travel time, which can be considerable, is not reimbursable by insurance. As one respondent noted:

   “If a clinician travels to someone’s home, it involves transportation and the time it takes to travel. This doesn’t fit the current reimbursement structure. When including travel time, a home visit takes approximately 2½ hours but only one hour of reimbursement is received.”

   b. *Medicare homebound requirement is a barrier*

Several interviewees cited Medicare’s homebound requirement as a barrier to mental health services for elders in the home. They noted that Medicare is unlikely to consider a beneficiary “homebound” based solely on a psychiatric diagnosis, which means that the individual must be considered “homebound” due to a physical condition first in order to receive any services for the mental health condition. Other respondents pointed out that for community-dwelling elders with psychiatric issues that are covered by Medicare, the home health agency often tries to involve them in the community as part of their treatment. This then jeopardizes their homebound status with Medicare.

   c. *Greater use of psychiatric nurses in home-based care is needed*

As several respondents noted, both MassHealth and Medicare home health benefits cover psychiatric nursing under skilled nursing in the home setting. Some home health agencies have hired psychiatric nurses to address the mental health needs of elders on their caseloads. Both payers have specific eligibility requirements in order for an elder to be approved for home health services. Respondents who mentioned the role of psychiatric nurses in home care all commented that more use of these professionals is needed. As one respondent noted: “There are a few VNAs in the Commonwealth that provide psychiatric services for MassHealth elders in the home. They are able to receive approval for services by justifying that their services are the least costly alternative.”

Another respondent mentioned that his practice utilizes on-staff nurse practitioners to make home visits to patients who have mental health conditions.
In the long run, noted one practitioner, sending psychiatric nurses into the home may cut down on emergency department visits.

3. Nursing facility barriers

   a. Social workers cannot bill for providing mental health services in SNFs

As noted in the policy review above, social workers who provide mental health services in a skilled nursing facility (SNF) cannot bill directly to Medicare, unlike a physician, psychiatrist or a psychologist. This Medicare policy was an important barrier identified by a number of those interviewed. Given the shortage of workforce for elders with mental health issues, it seemed illogical to the interviewees that Medicare would not cover an available and appropriate practitioner such as a nursing home social worker. As one respondent said: “A major part of the workforce (social workers) is eliminated from providing care. Psychiatrists and psychologists are the highest paid level of staff to provide mental health services and they are not easy to access.”

5. Primary care physician barriers

Many of the respondents noted that mental health issues often come to light during a visit with the elder’s primary care physician. One respondent summed up a common view echoed by several interviewees:

“The health care system is not set up for the primary care physician to address acute or chronic mental health issues for elders. A primary care physician sees patients for 15-minute visits. 15 minutes is insufficient to address the many medical concerns an elder may have in addition to a mental health concern. If the physician is interrupted with a 30-minute call about an elderly patient, the patients who have appointments have to wait. However, it is possible that the 30-minute call could have prevented an acute situation.”

Respondents noted several concerns regarding mental health diagnosis and treatment in the primary care setting. As one respondent noted, primary care physicians often treat elderly patients when they are in crisis, e.g., when the patient may be functioning poorly at home because of co-occurring physical illness and depression. Several respondents noted that not all primary care physicians are equipped to handle the unique aspects of geriatric patients with mental health issues, particularly if there is pharmacology involved. Respondents noted that primary care physicians have different comfort levels handling mental health issues especially those involving psychopharmacology. As one respondent said, “It is not uncommon for an elderly patient with mental health issues who is in crisis to be sent to the emergency room by a primary care physician who does not know what else to do.”
B. Reimbursement Issues

As noted in the policy review section above, there is lack of parity in reimbursement rates for mental health coverage by Medicare and the private insurer HMO Blue. All those who were interviewed for this report felt that the inequitable reimbursement rates created a tremendous barrier to obtaining mental health services, as well as impacting quality of service and willingness of practitioners to enter the field of geriatric mental health. The following themes regarding reimbursement were noted:

1. High cost of co-insurance for beneficiaries

Several respondents said that the 50% coinsurance for mental health benefits under Medicare is not only a barrier to a beneficiary obtaining or receiving care, but it also impacts the Medicare provider enrollment rates for mental health services because the low reimbursement creates a disincentive for participation by providers. One provider interviewed said his solution to the high co-insurance is not to bill the individual for their share of the coinsurance at all as it is likely that the patient would not continue treatment.

2. Low provider reimbursement rates

Several respondents noted the need for financial incentives to encourage practitioners to specialize in clinical geriatrics. The low Medicare and Medicaid reimbursement rate combined with greater complexity of many geriatric patient health situations affect practitioners’ income and create a disincentive to go into geriatric mental health. As one respondent said:

“[Outpatient medical] services for the elderly do not operate efficiently and the reimbursement does not take this into consideration. Treatment involves more support staff because of the work required between visits. There are more calls to families and pharmacies. Elderly patients cannot be rushed and often miss appointments. They may not have transportation or they may forget and come for the appointment on the wrong day.”

Some respondents noted that, for the relatively few psychiatrists who do treat geriatric patients, many prefer to provide care in the nursing home setting; although the Medicare and MassHealth reimbursement is still low, in a nursing home, several visits can be scheduled in a day and there are no missed appointments.
3. Reimbursement impact on quality of care

Respondents uniformly commented that the low reimbursement rates had an impact on quality. As one respondent put it: “As a result of low reimbursement rates, it may be difficult to find qualified practitioners. There may only be those persons who are willing to settle for a low wage.”

4. 2007 Medicare rate decrease for mental health services

Most of those interviewed discussed Medicare’s 2007 rate decrease as a further reimbursement problem. As one respondent noted: “Practitioners’ expenses are not going down. One can see why there would not be an increase but a 9% cut [from the earlier rate] is difficult to understand.”

5. Coordination with more than one payer

Another reimbursement issue mentioned frequently by respondents was that of secondary payers. As noted above, Medicare is the most common insurer for elders. However, due to gaps in Medicare coverage for mental health services, working with Medicare also involves the need to work with and submit claims to other insurers, such as Medicaid and the Medicare supplemental plans.

The respondents discussed the reimbursement issues associated with the secondary payers, noting that in some cases, beneficiaries are covered by MassHealth, Medicare, and commercial insurance. Coordination of benefits in this situation can be very challenging. As one respondent commented: “In some cases, the administrative work on behalf of the provider to bill multiple insurers takes so much time that the billing deadlines have passed and no reimbursement is available.”

C. Administrative Issues

1. Medicare and MassHealth Administrative Issues

   a. Billing

Respondents’ experiences with billing issues for Medicare and MassHealth varied widely, with some providers pleased with this aspect of administration and some not as pleased. Billing staff interviewed felt that Medicare and MassHealth policies were clear-cut. Independent clinicians who billed for their own services were very frustrated. It is likely that when billing is one’s primary job responsibility, there is the time and needed patience to gain experience and master the issues presented by these payers.

   b. Enrollment
A number of those interviewed felt the process for enrolling a mental health provider into Medicare and MassHealth was time-consuming and unnecessarily complicated. Problems with Medicare and MassHealth provider enrollment were noted by respondents. As one interviewee noted, to practice in a nursing home, the practitioner must indicate the specific facility where he or she will be providing care. As a contractor who consults with the nursing home, the practitioner may not be well known in the facility. This is a problem when Medicare calls and is unable to verify that the practitioner provides care in the facility. Another respondent had similar concerns with the MassHealth provider enrollment process. One provider’s experience was that there was no notification with regard to the approval of the application and there was no information about the program provided once the application was approved.

2. Commercial Insurance Administrative Issues

Blue Cross Blue Shield/HMO Blue policy was reviewed for this study. While many interviewees had experience billing services to HMO Blue, their responses tended to focus on commercial insurance coverage in general. In some circumstance, those interviewed discussed Medicare Advantage plans, Medicare supplement plans, or managed care plans in general. The findings discussed below, should thus be taken in the general context of commercial insurance rather than as representative only of HMO Blue.

   a. Billing

As noted in the policy review above, one problem with mental health reimbursement is that commercial insurers tend not to reimburse for the billing codes that contain the Evaluation/Management (E/M) component of the service. The E/M component consists of the medical decision-making such as prescription writing, medication management and physical observation. For a medical practitioner such as a psychiatrist, this can be an important part of caring for patients, but it is not possible to bill directly for these services. Similarly, there is lack of reimbursement for home psychiatric nursing under commercial insurance. Services provided by psychiatric nurses in home settings fall under the mental health benefit of the insurance plan rather than the home health benefit. The individual must then use up his or her limited outpatient mental health benefit rather than use the more extensive home health coverage in the plan.

   b. Enrollment and Networks

Several respondents noted that commercial insurance provider networks are often limited. As one respondent said: “Commercial insurers may list a large number of providers in their marketing materials. However, the marketing
materials do not indicate that many of the mental health providers are not accepting new patients and some may not have geriatric expertise.” Another interviewee pointed out that some commercial providers have contracted out mental health services to separate vendors with even more limited networks of providers.

One respondent commented that these limited mental health provider networks may result in dilemmas for the primary care physician. Said one respondent:

“There are circumstances in which the elderly patient is referred to a mental health provider who cannot prescribe medication. The elder’s primary care physician may then receive a call from the patient requesting psychotropic medication because it was recommended by the mental health provider. This results in a situation where the primary care provider must coordinate his patient’s care with an unknown mental health provider.”

c. Prior authorization for commercial plans

Several respondents noted the administrative burden presented by the prior authorization process in commercial plans. Said one interviewee:

“One insurer requires a letter from the primary care physician. This is difficult when working with patients in a nursing home because the attending physician in the facility may not be the same as the patient’s primary care physician in the community.”

Another respondent noted that the requirement of approval for a certain number of visits by commercial insurers creates an administrative burden on providers who must keep track of number of visits in order to be able to treat patients. Additionally, according to one respondent, if there are no allowed visits left, the provider may need to complete a treatment plan. This treatment plan may or may not be approved for additional visits.

Respondents noted that the prior approval process is much less burdensome on larger medical practices. For example, one mental health provider interviewed has a prior authorization team to assist with obtaining approval for services. This provider also has 2.5 FTEs that spend 100 hours per week focusing on obtaining payment for denied claims from commercial insurers.
VII. Conclusion and Recommendations

The current reimbursement mechanisms play an important role in access to and delivery of mental health services to elders in MA in the following ways:

- Low provider reimbursement rates have an impact on the number of available practitioners.
- High cost sharing for Medicare beneficiaries is a barrier to accessing outpatient services.
- The administrative burdens and network issues associated with commercial insurers impede access to care.

Based on our review of current reimbursement mechanisms across the three major payers for mental health services, our key informant interviews with mental health providers, and current literature, we offer the following recommendations to improve the current reimbursement and payment system.

**Medicare**

1. Work toward parity with regard to the coverage and the reimbursement of the medical and mental health benefits that are provided to elders in order to reduce the stigma, increase reimbursement and thereby increase access for mental health services. In Massachusetts, the Mental Health Parity Act only applies to commercial insurers. The lack of parity in Medicare mental health benefits continues to present a barrier for elders. As noted above, pending federal parity legislation, if enacted, could remove this key barrier.

2. In order to increase and maintain the availability of services, consider utilizing and reimbursing for all available qualified mental health practitioners where appropriate. For example, Medicare does not allow clinical social workers, unlike psychiatrists and psychologists, to bill directly for diagnosis and therapy services provided to SNF residents. This policy can prevent elders from accessing services they may need during their Medicare-covered stay.

**MassHealth**

3. Increase reimbursement for mental health services provided to individuals dually eligible for Medicare and MassHealth by increasing the secondary payment from MassHealth up to the Medicare allowed rate. (It is currently reimbursed up to the MassHealth allowed rate.) Medicare fees for outpatient services are higher than MassHealth fees.
4. Administrative and billing policies such as prior authorization need to be developed in a way that is not burdensome and does not delay or impede appropriate care. The policies need to be clearly communicated, and consistent among payers.

All Payers

5. Provide fair reimbursement for practitioners and providers in all disciplines and settings. Those interviewed mentioned that an ideal reimbursement structure would need to consider all the components of providing mental health services to elders. This includes the additional time of actually providing the care, coordinating the care, working with family members and possible travel time to an elder’s home. Addressing these considerations is more likely to attract a workforce of providers willing to spend their careers working with this population. It is important to note that reimbursement mechanisms must also contain incentives to ensure the provider’s efficient delivery of the services.

6. The visit with a primary care physician is often where elders’ mental health issues come to light. Therefore, primary care physicians need to more easily consult with mental health practitioners that are familiar with the complex medical and social issues elders may be facing. The Massachusetts Behavioral Health Partnership’s policy of reimbursing telephonic consultations to improve coordination of care could expand access to care if covered by all payers. Also, increased coordination and communication with the elder’s multiple caregivers including the primary care physician may prevent or delay a potential crisis.

7. Reimbursement for mental health services needs to include the home setting. Due to issues of mobility or transportation, many elders need mental health services to be provided in their home. Rates must be adequate to cover transportation costs and time if this is to be a viable option.

This review of the financial and reimbursement mechanisms that facilitate or impede the delivery of community-based mental health services to elders has highlighted a variety of problems with access, reimbursement and administration of benefits. The key informant interviews reinforced the fact that the current reimbursement mechanisms do not always support keeping elders in a community setting. Benefits are available; however, there are barriers to accessing mental health services. Addressing the above barriers to the extent possible would improve access to mental health services for elders in Massachusetts.
Appendix A

Interview Guide

Project Question: What are the financial and reimbursement mechanisms that facilitate or serve as barriers for elders to receive behavioral health services?

General Background
1. Can you describe your current and/or past role as it relates to elder mental health services?

Billing / Claims Processing
2. Do you have experience billing any of the following:
   a. Medicare
   b. Medicaid
   c. BCBS HMO Blue

Reimbursement
3. What is your impression of elder mental health service reimbursement for Medicare, Medicaid and BCBS HMO Blue
   a. Is payment timely?
   b. What percentage of claims submitted actually get paid?
   c. Is there the ability to appeal denied claims?

4. Do you provide mental health services for elders that are not reimbursed?

5. How do reimbursement issues impact the treatment plan for your patients? Do reimbursement issues ever cause you to alter your treatment plan?

6. Do reimbursement issues affect the setting where services are delivered?

7. Do you see prior authorization or other payer processes as a barrier to reimbursement? If so, do you know the payer's reason's not approving the services?

Access / Quality
8. Are you aware of any access to services issues in the community, which may be due to reimbursement issues? Do you think this may lead to unnecessary admissions to an institutional setting?

9. Do you have any suggestions with regard to reimbursement that could improve the access for elders to mental health services?
10. Do you believe that reimbursement issues can affect quality of care? If so, how?

11. Are you aware of any payer’s beneficiary cost sharing policies that may impact access, service delivery or quality of mental health services for the elderly?

**Benefit Coordination**
12. Do you coordinate benefits when the patient has more than one insurance?

**Credentialing / Provider Enrollment**
13. Are there any credentialing / provider enrollment requirements for each payer that impact access, service delivery or quality?

**Other**
14. Are you familiar with any “model” programs, either in MA or another state? If so, do you know how they are reimbursed?
## Appendix B

### List of Interviewees

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Type of Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Worker - LICSW</td>
<td>Private Practice</td>
</tr>
<tr>
<td>Geriatric Psychiatrist</td>
<td>Hospital-based Practice</td>
</tr>
<tr>
<td>Geriatric Case Manager</td>
<td>Private Practice</td>
</tr>
<tr>
<td>District Manager - Billing Dept</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>Home Health Care VP</td>
<td>Visiting Nurses Association</td>
</tr>
<tr>
<td>Operations / Psychiatric Nurse Consultant</td>
<td>Visiting Nurses Association</td>
</tr>
<tr>
<td>Director Of Social Services / Physician Assistant</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>Community Health Center</td>
</tr>
<tr>
<td>President</td>
<td>Large Mental Health Service Provider</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>Hospital-based Practice</td>
</tr>
<tr>
<td>Psychiatrist Outpatient Practice</td>
<td>Private Practice</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>Mental Health Billing Manager / Billing Researcher</td>
<td>Hospital</td>
</tr>
<tr>
<td>Geriatrician</td>
<td>Hospital-based Practice</td>
</tr>
<tr>
<td>VP of Outpatient Services</td>
<td>Mental Health Service Provider</td>
</tr>
<tr>
<td>Billing Specialist</td>
<td>Public Hospital</td>
</tr>
<tr>
<td>VP</td>
<td>Small Mental Health Service Provider</td>
</tr>
</tbody>
</table>
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