

Is Medicare A Missed Opportunity?

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Medicare Beneficiaries and Behavioral Health Conditions*

- Depression ranks #7 in top 10 conditions in the Medicare-Medicaid population.
- The most prevalent classes of conditions among the Medicare-Medicaid population include cardiovascular, metabolic and **mental health conditions**.
- The second most prevalent is the category of mental health conditions, affecting close to one half (41%) of FFS Medicare-Medicaid enrollees
- The following mental health conditions also demonstrate prevalence above 10%: anxiety disorders (15%), depression (25%) and schizophrenia and other psychotic disorders (12%).
- Elevated suicide rate for persons age 65 and over.
- Opioid Misuse potential for persons age 65 and over.

*Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees Centers for Medicare & Medicaid Services- September 2014

Access to Behavioral Healthcare for Medicare Enrollees

- Medicare enrollees are covered under Medicare Part B for mental health and substance use disorders.
- Normal deductibles apply to most behavioral health services arising as a barrier to access for some. 20% for Medicare and this may be different for persons with Medicare Advantage Plans.
- Some Behavioral Health Services have “0” deductible and/or co-pays. (Annual Depression Screening)
- Medicare covers many Outpatient Behavioral Health Services and 6 types of health care professionals.
- Growth among persons over 65 in many communities.

Common Barriers for Medicare Enrollees To Receive Behavioral Health Care

- Community providers have focused more on Medicaid enrollees while hospital providers have focused more on Medicare enrollees. Medicaid revenue dominates most community-based providers.
- Community providers lack enough capacity among approved Medicare providers - Clinical Social Workers/Psychologists, Psychiatrists and Nurse Practitioners.
- Community providers uncomfortable with incident to provider arrangements that would allow other qualified professionals to receive care.
- Medicare enrollee mobility and transportation challenges limits access to “four-wall” services.
- Certain effective community-based services are not accepted by Medicare. (Crisis Residential, Assertive Community Treatment Team, Intensive OP)

Where Does Your Community Stand? Assessment Needed

- Growth of Medicare Enrollees in your community?
- Are Medicare enrollees properly served or “under-served”?
- What percent of your revenue budget is supplied by Medicare revenue?
- What percent of your service population are either Dual Eligible (Medicaid/Medicare) or Medicare Enrollees?
- Is your area or sub-area designated as a Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area? These can be “originating sites” for Medicare allowing Telehealth delivered Behavioral Health Services.
- Is integrated physical and behavioral healthcare (IHC) available to Medicare enrollees? IHC is a key strategy to better serve Medicare enrollees.
- Are we ***motivated*** to meet the needs of Medicare enrollees?

What Do Medicare Enrollees Say About Behavioral Health

- “If I tell my doctor I’ve been feeling depressed, they only think medicine as a tool and I’m taking enough medicine at my age and don’t want more”.
- “My doctor does not have the time to listen and provide counseling to me...so I keep many of those problems to myself”.
- “My doctor’s office has a counselor and I can see them when I need that – they were real helpful with a recent problem”.
- “While I believe that brief mental health treatment would be helpful to me...I’m not sure that my doctor believes the same...so I don’t ask”.
- “I have lots of friends my age that need mental health assistance but do not get that...they talk to their friends but not to any professional...they don’t know where to go or how to get there”.



Medicare Promotes Telehealth

- Medicare first began to reimburse for telehealth services with passage of the Balanced Budget Act of 1997. Reimbursement conditions in Medicare were expanded in the Benefits Improvement and Protection Act of 2000.
- In order to be reimbursed for live-video telehealth, the patient must be located in a non-Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HSPA).
- Medicare limits the originating sites eligible to receive services through telehealth to eight locations.

Medicare Promotes More Telehealth Options with New Policy* in 2019

Medicare plans to separately pay for the brief communication technology-based services when the patient checks in with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. This would increase efficiency for practitioners and convenience for beneficiaries. Similarly, the service of remote evaluation of recorded video and/or images submitted by an established patient would allow practitioners to be separately paid for reviewing patient-transmitted photo or video information conducted via pre-recorded “store and forward” video or image technology to assess whether a visit is needed.

*CMS Medicare Final Rule Released for 2019 Physician Fee Schedule

Medicare Designated Originating Sites for Telehealth

Designated Sites are the Location the Medicare Enrollee is to Receive the Care:

- The offices of physicians or practitioners (integrated care);
- Hospitals;
- Critical Access Hospitals (CAH);
- Hospital-based Renal Dialysis Clinics;
- Rural Health Centers;
- Federally Qualified Health Centers (FQHC);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

Medicare Distant Site Practitioners for Telehealth

Distant sites are the location where the practitioner is providing Telehealth services from.

Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:

- Physicians;
- Nurse practitioners (NP);
- Physician assistants (PA);
- Nurse midwives; Clinical nurse specialists (CNS);
- Clinical psychologists (CP) and clinical social workers (CSW).

Potential Missed Opportunities



Opportunities

- Addressing the Behavioral Health needs of Medicare enrollees
- Adjusting the payer mix percentage (e.g. increasing Medicare revenue by percentage) could create an expansion of care or reduction of dependence on another payer source (re-balancing payer mix)
- Recruitment and retention of qualified professionals
- Improving the outcomes and results of healthcare to persons age 65 and over
- Taking Behavioral Health services to where Medicare enrollees are may produce earlier intervention in emerging conditions (assisted living, nursing, LTC)
- Designing service systems around Medicare enrollees and their needs may produce excellent results

Solutions Needed to Overcome Barriers and Seize Opportunities

- Although we may disagree with these limits, Medicare has defined qualified clinical professionals to be directly enrolled to provide care to Medicare Members. They include:
 - Psychiatrist or other Physician
 - Clinical Psychologist
 - Clinical Social Worker
 - Clinical Nurse Specialist
 - Nurse Practitioner
 - Physician Assistant
 - Recruit these in a design to increase access for Medicare enrollees. Many are provided through Telehealth provider companies.

Solutions Needed to Overcome Barriers and Seize Opportunities

Become comfortable with Incident To Medicare Services.

- Draft Policy and Procedures for Staff (support and compliance)
- Follow the incident to rules for state-licensed professionals (Counselors, Psychotherapists, and Addiction Specialists) to provide care incident to other approved professionals.
- Design Medicare services incident to around the supervisor of the case by location/days of the week/hours in a day.
- Keep attendance personnel records showing case supervisor under whom billing is reported.
- Use quality improvement and compliance processes to reduce or eliminate risk of incident to services.



CMS 2014 Medicare Billing Rule Changes for Incident To

Compliance with State Law for Incident To Services: We are requiring as a condition of Medicare payment that “incident to” services be furnished in compliance with applicable state law. This policy strengthens program integrity by allowing Medicare to deny or recoup payments when services are **furnished not in compliance with state law**. We also eliminated redundant regulations for each type of practitioner by consolidating the “incident to” requirements for all practitioners that are permitted to bill Medicare directly for their services, reducing the regulatory burden and making it less difficult for practitioners to determine what is required in order to bill Medicare for “incident to” services.

Solutions Needed to Overcome Barriers and Seize Opportunities

- Identify what services are provided that are not approved by Medicare.
- Should our center develop services specific to the Medicare population like we do for Medicaid? (We develop ACTT around a Medicaid high need population – do we develop Partial Hospital for the same reason? What about Partial Hospital as a Medicare service for Intensive Out Patient for Substance Use Disorder Treatment?)
- Are we maximizing the psychiatric care we have now? (Conversion to Evaluation and Management services that are identical to other specialists in terms of time to provide; Using physicians to provide incident to services extending their care)
- Integrate behavioral health into primary care/internal medicine for collaborative care directed to Medicare enrollees.

Whole Person Integrated Care

Integrated Care (Bi-Directionally)
can be the single greatest
contributor to increasing access to
Behavioral Healthcare for Medicare
Enrollees

Solutions Needed to Overcome Barriers and Seize Opportunities

- Integrated behavioral health care into primary care is widely accepted to deliver better outcomes.
- Medicare enrollees generally attend to physical health conditions through a primary care or internal medicine physician.
- Creating one-stop integrated care systems of care can be successful at assessing, providing early intervention, and brief treatment for many of the conditions co-morbid to physical health conditions.
- Use of treat-to-target approaches and family/caregiver interventions.
- These integrated systems of care should provide rapid (same day) access to specialty behavioral health for more complex conditions when found.
- Medicare Part B generally allows for multiple services on the same day (e.g. physical health service and a behavioral health psychotherapy service).

Medicare Approved Out Patient Behavioral Health Services

- Annual Depression Screening
- Screening Brief Intervention Referral to Treatment (SBIRT)
- Individual and Group Psychotherapy
- Family Counseling
- Evaluation and Management Services (992XX) or Psychiatric Diagnostic Evaluation with Medical Services (90792)
- Partial Hospitalization
- Crisis Intervention and Management
- Assessment – Psychiatric Diagnostic Evaluation without Medical Services (90791)

Medicare Rates are Set by Medicare Administrative Contractors (MACs) Serving a Geographic Region

- Find Fee-For-Service Rates by using the CMS Physician Fee Schedule Look up Tool on line for your MAC.
- Medicare Access and Chip Reauthorization Act of 2015 (MACRA) has reformed Part B Payments to be adjusted based on the quality and efficiency of care.
- Providers delivering higher quality care (measured against quality metrics) will receive bonus payments. Providers unable to show quality outcomes will receive lower payments.
- Your Quality Management program and Back Office needs to be reporting required and will be able to assist with MACRA.
- Measurement of outcomes.





Medicare Rates are Set by Medicare Administrative Contractors (MACs) Serving a Geographic Region

Georgia Example

Use Non-Facility Price and the Proper MAC

- 90791-Psychiatric Diagnostic Eval without Medical Services - \$140.46
- 90832 – 30 min Individual Psychotherapy - \$68.60
- 90834 – 45 Min Individual Psychotherapy - \$91.35
- 90893 – 60 Min Individual Psychotherapy - \$137.22
- 90853 – Group Psychotherapy - \$27.44
- 99213 – E&M Level 3 - \$75.43
- 99214 – E&M Level 4 - \$110.44
- 99215 – E&M Level 5 - \$148.04

Additional Medicare Behavioral Health Services and Codes for Integrated Care

- **G0502, G0503, G0504 Psychiatric Collaborative Care Services**
 - There are several requirements and the psychiatric consultation is specific to the following:
 - ***Regular case load review with psychiatric consultant – The primary care team regularly (at least weekly) reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care as needed***

Additional Medicare Behavioral Health Services and Codes for Integrated Care

G0507 General Behavioral Health Integration

- May be used to report models of care that do not involve** a psychiatric consultant, nor a designated behavioral health care manager (although such personnel may furnish General BHI services). 20 minutes is allowed monthly under the general supervision of the PCP but can be provided by the Clinical Social Worker.
- *The service may be provided in full by the billing practitioner (PCP). Alternatively, the billing practitioner may use qualified clinical staff to provide certain services using a team-based approach (Clinical Social Worker). These clinical staff may- but are not required to-include a designated behavioral health care manager or psychiatric consultant.*



Medicare's Incentive to Deliver Behavioral Healthcare

- “For eligible Telehealth services, the use of a telecommunications system substitutes for an in-person encounter”*.
- Medicare has opened a wide door for integrated behavioral health in primary care to be the primary manner in which Medicare enrollees are assessed for treatment.
- Alternate providers, other than the six (6) directly enrolled, are payable through Incident To practices.

* Medicare Learning Network, CMS, February 2012



Questions-Comments-Discussion

Contact us

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