

Reimbursement of Mental Health Services in Primary Care Settings



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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Executive Summary

In 2005–2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), with guidance from the Centers for Medicare & Medicaid Services (CMS), jointly sponsored a study to identify the barriers to, and possible solutions for, reimbursement of mental health services provided in primary care settings. The Federal Action Agenda, emanating from the 2003 report of the President’s New Freedom Commission, “Transforming Mental Health Care in America,” includes direct reference to addressing barriers to reimbursement for mental health in primary care. This study, in response to that identified need, was divided into two main efforts to better understand the payment policies and practices that may prohibit or discourage the provision of mental health services in primary care settings.

The first part of the effort synthesized an Environmental Scan, literature review, and Key Informant Interviews into a White Paper background report. The White Paper identifies the barriers to successful provision and reimbursement of mental health services by practitioners in primary care settings. The second part convened a high-level Expert Forum, with participants chosen from various organizations (including consumers, practitioners, providers, government, and researchers), who reviewed the White Paper, discussed and ranked suggested actions to reduce those reimbursement barriers. This Final Report incorporates their deliberations and addresses the following:

- Describes the purpose and rationale of the project,
- Outlines the project’s tasks,
- Details findings from the White Paper,
- Summarizes the June 2006 Expert Forum discussion, and

- Provides suggested actions to the Federal government on steps to overcome existing or perceived barriers to reimbursement and provision of mental health services in primary care settings.

An annual survey undertaken by SAMHSA has established the prevalence and treatment rate of mental health problems. In 2005, this survey, the National Survey on Drug Use and Health (NSDUH), found an estimated 24.6 million adults ages 18 or older with Serious Psychological Distress (SPD); this represents about 11.3 percent of all adults (SAMHSA, 2006). Among the 24.6 million with SPD, 11.1 million (45 percent), received treatment for a mental health problem in the past year. Among adults in this study who reported an unmet need and who received no treatment in the past year for mental health problems, about 47 percent reported cost or insurance issues as one of the main barriers to treatment (SAMHSA, 2006). The primary care

setting provides the initial, and often only, opportunity for access to mental health services, with more than 40 percent of patients with mental health problems initially seeking care in primary care settings (Chapa, 2004).

Research has confirmed that the provision of frontline mental health services in primary care settings, when appropriate, has positive impacts, including the improvement of patient, practitioner, and provider satisfaction; overall health care cost efficiency, including primary and specialty costs for physical health care; improved clinical and functional patient outcomes; and adherence to regimens and treatment of mental health disorders. Receipt of mental health services in primary care settings also reduces stigma for some consumers, who are no longer limited to accessing care through the specialty mental health setting, and avoids unnecessary consumption of care by “high utilizers” (Asarnow, Jaycox, Duan, LaBorde, et al., 2005; Kessler, Soukup, Davis, Foster, et al., 2001; Mauksch, Tucker, Katon, Russo, et al., 2001; Nitzkin & Smith, 2004; Rost, Nutting, Smith, Werner, et al., 2001; Simon, Katon, Rutter, VonKorff, et al., 1998; Unutzer, Katon, Callahan, Williams, et al., 2002).

This project was undertaken to reduce reimbursement barriers to mental health services for persons with public insurance who come to the primary care setting for health care.

Project Steps: Environmental Scan, Key Informant Interviews, White Paper, and Expert Forum

Project steps included an Environmental Scan, Key Informant Interviews with 20 experts, a background White Paper, and an Expert Forum panel review of findings. These steps

and the information produced were synthesized to form the project’s findings, as presented in this report.

The Forum

In 2006, SAMHSA, HRSA, and CMS convened an Expert Forum to discuss barriers to the reimbursement of mental health services in primary care settings and to identify solutions. Forum attendees were selected by the government project officers to represent various sectors, and included individuals from all types of government and nongovernmental organizations, mental health consumer groups, primary care practices, insurers, researchers, professional associations, health care systems analysts, and managed care organizations. The members of the Expert Forum considered the reimbursement barriers presented in the White Paper. The experts identified additional barriers, prioritized barriers, and proposed next steps and suggested actions, which were viewed as practical and achievable.

Findings

The Expert Forum identified the following seven priority barriers:

1. State Medicaid limitations on payments for same-day billing for a physical health and a mental health service/visit;
2. Lack of reimbursement for collaborative care and case management related to mental health services;
3. Absence of reimbursement for services provided by nonphysicians, alternative practitioners, and contract practitioners and providers;
4. Medicaid disallowance of reimbursement when primary care practitioners submit bills listing only a mental health diagnosis and corresponding treatment;

-
5. Level of reimbursement rates in rural and urban settings;
 6. Difficulties in getting reimbursement for mental health services in school-based health center settings; and
 7. Lack of reimbursement incentives for screening and providing preventive mental health services in primary care settings.

The Forum's suggested actions included reimbursement policy clarification, government and stakeholder collaboration, education and technical assistance, and provision of additional services. They are summarized in Section 6 of this report.

Clarification

To improve reimbursement of mental health services in primary care settings, the Expert Forum's most frequently suggested action was the need to *clarify policies, definitions, and services*, and *broadly disseminate the clarifications*.

Collaboration

The Expert Forum emphasized the importance of *targeted collaboration among the Department of Health and Human Services agencies and national stakeholder organizations* to support the provision and reimbursement of mental health services in primary care settings. Collaboration occurs when agencies and individuals *support and promote a particular mission or undertaking or particular values*.

Education and Technical Assistance

The Expert Forum identified *education and technical assistance recommendations* that cross settings, payers, and practitioner and

provider types. The Expert Forum stressed that consistent information must be shared among all players.

Additional Services and Support

Finally, the Expert Forum suggested the *support of additional services and measures* to improve the provision and reimbursement of mental health services in primary care settings, such as linking payment incentives to prevention, screening, and follow-up; improving cross-setting integration between primary and specialty care; and enlarging the workforce through the use of allied professions and telemedicine.

Conclusion

Implementing these practical and largely achievable suggestions will improve access to timely and targeted mental health services in primary care settings. Program and clinical experts agree that the early prevention and treatment of mental disorders will result in decreases in individual suffering, family burden, and medical costs. This project provided an important opportunity to review policy and service-delivery change mechanisms aimed at improving the reimbursement of mental health services in primary care settings. By using knowledge from a variety of individuals and settings and combining empirical research with qualitative interviews and the Expert Forum proceedings, this project identified areas where Federal agencies, states, provider organizations, and commissioner associations can clarify, collaborate, educate, and provide support to improve the reimbursement of and access to mental health services in primary care settings.



Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), with guidance from the Centers for Medicare & Medicaid Services (CMS), conducted a study intended to identify barriers and solutions to the provision of mental health services in primary care settings. To better understand reimbursement policies that affect the provision of mental health services in primary care settings, the study was divided into two main efforts:

1. An Environmental Scan of the literature was combined with results of 20 Key Informant Interviews to produce a White Paper that summarized the barriers impeding the reimbursement of mental health services in primary care settings.
2. Using the White Paper as a background report to participants, a high-level Expert Forum was convened, including experts from consumer, provider, government, and research organizations. The purpose of the Expert Forum was to discuss and define

suggested actions to overcome barriers to the reimbursement of mental health services in primary care settings.

This Final Report describes the purpose and rationale of the project, outlines the project's tasks, details findings from the White Paper, summarizes the recommendations from the Expert Forum, and provides the Federal government with suggested next steps that could be taken to overcome existing or perceived reimbursement barriers.



Purpose and Rationale of the Project

The 2003 report of the President's New Freedom Commission (NFC) on Mental Health, *Transforming Mental Health Care in America*, established six goals for a transformed mental health care system in the United States, two of which specifically address the integration of mental and physical health:

- Goal 1: the recognition of mental health as integral to all health
- Goal 4: the need for “early mental health screening, assessment, and referral [as] common practice”
 - Subgoal 4.4: the need to “screen for mental disorders in primary health care across the life span and connect to treatment and supports”

Key action steps designed to achieve these goals led SAMHSA and HRSA, with CMS's participation, to form an interagency collaboration. The purpose of the collaboration is to clarify and to seek solutions to the barriers to the reimbursement of mental health services in primary care settings, specifically reimbursement by Medicare and Medicaid. The rationale for this study is to assist in developing a plan to implement a specific step of the Federal Action Agenda that targets elimination of barriers to the reimbursement of mental health services delivered in the primary care arena.

According to a 2005 survey conducted by SAMHSA, 5.7 million adults reported an unmet need for mental health services and did not receive treatment in the past year for mental health problems. These individuals identified more than one, including the fol-

lowing barriers to receiving treatment (SAMHSA, 2006):

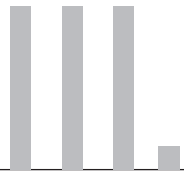
- Cost or insurance issues (46.8 percent)
- Not feeling a need for treatment at the time or believing that the problem could be handled without treatment (36.7 percent)
- Stigma associated with treatment (23.4 percent)
- Not knowing where to go for services (8.5 percent)

The primary care setting is an integral point of entry and opportunity for identifying and treating mental health problems (Office of the Surgeon General, 1999). It includes the first points of contact for health care, and involves providers in general practice, family practice, pediatrics, internal

medicine, obstetrical/gynecological, and some nonphysician and nonspecialty care. Additionally, in the context of managed care, the primary care setting is often the point of entry and the gatekeeper for all other care. Primary mental health services include prevention; screening; assessment and diagnosis; and referral, treatment, and follow-up of common mental health disorders, such as depression and general anxiety disorder. Primary prevention is an intervention or service designed to stop or delay the development of a disease before it occurs, which may, but does not necessarily, include screening to identify potential mental health problems.

Integration of primary care and mental health services is crucial to creating a seamless system of health care for all Americans. Provision of mental health services in primary care settings represents a first step to integrating care and increasing access to mental health services. However, there are many barriers to the provision of mental health services in primary care settings. The resolution of reimbursement and financial barriers has been identified by the Institute of Medicine's *Crossing the Quality Chasm* report

(IOM, 2001) and the New Freedom Commission as critical to improving access to and provision of mental health services in primary care settings. A number of barriers to provision of timely and appropriate mental health services in primary care settings are cited throughout the literature and were discussed in the Expert Forum. Financial barriers include lack of awareness of allowable payment mechanisms, multiple reimbursement mechanisms, mental health carve-outs that do not include or allow for payment of primary care providers (PCPs) or school-based providers in practitioner networks, payment for only a limited number of visits, and low reimbursement rates. Other barriers that prevent those in need from getting screened, diagnosed, and treated include lack of access to primary care providers, closed networks of providers, misunderstanding and misperception of covered services and reimbursement rules, lack of practitioners in rural or urban areas, lack of Medicare mental health parity, and lack of payment for the key components of the collaborative care model and team approaches to providing care.



Project Tasks

3.1. Environmental Scan

The first task of the project was to conduct an Environmental Scan to identify and gather a broad range of information on the provision and reimbursement of mental health services in primary care settings. Of particular interest were the issues regarding Medicare and Medicaid reimbursement. Relevant studies were identified through a computerized search of thousands of health, mental health, and financial journals, newsletters, and trade journals, using defined key issues, search terms (e.g., “primary care,” “mental health,” “reimbursement,” “payment mechanisms,” “coordination of care,” and “integration of care”), research questions, and carefully established

selection criteria.¹ Additionally, the project team designated government Web sites, provider manuals, laws, regulations, State Medicaid program guidances, studies produced by associations, and other research documents for review and inclusion in the Environmental Scan. The focus of the Environmental Scan was on peer-reviewed articles published in English between 1995 and 2006; however, the resulting document also incorporated a few highly relevant articles published prior to 1995. Through this process, the authors reviewed 410 articles and included 227 articles, reports, memoranda, and other documents in the Environmental Scan report.

¹ Criteria included the following: the document addresses at least one of the key issues/research questions, has scientific merit (as defined by publication in a peer-reviewed journal or by our own technical review), has public interest merit in that it cogently reflects the reasoned opinions and positions of the constituencies affected by access limitations or managed mental health care, or is designated by the Federal partners.

The Environmental Scan is available on request to the government project officer from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, identified in “Acknowledgments.”

3.2. Key Informant Interviews

Twenty Key Informant Interviews were conducted to solicit structured input from specifically identified academic, policy, and practice experts to determine their opinions and suggested resources on (a) barriers to reimbursement, (b) policies or practices that positively or negatively impact the reimbursement of mental health services in primary care settings, and (c) successful billing practices. Key Informants were identified and approved by the project team. A number of Key Informants work in organizations designated as safety-net providers, including federally qualified health centers, rural health clinics, community mental health centers, HIV/AIDS providers, and

maternal and child health centers. Key Informant Interviews confirmed many of the issues found in the literature. The main finding, based on input from provider Key Informants working in a number of states and a range of clinical settings, was that variation exists in the interpretation and application of the Federal program rules and guidelines. Moreover, the interviews revealed several key challenges in operating under the rules for coverage and reimbursement in the Medicaid and Medicare programs, as well as promising practices in securing reimbursement. A listing of the Key Informants is found in Appendix A.

3.3. White Paper

The White Paper summarized the major findings on barriers to financing mental health services delivered in primary care settings from the Environmental Scan and Key Informant Interviews. It was used as background preparation for participants of the Expert Forum. Principal findings of the White Paper are discussed in greater detail in section 4. The White Paper, a working document, is available on request to the government project officer, identified in “Acknowledgments,”

from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

3.4. Expert Forum

On June 19, 2006, SAMHSA, HRSA, and CMS convened an Expert Forum to discuss barriers to the reimbursement of mental health services in primary care settings and identify the most promising solutions. The project team identified the Forum attendees. The participants included individuals from nongovernmental organizations, such as mental health consumer groups, primary care providers, insurers, researchers, professional associations, health care systems analysts, and managed care organizations; and various key government officials, including individuals from the CMS–HRSA–SAMHSA Federal team, state mental health programs, and State Medicaid programs. After discussion on barriers presented in the White Paper and identification of additional barriers, the Expert Forum constructed possible solutions to the top seven prioritized barriers. Section 5 provides additional detail on the Expert Forum and its conclusions. A listing of the Expert Forum attendees appears in Appendix B.

IV.

White Paper Principal Findings

A number of barriers to provision of timely and appropriate mental health services in primary care settings are cited throughout the literature and were discussed in the Key Informant Interviews. These barriers include attitudes, knowledge, beliefs, culture, training, stigma, and organizational constructs, such as financing policies that affect providers and patients alike.

The following sections describe the fundamental Medicaid and Medicare reimbursement policies identified through the Environmental Scan and Key Informant Interviews that create barriers to providing mental health services in the primary care setting. In certain sections, the literature and interviews identified possible actions that practitioners in primary care settings can undertake to improve the reimbursement of mental health services.

4.1. Medicaid

The following sections describe the barriers to and difficulties with receiving reimbursement under Medicaid. It includes anecdotal information as reported by Key Informants and practitioners, as well as some background coding information pertinent to both Medicaid and Medicare. It is important to note when reviewing the material in this section that states have broad flexibility in designing their payment structures and billing methods to be responsive to state business customs and compliant with Federal laws and regulation.

4.1.1. *Reimbursement of Medicaid Mandated and Optional Services*

Federal law mandates 12 services that states must provide as a condition of participation in the Medicaid program, and allows addi-

tional optional services for states to include if they so choose.² Mental health services are not a separate mandated or optional service, but can be delivered through either type, if the state chooses to, and includes it in their

² The following 12 services are mandatory under Medicaid: Physician services, laboratory and X-ray, inpatient hospital, outpatient hospital, EPSDT, family planning, rural health clinic services, Federally qualified health centers, nurse-midwife services, certified nurse practitioner services, nursing facility services for adults, and home health services. Optional services are more numerous, and include dental services, prosthetic devices and glasses, therapies (PT/OT/ Speech/Audiology), targeted case management, clinic services, personal care, home and community-based services, hospice, ICF/MR, psychiatric residential treatment facility for <21, and rehabilitative services.

state plan. Mental health services can be delivered within the following mandated Medicaid services: inpatient hospital services, outpatient hospital services, federally qualified health center (FQHC) and rural health center (RHC) services, and physician services (Social Security Administration, 2004).

In Section 1905 of the Social Security Act (42 U.S.C. 1396d), physician services under Medicaid are defined as:

(5)(A) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1861(r)(2)) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1861(r)(1))

http://www.ssa.gov/OP_Home/ssact/title19/1905.htm

SEC. 1861 of the Social Security Act. (42 U.S.C. 1395x). For purposes of this title—

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#r1

Each state is required to submit to CMS a State Plan amendment (SPA) whenever it decides to change/modify eligibility criteria, service coverage, provider qualifications, state program administration, or reimbursement methodology. These SPAs are sent to the Centers for Medicare & Medicaid Services for their review and approval. The plan describes the Medicaid eligibility criteria, service coverage, provider qualifications, reimbursement, and state program administration. An individual State Medicaid agency (SMA) may choose or not choose to cover services defined as "optional" to the Medicaid population.³ Although states are not required to provide any of the categories of optional services, all states have chosen to provide one or more optional services (Robinson, Kaye, Bergman, Moreaux, et al., 2005). Following is a list of those optional service categories under which states can establish coverage of mental health services:

- Other licensed practitioners (for mental health services, this might include a family therapist, psychologist, marriage and family therapist, certified social worker, etc.);
- Clinic services;
- Inpatient hospital services for children under age 22;
- Rehabilitation services;
- Targeted case management; and
- Home- and community-based services.

Mental health services are usually provided via the optional clinic or rehabilitative services. States are not required to cover the

³ For individual State plans, please see the Centers for Medicare & Medicaid Services Web site, <http://www.cms.hhs.gov/medicaid/stateplans>.

above optional services; therefore, states have substantial flexibility in defining their covered services. Additionally, because there is no single optional category labeled “behavioral or mental health,” states have flexibility as to where they describe and cover mental health services in their State Plans (Robinson et al., 2005). The 2005 report *State Profiles of Mental Health and Substance Abuse Services* examined State Medicaid programs to identify State policies related to individuals covered by the programs, what services the programs provided, and how services were delivered.

States also have the option to waive certain federally mandated provisions and to add optional and supplementary services under the authority of Medicaid waivers approved by CMS. States combine the use of eligibility standards, service selection, and service limits to manage the amount, duration, scope, and costs in delivery of these programs. By defining which services and populations are covered and limiting coverage of those services, states impose controls on utilization and cost pursuant to their administrative responsibilities for the Medicaid program. States are thus able to define their optional services for mental health coverage, including parameters around reimbursement for other licensed practitioners, services provided in different clinics or sites, number of visits, and minutes/hours of practitioner time reimbursed for a given service.

States may choose to provide all of their Medicaid services, including mental health, through a contract with a managed care plan. These contracts have varying levels of final risk to the State Medicaid agency, managed care organizations (MCOs), individual practitioners, and managed behavioral healthcare organizations (MBHOs).

4.1.2. Reimbursement of Mental Health Diagnosis and Treatment

The 1996 passage of the Health Information Portability and Accountability Act (HIPAA) mandated the use of Healthcare Common Procedure Coding System (HCPCS) codes for all transactions involving health care information. HIPAA also mandated that every applicable HCPCS procedure code be submitted along with a diagnosis code from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The ICD-9-CM coding system classifies diseases and injuries into groups. This system allows medical terminology to be translated into numbers or codes. The ICD-9-CM codes have been widely used in various health care facilities, but it was not until recently that national use of these codes was mandated by HIPAA.

The following sections were drawn from the Centers for Medicare & Medicaid Services’ Web site. For additional information on the HCPCS, please see:

- The Centers for Medicare & Medicaid Services Web site <http://www.cms.hhs.gov/MedHCPCSGenInfo>

There are two different and major national levels of the HCPCS coding system. Both Medicaid and Medicare use some of both types of HCPCS codes, Level I and Level II codes, so this can be confusing, but the following overview highlights their differences.

Level I is the Current Procedural Terminology (CPT) 5-digit numeric coding system, which is a proprietary product of and maintained by the American Medical Association. CPT was initially published in 1966 and is updated by the American Medical Association with revisions, deletions, and additions on an annual basis. The CPT codes are used

to identify medical services and procedures furnished by physicians and health care professionals. Health care professionals use the Level I CPT codes to identify services and procedures they bill to private and public insurance. Billing under Medicare often uses Level I codes (CPT) that CMS has also deemed approved for payment. In the broadest sense, the HCPCS Level I is the correct term to use for all medical codes (which include the psychiatric codes) for procedures that may be administered in a health care provider's office, clinic, or health agency employing CMS guidelines. However, just because the AMA has issued a CPT code does not automatically mean CMS will reimburse for it. For Medicare payment, CMS specifies which CPT codes will be covered as part of their Medicare benefit design. For Medicaid payment, each State specifies the codes (more often Level II ones) for which they allow reimbursement, based on their State plan. Table 4.4 provides a chart that clarifies the type of billing code, Level I or Level II, to be used when billing Medicare or Medicaid for mental health services.

There are six sections within the CPT manual. Two of them are relevant to coding mental health services: the Evaluation and Management section and the Medicine section:

99201 – 99499	Evaluation and Management
00100 – 01999	Anesthesia
10040 – 69999	Surgery
70010 – 79999	Radiology
80002 – 89399	Pathology and Laboratory
90700 – 99199	Medicine Section

Level I HCPCS codes used for mental health services are in the Evaluation and

Management (selected codes within range 99201–99340) and the Medicine sections of the CPT manual. Within the Medicine section, the two areas that apply specifically to mental health services are the Psychiatry codes (90801–90899) and the Health Behavioral Assessment and Intervention (HBAI) codes (96150–96155).

National HCPCS Level II codes are the alphanumeric standardized coding system that is maintained and distributed by CMS and updated on an annual basis. The Level II codes consist of one letter (A–V) followed by four numbers. These codes are used to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies used outside a physician's office. These codes are facility based. Supplies that are billed with a CPT code are not generally reimbursed if there is no identified Level II code. Level II codes can be used in primary care settings by primary care physicians and mental health specialists, but must be approved by the payer. An example of such a code billed to the State under Medicaid would be “H0002, Behavioral health screening to determine eligibility for admission to treatment program,” to determine the eligibility of a client for admission to a drug treatment or mental health program.

States billing under Medicaid may use Level I or Level II codes, but more often allow use of Level II codes; it is up to each individual State Medicaid program. Some Level II codes are for Medicaid only (H and T codes). As previously stated, billing Medicaid for primary care practice services requires both a diagnosis and a procedure code. Some State Medicaid agencies limit the types of providers, practitioners, and procedures for which

primary care practices can bill and receive reimbursement (Bachman, Pincus, Houtsinger, & Unutzer, 2006). Additionally, as primary care physicians are not considered “experts” on mental health diagnoses and treatment, some practitioners have had difficulty receiving reimbursement for providing a primary mental health diagnosis or treatment (E. Frazier, personal communication, January 24, 2006). To avoid the denial of reimbursement, some practitioners submit claims that have a primary diagnosis of “symptom codes”—such as fatigue, insomnia, or hypersomnolence—or the practitioner makes what would have been a secondary diagnosis the primary diagnosis (E. Frazier, personal communication, January 24, 2006). Each practitioner should check with his or her insurance company, State Medicaid agency, and/or Medicare fiscal intermediary for appropriate billing and reimbursement procedures. This is particularly the case with Medicaid—each state operates under different rules, and what is acceptable in one state may not be acceptable in another state.

Table 4.1 summarizes diagnostic and procedure coding tips revealed in an analysis of claims that were tracked in a coding study, and provides valuable insight on what was acceptable and approved for a single situation. To alleviate the difficulty and perceived challenges experienced by some primary care practitioners when submitting a primary diagnosis depression claim, the Mid-America Coalition on Health Care’s Community Initiative on Depression created

a Depression Diagnosis, Coding, and Reimbursement Task Force (Mid-America Coalition on Health Care, 2004). The Task Force was composed of health plan representatives and medical managers to “address the system’s complexities, which deter a primary care physician from coding a claim ‘depression’ and submitting that claim for reimbursement to a health plan.” The Task Force conducted the “Life of a Depression Claim” analysis, which revealed system errors that resulted in depression claims being denied. Once the errors were corrected, the Task Force analyzed more than 100,000 primary care depression claims, of which 3,176 claims had a primary diagnosis of depression. The Task Force found that when a primary care practitioner submitted an Evaluation and Management (E/M) office visit code along with a depression diagnosis ICD-9-CM code 311 (depressive disorder), the visit was paid. According to further claims analysis, less than 1 percent of the nonpaid claims were denied due to the depression diagnosis, which is more or less what occurs with other claim denials. From the Task Force’s research and analyses, the Mid-America Coalition on Health Care composed “Tips” on submitting claims and being reimbursed for depression care services. While there may be other codes that are appropriate and reimbursable depending on service location, provider, and plan type, the codes cited in table 4.1 below were tested and received payment during the “Life of a Depression Claim” analysis.

Table 4.1: Claim Tips for Primary Care Providers from the Mid-America Coalition on Health Care

Tip #1: Diagnosis Codes

Use one of the following ICD-9-CM diagnosis codes, if appropriate:

- 311 Depressive Disorder, Not Otherwise Specified (NOS)
- 296.90 Mood Disorder, NOS
- 300.00 Anxiety Disorder, NOS
- 296.21 Major depressive disorder, Single episode, Mild
- 296.22 Major depressive disorder, Single episode, Moderate
- 296.30 Major depressive disorder, Recurrent
- 309 Adjustment Disorder with Depressed Mood
- 300.02 Generalized Anxiety Disorder
- 293.83 Mood Disorder due to Medical Condition—(e.g., Postpartum Depression)
- 314 or 314.01 Attention Deficit/Hyperactivity Disorder (Inattentive and combined types)

Tip #2: Evaluation and Management (E/M) CPT Codes

- Use E/M CPT codes 99201–99205 or 99211–99215 with a depression claim with any of the ICD-9-CM diagnosis codes in Tip #1.
- Do not use psychiatric or psychotherapy CPT codes (90801–90899) with a depression claim for a primary care setting. These codes tend to be reserved for psychiatric or psychological practitioners only.

Note: According to the *American Medical Association (AMA) Current Procedural Terminology (CPT) 2005 Evaluation and Management Services Guidelines*, when counseling and/or coordination of care dominates (more than 50 percent) the physician/patient and/or family encounter, then time may be considered the controlling factor to qualify for a particular level of E/M service; this may allow the physician to code a higher level of service.

(Source: Mid-America Coalition on Health Care, 2004)

Not only is it important to understand how primary care providers in private practice can bill for mental health services, but also to examine how clinics serving the most vulnerable, underserved persons can bill the State or Medicaid for such services. In 2006, the National Council for Community Behavioral

Healthcare commissioned a paper clarifying the billing and payment organizations. The following table presents a summary of Medicaid payment for mental health services to beneficiaries given at Community Mental Health Centers and Federally Qualified Health Centers (Mauer, 2006).

Table 4.2: Medicaid Payment of Mental Health Services to CMHCs & FQHCs (Mauer, 2006)

Type of benefit	Community Mental Health Center (CMHC) Sites	Federally Qualified Health Centers (FQHCs)
Fee for service MH Benefit	Services billable to Medicaid agency and/or Medicaid Health Plans per agreements between the parties and the State Medicaid agency.	Services billable by FQHCs based on a CMS memo dated 9/22/03 and HRSA Program Information Notice 2004–05 to State Medicaid Agencies, where an agreement has been put in place. CPT Level I Code Series 96150–96155 (HBAI); 90804–29 Psychiatric Series, 90853–57 Series, 90649–69 Series, 99140–5 codes.
Capitated MH Benefit with providers under MCO or MBHO contract	Services based on waiver requirements, modalities in State Medicaid plans, rates as established by actuarial review, oversight by external quality review organization process.	Depends on state, regional, and/or local decision-making.

Note: MH = mental health; MCO = managed care organization; MBHO = managed behavioral healthcare organization.

4.1.3. Restrictions on Same-Day Billing

A number of barriers to provision of timely and appropriate mental health services in primary care settings are cited throughout the literature and were discussed in the Expert Forum as well as cited in the Key Informant interviews. Of the most often mentioned, those problems encircling “same-day billing” were most often cited as impeding reimbursement. The various and related scenarios are discussed below.

Billing by two different practitioners within one provider organization, on the same day

While the Federal government does not restrict two practitioners or provider organizations from billing on the same day, some State Medicaid agencies have payer rules that prohibit billing for activities by two different practitioners on the same day; for example, one primary care visit and one mental health visit (American Association of Community

Psychiatrists, 2002). This undermines one of the key strengths of the collaborative care model—the “warm handoff,” in which the primary care practitioner brings the behavioral health practitioner into the exam room. These are two distinct visits by two distinct practitioners, but if they are billed by the same provider organization, the second is frequently denied. This restriction creates difficulties for patients who cluster their medical visits and for providers who seek reimbursement for providing services to these patients.

Billing by the same practitioner who is not certified to provide both services

A number of State Medicaid programs do not allow medical and mental health services to be provided on the same day by the same practitioner if the practitioner is not separately licensed to provide both services (American Association of Community Psychiatrists, 2002). In these cases, the practitioner may receive reimbursement for the service for

which he or she is licensed, but will not receive reimbursement for the nonlicensed service. Additionally, according to some Key Informants, the problems associated with the same-day billing restrictions are compounded when a practitioner is licensed to provide one service, but is not licensed to provide the second service and errs in billing for both services on the same day. One would have been paid, but is not, due to the error in billing for the second, non-certified service.

Billing for two services given by one practitioner on the same day at one provider organization

A frequent Key Informant comment pertained to the inability of many respondents to bill for both a medical and psychiatric visit provided on the same day by a single practitioner, even if the organization under which the practitioner bills is certified to deliver both services (Key Informant Interview, 2006). All Key Informants described the additional burden on patients who have a difficult time with travel, child care, work leave, keeping appointments, and/or finding people to bring them to and help them through medical and psychiatric visits. Those Key Informants emphasized that providing and being reimbursed for two services in a single day by a single practitioner is critical to overcoming some of these barriers.

Correct Coding Initiative (CCI) imposing limitations on billing for two services in the same day

The Office of the Inspector General published a report in 2004, *Applying the National Correct Coding Initiative to Medicaid Services*, that summarized mandatory requirements for Medicare carriers to limit same-day billing by nonpsychiatric practitioners for certain paired codes of services and practitioner types

(Office of the Inspector General, 2004).

Many of the paired codes included psychological services (such as family psychotherapy and individual psychotherapy provided by specific professionals). Furthermore, the report recommended that CMS encourage states to apply similar limitations to Medicaid claims.

For example, under the National Correct Coding Initiative, the behavioral practitioner cannot bill psychiatric codes (CPT 90801–90899) and Health Behavior Assessment and Intervention (HBAI) codes (96150–96155) on the same day (American Psychiatric Association, 2006). For services rendered to patients who require both psychiatric and HBAI services, the practitioner must report only the principal service being provided (American Psychiatric Association, 2006). This requirement has limited some billing for same-day services under Medicare. Whether this requirement has also influenced or had an impact on same-day billing by the same practitioner under Medicaid in the states cannot be determined from the Environmental Scan or the Key Informant Interviews.

4.1.4. Carved-Out Behavioral Health Services

In 2002 and 2003, 34 states and the District of Columbia utilized carve-out managed care organizations to provide mental health services (Robinson et al., 2005). These states were Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Iowa, Maryland, Massachusetts, Michigan, Missouri, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin. Sixteen states—Alabama, Alaska, Arkansas, Georgia, Indiana, Kansas,

Kentucky, Louisiana, Maine, Mississippi, Montana, Nebraska, New Hampshire, North Carolina, West Virginia, and Wyoming—did not use a managed care system to deliver mental health services (Robinson et al., 2005). Practitioners with mental health specialty credentials are favored in carve-out networks, which often exclude primary care practitioners (Mauch, 2002). Typically, community health centers (CHCs) and other primary care provider groups cannot directly access and/or participate in carve-out panels.

According to Key Informant interviews, among primary care practitioners who operate within 1 of the 35 Medicaid carve-out states, some providers have had difficulties getting reimbursed for providing services to patients with a primary mental health diagnosis. Additionally, for patients who do not have a primary mental health diagnosis, the primary care provider is restricted from diagnosing and treating mental disorders. Primary care practitioners who are unable to be reimbursed because they are not in the carve-out network may not have an incentive to evaluate the need for or provide primary mental health care to their patients. In certain instances, this disincentive leads to limited provision of psychiatric assessments in primary care settings, which decreases identification of treatment needs among primary care populations (Key Informant Interview, 2006).

4.1.5. Reimbursement of Telemedicine, Telehealth, and Patient Outreach

Telephone psychotherapy and telephone care management represent cost-effective methods to reach individuals who have difficulty accessing mental health services because of transportation issues, geographic constraints, and other challenges (Capoccia, Boudreau, Blough, Ellsworth, et al., 2004; Daugird & Spencer, 1989; Feinman, Cardillo, Palmer, &

Mitchel, 2000; Hartley, Korsen, Bird, & Agger, 1998; Hunkeler, Meresman, Hargreaves, Fireman, et al., 2000; Katzelnick, Simon, Pearson, Manning, et al., 2000; Oxman, Dietrich, Williams Jr., & Kroenke, 2002; Roy-Byrne, Stein, Russo, Mercier, et al., 1999; Simon, Katon, VonKorff, Unutzer, et al., 2001; Simon, Ludman, Tutty, Operaskalski, & VonKorff, 2004; Simon, Manning, Katzelnick, Pearson, et al., 2001; Simon, VonKorff, Ludman, Katon, et al., 2002; Trude & Stoddard, 2003; Tutty, Simon, & Ludman, 2000). Federal law has not named telemedicine as a defined benefit under Medicaid, and the Medicaid State manual does not recognize telemedicine as a distinct service. Some states include distant provider-to-patient contact as reimbursable, while others confine telemedicine to consultations between providers. One State, Kansas, defines telemedicine as “the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers” (<https://www.kmap-state-ks.us/Documents/Content/Bulletins/General%208-04%20b.pdf>). Another state defines telemedicine as the use of telecommunications to furnish medical information and services. In that state, telemedicine consultations must be made via two-way, interactive video or store-and-forward technology between a hub site and remote site (http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/DHS_id_008926.hcsp#tele). States *may* choose to include telemedicine as an optional benefit; currently, 24 states allow reimbursement of services provided via

telemedicine for reasons that include improved access to specialists for rural communities and reduced transportation costs (<http://www.cms.hhs.gov/home/medicaid.asp>). In the 24 states, the most common reimbursable services are medical and behavioral/mental health diagnostic consultations or treatment (Youngblade, Wegener, Malasanos, Aydede, et al., 2004). When billing for telemedicine, states generally use a modifier to existing CPT codes to identify a telemedicine claim. However, Key Informant practitioners in some states that reimburse for telemedicine stated that billing rules were complicated and repeated claims denials had discouraged some providers from seeking reimbursement. The Key Informants' perception of complexity in billing for telemedicine and telehealth services may be associated with a lack of training on reimbursement policies and procedures.

4.1.6. Reimbursement of Collaborative Care and Team Approaches

Team approaches to treating individuals with mental health conditions have been extensively studied, with reports indicating that team and collaborative treatments improve patient outcomes. Collaborative care models—for example, “IMPACT: Improving Mood: Providing Access to Collaborative Treatment”—use a team approach to deliver mental health care (Lorig, Ritter, Stewart, Sobel, et al., 2001; Noel, Williams, Unutzer, Worchel, et al., 2004; Unutzer et al., 2002). IMPACT employed case managers, specially trained nurses, and/or psychologists to work with the primary care providers (PCPs) to educate patients and track symptoms and medication side effects. IMPACT found that working with a team of practitioners or a single manager of care significantly improved patients' adherence to and outcome of mental health treatment (Lorig et al., 2001; Noel et al.,

2004; Unutzer et al., 2002). Some collaborative care models use psychiatrists and primary care experts to support the patient's regular primary care physicians, while others employ clinical pharmacists (Lorig et al., 2001). While collaborative care models and team approaches are effective methods to improve patients' access to mental health services in primary care settings, receiving reimbursement for the provision of these services is uncommon and difficult. According to Key Informants, reported experiences of state contacts, and the CMS State Medicaid Manual, Medicaid policy does not allow for the reimbursement of practitioner-to-practitioner communication, a critical element to the collaborative care model and team approaches to the provision of mental health services in the primary care setting (Berren, Santiago, Zent, & Carbone, 1999; Brazeau, Rovi, Yick, & Johnson, 2005; Brody, Thompson, Larson, Ford, et al., 1994; Feinman et al., 2000; Feldman, Ong, Lee, & Perez-Stable, 2006; Goldberg, 1999; Hoffmann, Young, Manges, Chambers, et al., 2004; Katon et al., 1995, 1996; Katon, Russo, VonKorff, Lin, et al., 2002; Katzelnick et al., 2000; Lester, Tritter, & Sorohan, 2004; Lin, Katon, Simon, VonKorff, et al., 1997, 2000; Quirk, Rubenstein, Strosahl, & Todd, 1993; Unutzer et al., 2002; Unutzer, Schoenbaum, Druss, & Katon, 2006). The CMS State Medicaid Manual says that for provider-to-provider communication to qualify as a covered service, it must be medical or remedial in nature. This coverage principle is defined as follows: (1) it must involve direct patient care and (2) it must be for the express purpose of diagnosing, treating, preventing, or minimizing the adverse effects of illness.... In order for a service to be covered, it must meet both of these elements. Since a physician's consultation over the phone with another physician

does not involve direct patient care, it would not qualify as a covered service.

This coverage policy is located at section 4385(B) of the CMS State Medicaid Manual.

Consultation between providers is touched upon in the Social Security Act (SSA) under case management. Consultation may or may not be included as a covered service as defined by the State plan. Consultation, to be covered, would have to be part of the case manager's responsibilities, meet the definition of "case management" at 1915(g) of the SSA, and would have to be provided by a Medicaid qualified provider; or part of the rate for another covered service.

4.1.7. Reimbursement of Care and Case Managers

To improve outcomes for persons with mental illnesses who have multiple medical conditions and complex social needs, it is important to fund and reimburse services provided by care managers and social workers in primary care settings. Modifying health plans and reimbursement schemes to permit coverage-of-care coordination through care and/or case managers and social workers would improve patients' access to and coverage of their mental health services. Providers reimbursement for mental health services delivered in the primary care setting would also improve. Care managers, who may not directly see patients but provide essential services in the continuity of care, have difficulty getting reimbursed for services provided in primary care settings (Berren et al., 1999; Brazeau et al., 2005; Brody et al., 1994; Feinman et al., 2000; Feldman et al., 2006; Goldberg, 1999; Hoffmann et al., 2004; Katon et al., 1995, 1996, 2002; Katzelnick et al., 2000; Lester et al., 2004; Lin et al., 1997, 2000; Quirk et al., 1993; Unutzer et al., 2002, 2006). Case

management is a separate service under Medicaid. Some elements of this description may be part of a case manager's responsibilities. See section 1915(g) of the SSA.

4.1.8. Mental Health Care Services in Rural Settings

Providers and practitioners in rural settings may avoid diagnosing a mental disorder for a variety of reasons: protection of patient confidentiality, a lack of specialists with whom patients can consult, difficulties in accessing patients for follow-up and treatment, and a lack of reimbursement for practitioner-to-practitioner communication (Lambert & Hartley, 1998). The shortage of qualified mental health service providers is an issue that needs to be addressed in addition to reimbursement for services provided by current practitioners in rural areas. Telemedicine is a useful method for alleviating the distance and physician-shortage problems associated with providing mental health services in rural primary care settings. Improving reimbursement and simplifying billing procedures for telemedicine, as discussed under section 4.1.5., may increase access to and reimbursement of mental health services for rural communities.

4.1.9. Reimbursement of Services in Schools and School-Based Health Centers

Schools are a cost-effective setting for the delivery of health and mental health services, and are typically stable institutions that exist in all settings, including rural, impoverished, and other underserved areas. Health and mental health services are delivered in schools through a variety of arrangements, which affect the way in which such services are reimbursed. For example, there are approximately 1,700 school-based health centers (SBHCs) located in schools around

the country (Lear, 2007). These centers specialize in providing primary and preventive health care services, and almost two-thirds of SBHCs also employ mental health professionals. SBHCs can receive payment for these services from Medicaid when they provide them to school-age children and adolescents who have Medicaid coverage. However, Medicaid is able to make payments only to enrolled providers. Some SBHCs meet this requirement on their own, and others do so through a sponsoring organization; many SBHCs are sponsored by mainstream medical institutions such as hospitals, community health centers, health departments, or another health care entity that is enrolled with Medicaid. The sponsoring organization typically takes primary responsibility for financial management and billing (Smith, 2002).

Barriers to Medicaid reimbursement initially identified by SBHCs included Medicaid policies that required onsite supervisors and the denial of services not deemed “medically necessary.” Lack of experience and limited administrative capacity on the part of SBHCs have also presented problems. The requirements of health services billing—information systems, coding technology, collections personnel—are often out of reach for small health care programs (NASBHC, 2001).

In a monograph written for HRSA, Vernon Smith in 2002 wrote that only about 1 percent of schools in the United States are served by an SBHC; most school-based health services are provided by schools and school districts. In some states, schools and school districts can enroll as providers under Medicaid. Generally, the State Medicaid office and the State Department of Education have an agreement on the scope of school-based health services that will be reimbursed by Medicaid. The agreement would describe the documentation required and the proce-

dures to be followed for the school districts to participate in Medicaid claiming. In some cases, State legislation governs the process (Smith, 2002).

Through school health services rather than the SBHC, schools may typically provide occupational therapy, speech therapy, physical therapy, and mental health services for students who receive special education assistance through the Individuals with Disabilities Education Act of 1997 (IDEA) and section 504 of the Rehabilitation Act of 1973 (Smith, 2002). The most sizeable resources supporting school health services are Federal Medicaid payments to reimburse schools for certain health-related services provided to students in special education. In 2003, the U.S. Government Accountability Office (GAO) reported that combined state and Federal Medicaid spending for these services reached \$2.3 billion (Lear, 2007).

In some states, schools (unlike SBHCs) can also qualify for Medicaid reimbursement for certain Medicaid outreach activities carried out by school staff. There is wide variability among states in their policies for Medicaid reimbursement for schools, and policies in some states have been subject to recent Federal oversight (Smith, 2002).

A 2007 article by Julia Lear, published in *Health Affairs*, states:

“Medicaid funding for health services provided at school has been the subject of considerable debate. Not all states or school districts have pursued the option of Medicaid reimbursement: they don’t have the documentation and billing systems in place, they are uncertain about reimbursement rules, and some remain worried about being required to reimburse the Federal government if expenses were deemed improperly billed. Nonetheless, in some

states, school districts have begun to bill Medicaid extensively. Although the introduction of Medicaid managed care has made securing reimbursement for services provided to the general school population more difficult, services associated with special education requirements are typically carved out of Medicaid managed care plans, and school districts continue to bill Medicaid for all those services and others, although not without continued debate.” (Lear, 2007).

4.1.10. Lack of Incentives for Screening and Prevention

Early screening and intervention in primary care settings are critical to engaging and treating children and adults with mental health conditions (Nitzkin & Smith, 2004). However, as primary care clinics operate under financial and reimbursement constraints, they often rely on special grants to provide “innovations” like mental health screening and preventive care, or they refer patients to publicly funded mental health, maternal health, and child health clinics for these services. Because providers have few economic incentives to perform mental health screening, patients do not commonly receive the screening procedures necessary for early identification of a mental health problem.

4.1.11. Provision and Reimbursement of Training

Primary care providers, who operate under small budgets with limited available overhead and profits, do not have the additional funds necessary for training on mental health sys-

tems and treatment. Without supplementary resources, PCPs cannot access the training they need to be knowledgeable about presenting mental health symptoms, treatment options, and referral opportunities.

4.1.12. Incentives Associated with Pay for Performance

According to a few Key Informants, pay-for-performance provisions are a double-edged sword for safety-net and community health providers of mental health services. While these provisions may increase flexibility to offer both mental health and primary care services, primary care providers worry that their services to historically underserved, multicondition patient populations—whose poverty and mental illness may impair their ability to participate in and adhere to treatment and administer self-care—will not result in the sufficiently improved outcomes required to qualify providers for reimbursement and performance incentives.

4.2. Medicare

The following sections describe the barriers to and difficulties with receiving reimbursement under Medicare.

4.2.1. Outpatient Mental Health Treatment Limitation

Medicare mental health benefits do not have parity with general health care benefits in terms of inpatient service limits, copayment policies for outpatient services, or reimbursement of expensive services (Mickus, Colenda, & Hogan, 2000).

The Medicare statute explains limits on outpatient mental health care under the Medicare program.

With respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses, only 62½ percent of such expenses.

The Medicare Mental Health Outpatient Payment Reduction Overview is described on the CMS Web site at: www.cms.hhs.gov/Medigap/Downloads/mdgp0202.pdf - 2008-01-02 - . (CMS, December 2002). The Program Memorandum Transmittal No. 02-02 dated December 2002 states:

“For most covered Part B expenses, pursuant to section 1833(a) of the Act, Medicare pays 80 percent of the Medicare allowed amount, leaving the beneficiary responsible for the remaining 20 percent. However, section 1833(c) of the [Social Security] Act requires an intermediate step for certain outpatient mental health services [psychotherapy services for psychiatric diagnosis]. After the allowed amount is calculated, the Medicare carrier or fiscal intermediary applies the statutorily mandated payment reduction, leaving only 62½ percent of the allowed amount, to which it then applies the general 80 percent payment rule. The result is that Medicare pays only 50 percent of the allowed amount.

Due to this reduction, the beneficiary is responsible, after the Part B deductible has been met, for 50 percent of the Medicare allowed amount. In addition, the beneficiary is responsible for any balance billing above the Medicare allowed amount up to the limiting charge for physician services that are not under assignment.”

The limitation applies to therapeutic services provided to outpatients with a primary mental, psychoneurotic, or personality disorder (ICD-9-CM diagnosis codes 290–319)

identified by a physician or a mid-level non-physician practitioner. The payment adjustment does not apply to diagnostic services, medication management services, partial hospitalization services provided by a hospital outpatient department or a community mental health center, or to mental health services furnished to hospital inpatients. Medicare claims with a secondary or tertiary diagnosis of a mental, psychoneurotic, or personality disorder are not subject to the reduction. The psychiatric procedures to which the limitation may apply are those listed under the “Psychiatry” section of CPT, under the code range 90801–90899. The outpatient mental health treatment limitation does not apply to services furnished and billed under a partial hospitalization program.

In addition, section 1812(b)(3) of the Social Security Act imposes a 190-day lifetime limit on covered inpatient psychiatric hospital services.

Medicare copayments

As described above, in certain circumstances, Medicare pays for 50 percent of psychotherapy and counseling costs and for only a limited amount of psychiatric services. The balance is due from patients. This 50 percent copayment for mental health services for a patient diagnosed with a primary mental health problem, compared with a 20 percent copayment for ambulatory general health services, poses a substantial economic challenge for individuals living on fixed incomes. The

outpatient mental health limitation, which can be amended only through statutory changes, provides a disincentive to primary care providers to identify, diagnose, and treat mental health problems in Medicare patients.

According to the Key Informants interviewed, many health care providers perceive that it is challenging to recoup the 50 percent copayment for Medicare patients seen in primary care settings, because they serve a disproportionate segment of Medicare patients who are poor. Some clinics that provided primary care reported forgoing or covering the copays for their Medicare-eligible clients' mental health care from other sources. Additionally, some Medicare patients do not present with mental health problems because they cannot pay the 50 percent copayment associated with the services (Key Informant Interviews, 2006).

4.2.2. Current Procedural Terminology (CPT) Codes

CPT codes, known as Level I codes, are most germane to the discussion of mental health services in primary care as three separate categories within the CPT codes: the Health Behavioral Assessment and Intervention (HBAI) codes; the Psychiatric codes, and the Evaluation and Management services codes. Please refer to section 4.1.2. for more background on the Healthcare Common Procedure Coding System (HCPCS) and the International Classification of Diseases (ICD) coding system.

Health Behavioral Assessment and Intervention (HBAI) codes

In 2005, Medicare adopted new Current Procedural Terminology (CPT) Health Behavioral Assessment and Intervention (HBAI) codes, CPT 96150–155, to address the problematic utilization of previous CPT codes in docu-

menting care delivered to patients with a primary medical illness (e.g., those who have mental health complaints related solely to the medical illness). The HBAI codes are for specific mental health procedures used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. They are intended for use by specific mental health care professionals, such as psychologists, who provide mental health services related to a physical, not a mental health, diagnosis. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) physical diagnosis code that prompted the referral for mental health assessment and intervention must be submitted with the HBAI code claim. The claim must include the physical diagnosis, because HBAI services focus on patients whose primary diagnosis is a physical health problem.

HBAI codes are to be used by mental health specialists such as clinical psychologists because even though clinical psychologists are not authorized to bill Medicare for medical Evaluation and Management (E/M) services, psychologists' scope of program benefit is not restricted to services for the diagnosis and treatment of mental illnesses. HBAI codes are not for use by primary care and other physicians, mid-level nonphysician practitioners such as nurse practitioners, clinical nurse specialists, and physician assistants because they are required to use the medical E/M codes in lieu of the HBAI codes. (Conversely, psychologists cannot bill for E/M services under Medicare because the E/M codes involve services unique to medical management.) The primary care physician does a "warm handoff" of the patient to the mental health specialist in the primary care site. Since primarily physical diagnoses are

associated with the HBAI codes, it is logical that the outpatient mental health (MH) treatment limitation does not apply to these services. However, there is no national policy under Medicare law or regulations that specifically preclude application of the MH outpatient limitation to HBAI services (R. W. Walker, CMS, personal communication, June 15, 2007). Each practitioner should check with his or her insurance company, State Medicaid agency, and/or Medicare fiscal intermediary for appropriate billing and reimbursement procedures.

Additionally, clinical social workers may not use HBAI or E/M codes because the scope of their benefit as authorized by Medicare law specifically limits clinical social workers to services for the diagnosis and treatment of mental illnesses. Clinical social workers are authorized under Medicare law at section 1861(hh)(2) of the Social Security Act to bill services for the diagnosis and treatment of mental illnesses only. They are not eligible to bill using CPT E/M codes or the HBAI codes (R. W. Walker, CMS, personal communication, August 17, 2006).

Under the National Correct Coding Initiative (described in section 4.1.3.), a provider cannot bill Psychiatric codes (CPT 90801–90899) and Health Behavior Assessment and Intervention (HBAI) codes (96150–96155) on the same day. For services rendered to patients who require both psychiatric and HBAI services, the provider may report only the principal service given, even if services are provided by two distinct practitioners (American Psychiatric Association, 2006). For example, a psychologist doing an assessment under an HBAI code might request a psychiatric consultation. If there were a psychiatrist onsite in the clinic, this consultation would appropriately be billed under the Psychiatric codes, but the psychologist's services on that

same day could not also be billed under the HBAI codes (American Psychiatric Association, 2006). This prohibition has limited some billing for same-day services under Medicare.

Psychiatric codes

Under the Medicare Part B program, the category of “Psychiatry” CPT procedure codes 90801–90899 may be billed by physicians, clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, and an employer of a physician assistant. This range of Psychiatry procedure codes 90801–90899 is often used to treat patients with primary mental, psychoneurotic, and personality disorders that are identified by ICD-9-CM diagnosis codes 290–319. When submitting claims for outpatient mental health services under the Medicare program, the claim must contain an appropriate diagnosis code, procedure code, and a place of service code (R. Walker-Wren, CMS Memorandum, June 15, 2007).

A Medicare memorandum dated March 2003 to intermediaries and carriers on processing Medicare payment for outpatient mental health services states:

“Providers and suppliers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. In order for services to be covered and paid, physicians, nonphysician practitioners and allied health professionals must be working within their State scope of practice act and they must be licensed or certified by the state in which the services are performed to furnish mental health services.” (CMS, March 28, 2003).

The one qualification standard that the Medicare program requires uniformly under its Federal qualifications for physicians, nonphysician practitioners, and allied health

professionals is that these individuals must be licensed/certified by the state to practice and that the services that they provide must be services that fall under their State scope of practice. So, while the Medicare program does not limit the use of the Psychiatry CPT procedure codes to psychiatrists (physicians who specialize in treating mental health illnesses), the program directs its contractors (carriers and intermediaries), when processing claims for mental health services, to evaluate the individual's qualifications, whether they are operating within their State scope of practice, and whether the services furnished are reasonable/necessary (R. Walker-Wren, CMS, personal communication, September 11, 2007).

In other words, Medicare does not limit the use (by physicians) of psychiatric CPT codes to a psychiatrist (i.e., a doctor who is specialized in mental health); however, Medicare directs carriers for Medicare payment to evaluate billing as to the provider's qualifications and licensure or certification to perform mental health services, and to evaluate whether the physician is operating within the State scope of practice and the services are reasonable/necessary. This may be a source of variable interpretation and payment variability, in that states may vary in specificity of provider type they authorize to deliver specialized mental health services.

Evaluation and Management codes

Physicians and other authorized practitioners use the Evaluation and Management (E/M) CPT codes for mental health assessment and treatment services. Under the Medicare program, those who are authorized to bill E/M codes include physicians, nurse practitioners, clinical nurse specialists, and physician assistants (R. W. Walker, personal communication, August 17, 2006). Psychologists cannot

Table 4.3: Types of E/M CPT Codes to Be Used with an ICD-9-CM Diagnosis, by Primary Care Practitioners (Personal Communication with CMS, 2006)

Type of Service	E/M CPT Codes
Office	99201–99215
Consult	99241–99255
Homecare	99324–99340
Preventive*	99381–99429*

* Preventive codes 99381–99429 are not covered by Medicare. (J. Warren, personal communication with CMS, August 21, 2006).

Note: Medicare pays for Homecare codes 99324–99337. However, 99339 and 99340 are considered bundled under the Medicare physician fee schedule and are not paid separately. (A. Bassano, CMS, September 4, 2007).

bill for E/M services under Medicare because the E/M codes involve services unique to medical management.

The Evaluation and Management (E/M) consultation codes (99241–99255) and office codes (99201–99215) are to be used by the primary care physician and primary care extenders, such as physician assistants, nurse practitioners, and clinical nurse specialists, and are the most common codes used by providers in the primary care setting. Clinical psychologists and clinical social workers cannot bill for E/M under Medicare because the E/M codes involve services unique to medical management, such as laboratory results, medical diagnostic evaluations, and medication management. The series includes CPT E/M code numbers that vary according to the site where service is delivered, and each code series has associated payment rules. Services must be medically necessary, the practitioner must be practicing within his or her scope of practice as defined under Federal and State laws, and, due to the passage of the Health Insurance Portability and Accountability Act

(HIPAA), the codes must be used in conjunction with an ICD-9-CM medical or psychiatric diagnosis.

To summarize HCPCS Level I (CPT) and Level II coding information, the following table presents a summary of Medicare and Medicaid payments for mental health services.

Table 4.4: Medicare & Medicaid Payment for Mental Health Services

Type of Code	Service Codes	Diagnosis Codes	Type of Practitioner Allowed to Bill Medicare	Type of Practitioner Allowed to Bill Medicaid
CPT Psychiatry Codes (Level I Current Procedural Terminology, maintained by AMA)	Initial Evaluation: 90801 Psychiatric therapeutic codes: 90802–90899. Use with ICD-9-CM Psychiatry diagnostic codes.	MH diagnosis as Primary. Use psychiatric service codes w/ ICD-9-CM Diagnostic Codes 290–319 to identify mental, psychoneurotic, and personality disorders.	Mental health specialists: physicians and nonphysicians, such as certified clinical social workers (CSWs) licensed by the state and clinical psychologists, licensed by and subject to state criteria, operating within the scope of their practice as defined by the state.	Many states allow payment for these codes; check with individual State Medicaid Program.
CPT Health Behavior Assessment and Intervention (HBAI) Level I CPT	96150–155	Physical Diagnosis from ICD-9-CM as Primary Diagnosis.	Nonphysician mental health practitioners, such as psychologists, licensed by the state and subject to state criteria. CSWs may not use.	Up to the State; many do not yet pay for these newer codes.
CPT Evaluation and Management (E/M) Level I CPT	99201–99215 (Office) 99241–99255 (Consultation)	Physical or Psychiatric Diagnosis from ICD-9-CM as Primary.	Physicians and primary care extenders, such as nurse practitioners, clinical nurse specialists, and physician assistants, licensed by the state.	Many states allow payment for use of E/M service code in primary care, and report use of E/M with ICD-9-CM Psychiatric Diagnosis Codes 290–319; check with individual State Medicaid Program.
Level II HCPCS (“State” Codes, used more often by Medicaid; maintained by CMS)	A-V codes are standardized nationally; G codes include some substance use codes; W-Z codes are state-specific.	Depends on service.	Medicare pays for some Level II codes, including A, G, J codes; Medicare does NOT pay for H (State mental health codes), S, or T codes. H codes are for Medicaid only. As of 2008, two new Medicare alcohol/drug assessment brief intervention “G” codes: G0396 and G0397.	Medicaid State agencies more often allow the Level II codes. The H and T codes are for Medicaid only. Check with individual State Medicaid Program.

4.2.3. Reimbursement of Services Provided by Nonphysician Practitioners

Under the Medicare program, “nonphysician practitioners” are those individuals who are recognized under Medicare law but are not physicians. Nonphysician practitioners who

are authorized under the Medicare Part B programs to furnish mental health services include clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants. These practitioners must be licensed by the state to

furnish mental health services (42 CFR 410.71–76; and sections 1861 (ii), (hh), and (s) and section 1833(a) (1) of the SSA).

Medicare reimburses mental health services provided by nonphysician practitioners and mental health specialists such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants. However, Medicare does not pay marriage and family therapists or licensed professional counselors for their mental health services (Christenson & Crane, 2004). Marriage and family therapists and licensed professional counselors are not authorized to bill the Medicare program for mental health services because there is no defined program benefit under Medicare that specifically recognizes them and authorizes them to bill the program for their services. Marriage and family therapists and licensed professional counselors may receive payment indirectly for their psychotherapy services when furnished to Medicare patients under a partial hospitalization program that is provided by a hospital outpatient department or a community mental health center. In some cases, marriage and family therapists and licensed professional counselors may receive indirect payment for psychotherapy services furnished incident to the professional services of a physician, clinical psychologist, nurse practitioner, clinical nurse specialist, or physician assistant when the services are furnished in an office setting and they are licensed by the state to furnish psychotherapy services.

4.2.4. Medicare Managed Care Organizations Medical Review Policies

While Medicare laws do not place medically necessary limits on mental health services,

such as the need to show improvement as long as the services are medically necessary, Key Informants said that many Medicare Part B and Part C carriers have established medical review policies that restrict the services covered by Medicare. Moreover, while the Federal Medicare program may not have specific medically necessary restrictions, Forum participants stated that many managed care contracts have “medically necessary” clauses that may be subject to interpretation and may result in restricting mental health services.

4.2.5. Reimbursement to Prescription Drug Plans under Medicare Part D

This topic, while not directly related to “reimbursement of primary care providers,” was identified repeatedly by Key Informants as a potentially problematic area for those persons taking psychiatric medications, particularly for dually-eligible beneficiaries. The experts feared the implementation of Part D would impact reimbursement of patients who may be Medicare beneficiaries receiving prescription medications for psychiatric conditions. Informants from organizations that serve disabled and/or elderly adults identified problems with the shift of pharmacy benefits from Medicaid to Medicare Part D. Some informants voiced concerns that, although CMS required their prescription drug plans (PDPs) to “grandfather” enrollees’ current prescriptions for psychiatric medications, beneficiaries might lose the grandfather provision if they discontinue their medications, even briefly. They feared loss of coverage of their clients’ current prescriptions in favor of cheaper drugs.

Expert Forum Summary

The Expert Forum provided an opportunity for individuals from diverse professional backgrounds who work in the fields of mental health and/or primary care on a daily basis to discuss reimbursement of mental health services in primary care settings. The Expert Forum included 13 expert non-Federal participants, 11 government participants, and 12 invited observers. Among the invited experts were practitioners, policymakers, researchers, and program directors from a variety of settings, including HIV/AIDS clinics, federally qualified health centers, rural health clinics, state mental health and Medicaid agencies, and national association staff. Government participants included senior staff in each of the three sponsoring agencies and a variety of government observers. (For a listing of Forum attendees, please see Appendix B.)

The Forum opened with introductory remarks by the three sponsoring Federal agencies from SAMHSA, HRSA, and CMS. Introductory speakers emphasized the importance of designing a system that embraces mental health care and physical health care and using creative and innovative approaches to improve the reimbursement and provision of mental health care in primary care settings.

Following introductions, the White Paper findings were summarized (documented in section 4), and participants were asked to identify additional barriers that affect the reimbursement of mental health services in primary care settings. The following list represents the barriers and concerns identified by the Expert Forum:

- Reimbursement policies favor coverage of procedures, placing cognitive services and their practitioners at a disadvantage.
- Reimbursement rates are often too low to cover the costs of delivering care in rural and urban settings. These rates are established at the State Medicaid agency level or carve-out primary care provider level plan and do not sufficiently account for the variance in case mix of rural and urban clinics. Even enhanced payment rates received by rural clinics are not sufficient to cover the costs of services or placement of a behavioral health worker in this type of clinical setting.
- Limits in the number of reimbursable visits with nonphysician practitioners can be too severe, particularly in rural settings where the number of available physicians is insufficient to meet the demand for care.
- Fiscal intermediaries vary in their interpretation and approval of codes. Interpretations are often more narrow than Medicare law allows, creating misunderstandings on

reimbursement policies and denying reimbursement for allowable procedures.

- Codes used in unintended ways (e.g., use of the CPT 90801 for postnatal depression screen) can create reimbursement advantages for some providers; however, the allowance in some cases and denial in other cases causes confusion at the practice and plan levels.

After discussion of the reimbursement barriers, through a facilitated decision process, the Expert Forum prioritized the barriers to emphasize key issues or options from the many proposed. The top seven barriers identified during the decision process were the following:

1. State Medicaid restrictions on payments for same-day billing.
2. Lack of reimbursement for collaborative care and case management related to mental health services.
3. Lack of reimbursement of services provided by nonphysicians, alternative practitioners, and contract practitioners.
4. Medicaid disallowance of reimbursement when primary care providers submit bills listing only a mental health diagnosis and corresponding treatment.
5. Reimbursement rates in rural and urban settings.
6. Difficulties in getting reimbursement for mental health services in school-based health center settings.
7. Lack of reimbursement incentives for screening and providing preventive mental health services.

Next, the Expert Forum proposed solutions to the top seven barriers and made suggestions to the Federal agencies for actions aimed at alleviating the barriers to the reimbursement of mental health services in the primary care setting. Through extensive dialogue, the Expert Forum composed suggestions for future action:

1. To reduce denials associated with same-day billing, such as mental health and physical health services on the same day when services are provided on the same day by two separate practitioners.
2. To improve reimbursement of evidence-based practices (EBPs), collaborative/consultative care, team approaches to providing care, and reimbursement of care and case management services.
3. To increase payment for professional services by nonphysician practitioners under Medicaid and Medicare.
4. To improve primary care provider access to mental health services reimbursement through participation in carve-out networks.
5. To increase reimbursement rates in urban and rural settings.
6. To assist school-based health centers in getting reimbursed for mental health services.
7. To improve incentives for screening and prevention of mental illness.

VI. Suggested Actions

The Expert Forum looks to the Department of Health and Human Services (HHS) to provide direction and to ensure interagency coordination of efforts to address barriers to reimbursement of mental health services in primary care settings. A synopsis of the Expert Forum's suggested actions indicates the need for a collaborative approach across the HHS agencies, including CMS, HRSA, SAMHSA, and the Agency for Healthcare Research and Quality (AHRQ). Suggested actions include the tasks listed below.

6.1 Clarification

The Expert Forum's most commonly expressed recommendation to improve reimbursement of mental health services in primary care settings was to **clarify policies, definitions, and allowable services, and broadly disseminate clarifications.** These clarifications may require involvement of multiple levels or organizations. The Expert Forum suggested the following:

- Through collaboration among state and Federal governments and national commissioner associations, clarify the:
 - Federal Medicare and Medicaid role in coverage of services, coding and billing for services, and allowable services and licensed practitioners for the provision of mental health services in primary care settings.
 - Services that primary care physicians may bill for through Medicare and what services State Medicaid programs may cover per Federal guidance.
 - Services for which there is no Federal prohibition on employing nonphysician practitioners, and explicitly state that if barriers are present, it is not caused by the Federal government, but perhaps a state or local decision. Publicize states that allow reimbursement of services by nonphysician practitioners.
- Review Medicaid State Plans State-by-State to discern the allowable services by practitioner, provider/setting, payer, and managed care contract rule, including a review of rules for preauthorization, medical necessity, number of allowed services, and requirements for correct billing for providing mental health services. A suggested first step in this process is to revisit previous State-by-State reports, such as those conducted by Abt Associates, Inc., the National Council of Community Behavioral Health Organizations, State Medicaid agencies, the National Academy for State Health Policy, and other organizations. These reports provide further insight into individual states' coverage of services, including optional services and reimbursement criteria.
- Identify reimbursement policies for professional services that support the provision

of mental health services in primary care settings, including screening, care management, and psychiatric consultation.

- Disseminate a clarification on capitated rates that includes funding for screening and prevention in states with carve-out contracts, to ensure that providers are adequately screening and providing preventive services. For example, look at states with Medicaid managed care contracts that have capitated providers.

Widely disseminate and publicize the clarifications to payers, including State Medicaid agencies; state mental health departments; fiscal intermediaries contracted by the states and CMS; managed care organizations; practitioners; and providers, including primary care practices, national and state organizations representing primary care providers, and primary care provider and practitioner newsletters and journals.

6.2 Collaboration

The Expert Forum recommended *targeted collaboration among the Department of Health and Human Services agencies and national organizations* to improve the reimbursement of mental health services in primary care settings. Collaboration occurs when agencies and individuals have a desire to *support and promote a particular mission or undertaking or particular values*, such as improving the reimbursement of mental health services in primary care settings. For effective collaboration to occur, each partner must dedicate time and resources to achieve the goals under the collaboration's mission. To improve the reimbursement of mental health services in primary care settings, sustained collaboration is necessary among a variety of organizations and agencies with

clear lines of accountability, defined responsibility, and designated tasks that are targeted to sustainable solutions.

The Expert Forum proposed the following:

- Undertake collaboration among state and Federal governments and State commissioner associations to clarify what reimbursement is allowed in each state and at the Federal level, illuminating for providers, payers, and rulemakers correct coding and billing methods.
- Formalize a work project jointly staffed by SAMHSA, HRSA, CMS, and AHRQ to establish core competencies, service definitions, and reimbursement codes for collaborative care services. The agencies may examine state activities (e.g., North Carolina Medicaid) and research models on collaborative care (e.g., IMPACT) to find guidance on these issues. Under the Deficit Reduction Act, AHRQ has officially been charged to look at reimbursement of evidence-based practices. By collaborating with AHRQ, the agencies can provide a common definition of collaborative care evidence-based practices (EBPs).
- Support the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Medicaid Directors (NASMD) in collaboration targeted to encourage states to:
 - Provide reimbursement for services by nonphysician practitioners.
 - Publicize that “a service” is allowable or mandated under Federal Medicare, or there is a procedure code available to States under Medicaid guidelines.
 - Include in their State Plans the allowable and optional mental health services and services provided by nonphysi-

cians, particularly in underserved urban and rural primary care settings.

- Encourage carve-outs to include PCPs in behavioral health provider networks to broaden access to timely and appropriate diagnosis and treatment of mental health problems. The Federal government can encourage states to develop contract terms that require managed behavioral health-care organizations (MBHOs) to include primary care providers in their networks.

6.3 Education and Technical Assistance

The Expert Forum identified *education and technical assistance recommendations* that cross settings, payers, practitioners, and provider types. To improve reimbursement of mental health services in primary care settings, it is essential that consistent and correct information be shared among states, the Federal government, national nongovernmental organizations, provider associations, payers, and others. To improve the dissemination of consistent information, the Expert Forum concluded that Federal health agencies and state commissioner organizations should:

- Provide technical assistance on Primary Care Provider (PCP) and MBHO carve-out reimbursement “best practices” to states.⁴
- Disseminate materials on appropriate use of Current Procedural Terminology codes, such as Health Behavior Assessment and Intervention (HBAI), Evaluation and Management (E/M), and International Classification of Diseases, Ninth Revision, Clinical

⁴ Examples of “best practices” include studies describing a collaborative care intervention in primary care patients with depression (Katon, 2002), and self-management programs for those with chronic diseases (Lorig, 2001).

Modification (ICD-9-CM) diagnosis codes, and other mental health claims codes that are commonly accepted and reimbursed.

- Assist states in being better purchasers of value and support states’ ability to audit purchased services.
- Identify and promote the business and clinical cases for provision of best practices and use of nonphysician practitioners not currently eligible to be reimbursed by Federal programs (i.e., licensed professional counselors in Medicare and, in some states, certified social workers (CSWs) and licensed marriage and family therapists (LMFTs) by Medicaid).
- Educate states, payers, practitioners, and providers about currently effective reimbursement methods and mechanisms, and what states, managed care organizations (MCOs), MBHOs, and providers are doing to improve access to mental health services appropriately provided and reimbursed in primary care settings. It is critical to share examples with plans and providers of what is already working in the states.

6.4 Approval, Authorization, and Support of Additional Services

Finally, the Expert Forum discussed and recommended the approval, authorization, and support of additional services and measures to improve the provision and reimbursement of mental health services in primary care settings. This recommendation applies primarily to State Medicaid agencies and private insurers that have the flexibility to implement it. The types of changes the Expert Forum recommended included the following:

- Require linkages to long-term follow-up, as a criteria for receiving incentive payments for screening and prevention services.

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- Improve integration across mental health and primary care settings by providing incentives for continuity, consultations, and referrals to specialty care settings (onsite consultation and referrals for rapid care).
 - Use current performance measures in the Health Plan Employer Data and Information Set (HEDIS) and National Committee for Quality Assurance to address issues of integrating mental health in primary care settings. Use of HEDIS encourages evidence-based practices.
 - Implement geographic-specific actions; for example, in rural settings:
 - Promote use and coverage of technology (such as telehealth) and allied professions to improve rural access, and extend urban care to meet high demands for services.
 - Ease restrictions for use of modalities such as telemedicine, sufficient payment rates, multiple services and providers in the same day, and in schools or school-based health centers, to increase access to mental health services for workforce-shortage areas.
 - Provide additional guidance on which mental health conditions can be covered for reimbursement in rural health clinics.
 - Reimburse telemedicine and telehealth using simplified reimbursement procedures.
- Provision and support of the additional services, guidance, and actions can improve reimbursement of and access to mental health services in primary care settings.

VII. Study Conclusions

The primary care setting is often referred to as the “de facto mental health care delivery system” (Regier, Goldberg, & Taube, 1978). More than 40 percent of patients with mental health concerns initially seek care in primary care settings (Chapa, 2004). In 2005, the National Survey on Drug Use and Health found that there were an estimated 24.6 million adults ages 18 and older with Serious Psychological Distress; this represents about 11.3 percent of all adults (SAMHSA, 2006), many of whom can be identified, assessed, and treated in the primary care setting. The primary care setting provides a valuable opportunity to improve access to mental health services.

Using the White Paper that provided a synopsis of the key barriers resulting from an Environmental Scan and Key Informant Interviews, the members of the Expert Forum deliberated and identified priorities among reimbursement barriers and proposed suggested actions for the sponsoring agencies that the Forum participants viewed as practical and achievable. In summary, the Expert Forum’s recommended solutions included the following:

- Increase leadership collaboration at the Federal and state levels among government policymakers from Medicare, Medicaid, primary care, and mental health to ensure clarity in policies, rules, and procedures and to promote the provision and reimbursement of mental health services in primary care settings.
- Broadly disseminate clarified policies and procedures to patients, payers, practitioners, providers, and managers of care.
- Provide technical assistance and education to states, practitioners, providers, and managed care organizations.
- Encourage flexibility in State Medicaid benefit designs to cover mental health services in primary care settings, modeling changes based on best practices now in effect under some States’ Medicaid waivers.
- Expand coverage for nonphysicians, particularly in underserved rural and urban areas.
- At the state level, implement policies for adequate reimbursement of telemedicine services.
- Provide reimbursement for mental health prevention and screening services.

Implementing these practical and achievable solutions will improve access to timely and targeted mental health services. Program and clinical experts agree that timely, targeted intervention to prevent and treat mental

disorders early will result in the reduction of individual suffering, family burdens, social and medical costs.

This project provided an important opportunity to review policy and service-delivery mechanisms aimed at improving the reimbursement of mental health services in primary care settings. By using knowledge from a variety of individuals and settings and com-

bing empirical research with qualitative interviews and the Expert Forum proceedings, this project identified areas where the Federal government, states, provider organizations, and commissioner associations can clarify, collaborate, educate, and provide support to improve the reimbursement of, thereby increasing access to, mental health services in primary care settings.

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Appendix A:

Key Informants

- Carol Alter, M.D., President, Ten Project, Washington, DC.
- Nancy Conde, Director, North County Children’s Clinic, Watertown, NY.
- Mary Jane England, Chair of IOM Committee on “Improving the Quality of Health Care for Mental and Substance Use Conditions,” Weston, MA.
- Ellis Frazier, M.D., family physician in a Community Primary Care Center in Ohio; Board of Directors, Association of Clinicians for the Underserved (ACU).
- Betty Funk, M.B.A., President, Mental Health and Substance Abuse Corporations of Massachusetts, Inc., Natick, MA.
- Dennis Freeman, CEO, Cherokee Health Systems, TN.
- Shirley Gordon, Executive Director, New York State Assembly on School Based Health Care, Loudonville, NY.
- Henry Harbin, M.D., Commissioner, The President’s New Freedom Commission on Mental Health, Columbia, MD.
- Liz Kerschner, L.C.S.W., Director of Behavioral Health, Care South, Augusta, GA.
- Clare Malone, Executive Director, New York City Assembly on School Based Health Care, New York, NY.
- Mary Moran, Ed.D., Clinical Director, Catholic Charities of South Dakota, Sioux Falls, SD.
- Mark Olfson, NYSPI, Psychiatric Disorders in Primary Care, New York, NY.
- Harold Pincus, M.D., previously Chair of Psychiatry, University of Pittsburgh, Pittsburgh, PA; now at Columbia University.
- Denise Podeschi, Ph.D., Principal, Mercer Human Resources Consulting, San Francisco, CA.
- Katherine Rost, R.N., Ph.D., Consultant on Integrated Care, Aurora, CO.

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- John Schlitt, Executive Director, National Assembly on School Based Health Care, Washington, DC.
 - Kim Sibilsky, Michigan Primary Care Association, Lansing, MI.
 - Suzan Stecklein, Medicaid, CMS Central Office, Baltimore, MD.
 - Jeff Thomas, El Rio Santa Cruz Neighborhood Health Center, Tucson, AZ.
 - Jurgen Unutzer, M.D., Associate Professor, Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, University of California, Los Angeles, CA.
 - Regina Walker-Wren, Medicare, CMS Central Office, Baltimore, MD.

Appendix B: Expert Forum Participants List

Expert Forum Non-Federal Participants (13)

- Jennifer L. Bright, National Mental Health Association (for NMHA)
- Mirean Coleman, National Association of Social Workers (for NASW)
- Elizabeth Edgar, National Alliance on Mental Illness (for NAMI)
- Brian Hepburn, Department of Health and Mental Hygiene (for NASMHPD)
- Barbara J. Mauer, MCPP Healthcare Consulting (for NCCBH), via phone
- Dennis Mohatt, Western Interstate Commission for Higher Education, Mental Health Program (State of Nebraska)
- Dianne Pedulla, American Psychological Association (APA)
- Harold Alan Pincus, Columbia University
- Doug Porter, Department of Social and Health Services (State of Washington Medicaid Director)
- Maritza Rubio-Stipec, American Psychiatric Institute for Research and Education (for American Psychiatric Association)
- Kim Sibilsky, Michigan Primary Care Association
- Lynn Wegner, Learning and Development Associates (for American Academy of Physicians)
- Barry S. Zingman, Montefiore Medical Center

Federal Government Participants (11)

- Gale Arden, Centers for Medicare & Medicaid Services (CMS)
- Jeff Buck, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration
- Peggy Clark, CMS

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- Regan Crump, Health Resources and Services Administration (HRSA)
 - Terry Pratt, CMS
 - Alexander F. Ross, HRSA
 - Shelagh Smith, CMHS/SAMHSA
 - Suzan Stecklein, CMS
 - Regina Walker-Wren, CMS
 - John Warren, CMS
 - Donald Weaver, HRSA

Abt Associates, Inc. (4)

- Allison Goldberg
- Junius Gonzales
- Cori Kautz
- Danna Mauch

Invited Observers (12)

- Cynthia Arno, HRSA
- Christopher D. Carroll, CMHS
- W. Peter Donovan, Jr., CMHS
- Cynthia K. Hansen, CMHS
- Isadora Hare, HRSA
- Jean Hochron, HRSA
- Susan G. Keys, CMHS
- Elizabeth I. Lopez, SAMHSA
- Kristen Martinsen, HRSA
- Harriet McCombs, HRSA
- Kymian D. Ray, HRSA
- Mary R. Vienna, HRSA

