REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-15

Subject: Integrating Physical and Behavioral Health Care

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Referred to: Reference Committee A
(John Ingram III, MD, Chair)

At the 2014 Annual Meeting, the House of Delegates adopted Policy D-345.987, which states:

> That our American Medical Association (AMA), along with interested specialty and state societies, will study and report back at the 2015 Annual Meeting on our current state of knowledge regarding integration of physical and behavioral health care, including pediatric and adolescent health care, and make recommendations for further study, implementation of models of physical and behavioral health care integration, and any other tools or policies that would benefit our patients and our health care system by the integration of physical and behavioral health care.

In response to the request in Policy D-345.987 for the AMA to work with interested specialty and state societies on this issue, the Federation was solicited for input. The Council received responses from the following national medical specialty societies and state medical associations: American Academy of Child and Adolescent Psychiatry/American Association of Child & Adolescent Psychiatry, American Psychiatric Association, Colorado Medical Society, Minnesota Medical Association, Medical Society of New Jersey and the Medical Society of Virginia. These national medical specialty societies and state medical associations are involved in a variety of activities to integrate physical and behavioral health care. The Council greatly appreciates all the information that was submitted and took it into consideration when developing this report.

This report provides background on the movement toward integrated physical and behavioral health care; presents examples of integrated care approaches, including for children and adolescents; highlights state and specialty society activities; identifies medical and continuing education opportunities; explains payment options for integrated care; summarizes relevant AMA policy; discusses barriers and potential solutions to implementing integrated care; and presents policy recommendations.

BACKGROUND

Less than half of the 43 million adults identified with a mental illness and the 6 million children identified as suffering from an emotional, behavioral, or developmental issue receive treatment.[1] Mortality rates for individuals with behavioral health conditions are estimated to be twice as high as in the population as a whole.[2] Individuals with a mental illness and coexisting physical health condition experience an increased risk of adverse health outcomes. However, research indicates that coordinated care management of mental and physical health conditions improves disease control.[3]

There is an increasing emphasis to integrate the delivery of physical and behavioral health care in one setting. The movement toward an integrated delivery approach stems from clinical factors such as: the majority of behavioral health care takes place in primary care settings, some of which lack psychiatric resources; many individuals with behavioral health conditions do not experience coordinated care for their comorbid conditions; and some patients feel more comfortable receiving behavioral health care in their medical home. Financial costs also play a role in the focus to integrate care. A 2014 Milliman economic analysis estimated that health care spending for individuals with behavioral health needs is $525 billion annually. Furthermore, medical costs for treating individuals with physical and behavioral health conditions can be 2-3 times higher than medical costs for individuals without comorbid conditions. The analysis concluded that effective integration of physical and behavioral health care could save $26-$48 billion dollars annually in general health care costs.[4]

CONTINUUM OF INTEGRATED CARE

A continuum of treatment approaches provide integrated physical and behavioral health care ranging from coordinated care to full team-based integration. Coordinated care involves primary care physicians routinely screening patients for behavioral illnesses and behavioral health providers screening patients for physical illnesses. Patients are then assisted in obtaining the prescribed behavioral health or physical health care treatment(s). Next on the continuum are primary care physicians who consult with psychiatrists who are not physically located in the practice setting. Co-location further integrates care by having behavioral health and primary care providers share a physical space to collaborate on patients' care. The most integrated treatment approach "embeds" behavioral health providers in primary care teams that maintain one treatment plan to address all of a patient's health needs in a shared medical record. Some models integrate primary care providers and services into behavioral health care settings especially for patients with more severe behavioral health conditions.

EVIDENCE-BASED INTEGRATED CARE

Among the most advanced and evidence-based integrated care models is the collaborative care model (CCM), which the University of Washington in Seattle has been developing and testing for the past 20 years. A meta-analysis of 57 treatment trials concluded that a CCM can improve physical and behavioral health outcomes across a wide variety of care settings.[5] According to the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center, CCM is defined as a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach. The specific principles of care for this model include patient-centered care, population-based care, measurement-based treatment, evidence-based care, and accountable care.[6] The AIMS Center has developed a step-by-step guide to provide a broad overview of the major steps needed to successfully implement a CCM program.[7]

Integrated physical and behavioral health care should include telemedicine as needed. Especially in areas with a physician workforce shortage, telemedicine can improve access to behavioral health care. The AMA has policy and advocacy resources related to telemedicine.

PEDIATRIC AND ADOLESCENT INTEGRATED HEALTH CARE

Improved access to mental health services for children, adolescents and their families is a priority for the American Academy of Child and Adolescent Psychiatry (AACAP). AACAP has developed best practices for integrating child and adolescent psychiatry into the pediatric health home to

provide access to high quality mental health care. The principles include family-focused care, professional collaboration between primary care providers and child and adolescent psychiatrists, care plan development for children and adolescents with complex mental health needs, and care coordination.[8]

An example of a large pediatric medical home that provides integrated care is Goldsboro Pediatrics in North Carolina. The state is using concurrent 1915(b) and 1915(c) Medicaid waivers to provide a continuum of services to individuals with mental illnesses, developmental disabilities and substance use disorders. Through the waivers, Goldsboro Pediatrics has been supervising integrated care in six school-based health centers for more than 10 years. The health centers are integrated into the medical home through an electronic health record system. More than 5,000 behavioral health consultations are provided each year by private sector mental health professionals for at-risk students in the school-based health centers. Parents or guardians are invited to be involved in the treatment of their children. If needed, telemedicine consultation is provided.

STATE ACTIVITY

State activities to integrate care range from federally funded initiatives to local community networks. Following are three examples:

Colorado

In December 2014, Colorado was awarded a State Innovation Model grant of $65 million through the Centers for Medicare & Medicaid Services (CMS) to implement and test its state health care innovative plan, “The Colorado Framework.” The funding will assist Colorado in integrating physical and behavioral health care for 80 percent of the state’s residents in more than 400 primary care practices and community mental health centers comprised of approximately 1,600 primary care providers. The plan will create a system of clinic-based and public health supports to improve integration.

Massachusetts

The Massachusetts Child Psychiatry Access Project (MCPAP) aims to increase behavioral health screening and treatment for pediatric patients throughout the state. Any primary care provider can register with the program and receive phone and face-to-face behavioral consultations, help with referring children to community behavioral health centers, and continuing education through workshops and webinars. In 2014, the program included 455 practices, which totaled 2,915 primary care providers.[9]

Virginia

The North Virginia Primary Care/Mental Health and Patient Centered Medical Home (NoVa PCMH) Collaborative is a network of more than 100 primary care physicians, psychiatrists, psychologists and other mental health clinicians in Northern Virginia developed to provide mental health resources to primary care physicians. A website facilitates virtual consultations, connects local clinicians, stimulates collaboration about clinical situations, provides local resources, and develops relationships to foster potential co-location of mental health clinicians in primary care practices.

INTEGRATED MEDICAL AND CONTINUING EDUCATION

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) released a resource identifying core competencies on integrated practice relevant to behavioral health and primary care providers.[10] The recommended core competencies include: interpersonal communication, collaboration and teamwork, screening and assessment, care planning and care coordination, intervention, and cultural competence and adaptation. The development of these core competencies is intended to serve as a resource for provider organizations developing an integrated care practice as well as for educators who are developing curriculum and training programs.

The American Psychiatric Association (APA) recently reviewed the undergraduate, graduate medical education and continuing medical education environment to examine the availability of education on integrated health care.[11] The APA found that undergraduate medical education in integrated care is in the early stages of development, but that a significant number of general psychiatry and child and adolescent psychiatry residency programs are offering rotations and/or didactics in integrated care. The APA has taken a leading role in developing continuing medical education (CME) on integrated care through developing seminars and training programs, and providing courses at APA meetings as well as online. The APA acknowledges that CME providers with a large multispecialty audience are in a strong position to offer multidisciplinary and multispecialty CME on integrated care.

PAYMENT FOR INTEGRATED CARE

A high prevalence of individuals with behavioral health disorders are seen by primary care physicians who may be unaware of payment options for providing both physical and behavioral health services in one day. According to the AMA's 2015 Current Procedural Terminology (CPT®) codebook,[12] patients can receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using specific add-on codes for 30, 45 or 60 minute psychotherapy sessions (90833, 90836 and 90838) when performed in conjunction with E/M codes (99201-99255, 99304-99337, 99341-99350). Primary care physicians are not excluded from using these codes, however, private insurers may differ on whether they recognize them and pay for the services.

Medicare

Effective January 2015, primary care physicians can bill for chronic care management provided to their Medicare fee-for-service patients. The new CPT® code (99490) allows physicians to bill for non-face-to-face care for Medicare beneficiaries with two or more chronic conditions, including depression and anxiety. The code requires at least 20 minutes of chronic care management per month, such as reviewing lab reports, talking with families and patients by phone, arranging referrals, and helping to order medical equipment. Physicians can receive $42.60 per patient per month for providing these services.

Medicaid

Some state Medicaid programs prohibit same-day billing for physical and behavioral health care. The inability to receive both services on the same day is a significant barrier to integrated treatment for Medicaid beneficiaries.

In 2014, CMS released new guidance on the rule "Medicaid Payment for Services Provided without Charge" ("Free Care"). Schools that offer physical and behavioral health screenings to all children free of charge can now receive Medicaid payment for services provided to Medicaid-enrolled children as long as the services are covered under the state Medicaid plan. Not all state Medicaid plans cover these services, nor do all schools provide them. This new guidance allows for early identification and intervention in schools for all children with early-stage mental health conditions.

RELEVANT AMA POLICY

AMA policy supports access to and payment for integrated physical and behavioral health care regardless of the clinical setting and standards that encourage medically appropriate treatment of physical disorders in psychiatric patients and of psychiatric disorders in patients receiving medical and surgical services (Policy H-345.983). In addition, policy encourages the development of clinical approaches designed to improve outcomes for patients with depression and other mental illnesses who are seen in general medical settings (Policy H-345.984).

An adequate supply of psychiatrists, appropriate payment for all services provided, and sufficient funding levels for public sector mental health services is needed (Policies H-345.981, D-345.997, H-345.980 and H-345.978). Policy supports mental health insurance parity for mental illness, alcoholism, and related disorders under all governmental and private insurance programs (Policies H-165.888 and H-185.974).

AMA policy advocates for the provision of an adequate number of public psychiatric beds, comprehensive inpatient care, a full continuum of community-based outpatient psychiatric services, and the evolution of psychiatrist-supervised mental health care homes (Policies H-345.978 and H-345.976).

Age-appropriate education should be provided to students from preschool through high school, and to parents and caregivers, regarding mental illness (Policy D-345.994). Teacher education initiatives should be developed to help identify children at risk for psychiatric illnesses and potentially dangerous behaviors (Policy H-60.946). AMA policy encourages medical schools and primary care residencies to include the appropriate training to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition (Policy H-345.984). Policy also urges physicians to become more involved in pre-crisis intervention and treatment of chronically mentally ill patients (Policy H-345.995).

AMA policy emphasizes the need for mental health screening in routine pediatric physicals and recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children and adolescents have access to appropriate mental health screening and treatment services (Policy H-345.977).

DISCUSSION

There is an increasing recognition that the health of an individual includes both physical and behavioral components that should be treated holistically. Since a high prevalence of individuals with behavioral health disorders are seen by primary care physicians, there is a movement toward integrating the delivery of physical and behavioral health care in one setting. A key barrier to integrated treatment is the lack of payment for services provided on the same day. Accordingly, the

Council suggests encouraging Medicaid and private health insurers to pay for physical and behavioral health care services provided on the same day.

Until integrated physical and behavioral health care is provided as early as possible to our nation's children, the lack of comprehensive services will continue to have devastating consequences for individuals and the health of our society. As such, the Council suggests encouraging state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings in order to identify and treat behavioral health conditions as early as possible.

A continuum of treatment options exists to integrate care for physical and behavioral health conditions. With knowledge of these various approaches, physician practices can choose the ones that fit best for their patient population and delivery model. The Council believes practicing physicians should seek out continuing medical education opportunities on integrated physical and behavioral care.

The Council recommends reaffirming Policy H-345.983, which endorses access to and payment for integrated physical and behavioral health care, and rescinding Policy D-345.987, which calls for the study that has been accomplished by this report.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-345.983, which endorses access to and payment for integrated physical and behavioral health care, and supports standards that encourage medically appropriate treatment. (Reaffirm HOD Policy)

2. That our AMA encourage private health insurers to recognize CPT® codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day. (New HOD Policy)

3. That our AMA encourage all state Medicaid programs to pay for physical and behavioral health care services provided on the same day. (New HOD Policy)

4. That our AMA encourage state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings. (New HOD Policy)

5. That our AMA encourage practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care. (New HOD Policy)

6. That our AMA promote the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings. (New HOD Policy)

7. That our AMA rescind Policy D-345.987. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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