



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy



BEHAVIORAL HEALTH PROVIDERS:

EXPENDITURES, METHODS AND SOURCES OF PAYMENT, ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS FOR CERTAIN BEHAVIORAL HEALTH PROVIDERS POLICY DESCRIPTIONS

June 2010

Office of the Assistant Secretary for Planning and Evaluation

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**BEHAVIORAL HEALTH PROVIDERS:
Expenditures, Methods and Sources of Payment,
Electronic Health Record Incentive Payments
for Certain Behavioral Health Providers
Policy Descriptions**

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**ATTACHMENT: *Federal Register*, Wednesday, January 13, 2010,
42 CFR Parts 412, et al.**

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BACKGROUND

This report is intended to describe sources of payment for behavioral health providers and types of payments (methods, units, adjustments and updates) made to inpatient, outpatient, independent practitioners, and other providers of behavioral health services. A significant focus of this report describes these same factors in terms of Medicare and Medicaid spending.

For the purposes of this report, behavioral health is defined as the diagnosis and treatment of mental health and/or substance use disorders. The term “behavioral health” will precede the words providers, services, payments, organizations, and funding and have the same meaning as described in this paragraph throughout the report.

The term substance abuse treatment and substance use treatment are used interchangeably. For years, the treatment of addiction and heavy substance use was known as substance abuse treatment. The treatment community has identified with the terms addiction disorders, substance abuse and substance use treatment, among others to describe their discipline.

Information on the activities of the Certification Commission for Health Information Technology (CCHIT) related to the Comprehensive Behavioral Health Stand Alone and Behavioral Health Add-On to Ambulatory Care Electronic Health Record (EHR) Criteria has been provided under separate cover. This description is intended to align the CCHIT criteria to the standards of the Office of the National Coordinator (ONC) for Health Information Technology (HIT) contained in the January 13, 2010 ONC IFR.

Lastly, a determination of behavioral health providers who could qualify for the Centers for Medicare and Medicaid Services (CMS) EHR incentive payments if they meaningfully use a certified EHR product as described in the January 13, 2010, The CMS Notice of Proposed Rule Making (NPRM) is included at the end of this report.

Caution to Readers

Financing behavioral health services in the United States is a complex web of resource decisions and allocations, funding strategies, payer sources and recipient eligibility requirements that include a wide range of public and private payers. The information in this report is based on research that has been made publicly available through federal agencies including executive branch and congressional agencies; national trade associations that represent different providers of behavioral health services; scholarly journals; and information obtained through years of studying the financing of behavioral health services throughout the United States. Sorting through the information to illustrate a clear picture of behavioral health spending across payers and services is no easy task. The New Freedom Commission on Mental Health Interim Report to the President released in October 2002 summed up the situation precisely:

"The mental health services system defies easy description. Loosely defined, the system collectively refers to the full array of programs for anyone with mental illness. The programs deliver or pay for treatments, services, or any other types of supports, such as disability, housing, or employment. These programs are found at every level of government and in the private sector. They have varying missions, settings, and financing. The mission could be to offer treatment in the form of medication, psychotherapy, substance abuse treatment, or counseling. Or it could be to offer rehabilitation support. The setting could be a hospital, a community clinic, a private office, or in a school or business. The financing of care, which amounts to at least \$80 billion annually, could come from at least one of a myriad of sources -- Medicaid, Medicare, a state agency, a local agency, a foundation, or private insurance. Each funding source has its own complex, sometimes contradictory, set of rules."¹

Nonetheless, tables and information displayed in this report are intended to help educate the reader amid the difficulties of collecting information about a decentralized, multi-payer system of behavioral health services.

¹ *New Freedom Commission on Mental Health: Interim Report to the President*. 2002. Available at http://www.mentalhealthcommission.gov/reports/interim_report.htm#p75_10348.

OVERVIEW OF BEHAVIORAL HEALTH SPENDING IN THE UNITED STATES

Each year, more than 33 million Americans access behavioral health services to treat conditions resulting from mental health or substance use disorders at a cost of \$121 billion. Approximately 28 million Americans, or 13% of the total United States population aged 18 or older, received mental health treatment in an inpatient or outpatient setting, and more than 6% of American children and adolescents (about 13 million American children) aged 5–17 had contact with a mental health professional in a 2-month period according to the 1998–1999 National Health Interview Survey.²

Similar to other forms of health care, payers of behavioral health are many and diverse. For 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that spending on behavioral health services amounted to \$121 billion.³ The following table illustrates behavioral health spending among major United States payer sources.⁴

Payer Source	Amount in Millions	Percent of Total
Medicare	\$8,270	6.8%
Medicaid	\$30,101	24.9%
SCHIP	\$1,100	0.9%
Other Federal	\$6,591	5.4%
States	\$29,398	24.3%
Private Insurance	\$26,400	21.8%
Out of Pocket	\$15,730	13.0%
Other Spending	\$3,410	2.8%
Total Spending	\$121,000	100.0%
<small>* The use of "states" refers to the State Mental Health Authority within each United States state and territory. Six states do not report Medicaid funding for community mental health services (non-inpatient psychiatric facilities and outpatient services) to the National Association of State Mental Health Program Directors, National Research Institute, Inc.</small>		

Public sources of funding, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), other federal, and states, are the predominate payers of behavioral health services. Together, these payers contribute more than \$75.4 billion, or 62% to total behavioral health spending. *Medicaid, a jointly funded federal and state program, is the largest payer of behavioral health services.* Of the public payers, states play the

² *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, Institute of Medicine of the National Academies, The National Academies Press, Washington, DC. <http://www.nap.edu>.

³ Mark, T.L., K. Levit, R.M. Coffey, D. McKusick, H. Harwood, E. King, E. Boucherty, et al. 2007. *National Expenditures for Mental Health and Substance Abuse Treatment, 1993-2003*. SAMHSA.

⁴ Preliminary findings from SAMHSA report on Financing Mental Health and Substance Use Services, 2010. U.S. Department of Health and Human Services (HHS), SAMHSA. The figures from the preliminary findings from SAMHSA report on Financing Mental Health and Substance Use Services, 2010 are different than the SAMHSA 2007 report, although the SAMHSA 2010 report references the 2007 SAMHSA report.

most significant role in paying for services through state appropriations for non-Medicaid services, block grant spending, and the state's match for Medicaid and SCHIP programs. For Fiscal Year (FY) 2003, the states share of total behavioral health spending equaled \$42.3 billion, or 35% of total spending among all payers.

In 2003, the Federal Government through Medicare, Medicaid, SCHIP and other federal spending contributed \$33.1 billion, or 27% of total behavioral health spending among all payers.⁵

State Mental Health Agency (SMHA) is the term used to describe the state agency that has primary responsibility for the delivery of mental health and/or substance abuse services in each state. SMHAs have unique "spending" and "operational" characteristics which can exacerbate an already complex system of funding streams and provider designations. SMHAs take on many roles and may be considered as a payer and provider for the same behavioral health service. The SMHA can be one or more of the following:

1. A state general fund payer of behavioral health services purchasing such services at hospitals, community mental health centers, or independent practitioner offices.
2. A provider offering services to Medicaid and Medicare beneficiaries at a state hospital or state-operated community mental health center.
3. A recipient of federal funds that are passed-through to other government organizations or private outpatient mental health centers for the payment of behavioral health services.

Of the \$121 billion in behavioral health spending, \$20 billion or 17% was attributable to substance use treatment and \$100 billion or 83% for the treatment of mental health conditions. This amount includes 7% spending on insurance administration for both mental health and substance use diagnosis and treatment.

Public Behavioral Health Infrastructure

The role of the federal and state governments as primary funders of behavioral health services is important to understanding who are the providers of behavioral health services. The difference between the Federal Government, through Medicare, and how states structure their Medicaid behavioral health systems is important to understanding behavioral health spending and payment systems under the two insurance programs.

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act to reduce discrimination against those seeking treatment

⁵ On average, the Federal Government pays 57% of all Medicaid and 65% of SCHIP expenses.

for health and substance use conditions. The Act closed several loopholes left by the 1996 Mental Health Parity Act and extends equal coverage to all aspects of health insurance plans. The new Act does not apply to Medicare patients. Prior to passage of the 2008 Parity Act and also in 2008, Congress provided for Medicare coinsurance parity for Medicare patients by 2014, when it enacted “phase-in parity” under the Medicare Improvements for Patients and Providers Act. The later Parity Act of 2008 does apply to Medicaid managed care health plans.⁶

Medicare

Medicare Parts A, B, C, and D cover behavioral health services and providers for elderly and disabled Americans. These programs include a range of behavioral health services:

- Medicare Part A -- 190 day lifetime limit for inpatient free-standing psychiatric hospital stays. Stays in specialty psychiatric units of general hospitals in or general acute care beds are not subject to the 190-day limit.
- Medicare Part B -- Mental health and substance abuse services (counseling, testing, medical management) are provided on an outpatient basis by a physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner or physician assistant in an office setting, clinic or hospital outpatient department.
- Medicare Part C -- Medicare Part A and Part B behavioral health services are provided through private health plans. These Medicare Advantage (MA) plans may expand behavioral health services available to enrollees for an additional charge.
- Medicare Part D -- Coverage for certain outpatient and psychotropic prescription drugs.

Medicaid

Medicaid provides behavioral health insurance coverage for certain low-income Americans. States administer Medicaid within federal requirements which mandate coverage for certain individuals and services. States may choose to cover optional populations and services for which they receive federal matching funds. With the exception of early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21, states may impose restrictions on the number of services a recipient receives, the type of service that is provided, where the services are provided, and from whom the recipient receives the service. Each service must be sufficient in

⁶ American Psychological Association (APA), 2010. *How Does the New Mental Health Law Effect Insurance Coverage?* APA Health Center, Washington, D.C.

amount, duration, and scope to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity.

State Medicaid programs may cover behavioral health services by a variety of providers and settings. While there are not eligibility groups tied explicitly to mental health or substance use illness nor are there behavioral health benefits that are explicitly included in the required set of Medicaid benefits, behavioral health treatment instead is covered under several broad categories of benefits by all state Medicaid programs. Behavioral health services are covered by all states in the following mandatory health services:

- Physician services,
- Lab services,
- Inpatient hospital services,
- Outpatient hospital services,
- EPSDT services,
- Federally Qualified Health Center (FQHC) services,
- Rural health clinic (RHC) services, and
- Certified pediatric and family nurse practitioner services.

States Medicaid agencies develop their Medicaid covered behavioral health services with their state's behavioral health system in mind. For example, if a state general-funded behavioral health system covers medications for persons not covered by the Medicaid program, the Medicaid agency may opt to cover psychiatric medications for its Medicaid-eligible populations.

Optional Medicaid services are prevalent in state Medicaid plans. States may chose to cover behavioral health services as optional Medicaid services under their state plan. Behavioral health services are frequently selected by states to cover a broad range of behavioral health services that would otherwise not be covered by mandatory Medicaid services. Optional behavioral health services have included prescription drugs, care provided by licensed or certified professionals who can bill independently, rehabilitation services, clinic services, case management, peer support, and other special or remedial care. Nationally, 29.3% of all Medicaid recipients (including recipients of behavioral health services) are enrolled in Medicaid through state optional programs and account for 42% of all Medicaid spending. Every state in the nation has included the Rehabilitation Option in their Medicaid State Plan and offer behavioral health services through this program.

More than 65% of Medicaid beneficiaries are enrolled in some form of managed care. As of June 2005, 26 states contracted with a behavioral health care organization (BHO or managed care organization (MCO)) or an administrative services organization (ASO) that specialize in the delivery and management of mental health and substance use services. States may “carve-out” mental health services or specialty populations from a managed care BHO or ASO Medicaid arrangement or, from a fee-for-service (FFS) Medicaid program. In June 2005, there were 34 such carve-out arrangements

nationwide. Carve-out arrangements allow for mental health and substance use services to be provided by specialty providers and separates insurance benefits by condition or disorder, service category and/or population. Under a managed care behavioral carve-out, certain managed care tools such as utilization management, provider incentives, quality management and network access targets are required by states and used by behavioral health MCOs. States can seek authority under federal law through Medicaid waivers such as an 1115 demonstration waiver or 1915(b) managed care waiver to offer behavioral health managed care either through a carve-out organization or integrated with other waiver services provided to entire Medicaid populations regardless of condition or disorder.

Medicaid and Medicare payment for behavioral health services is significantly different and are described throughout this paper.

WHO ARE PROVIDERS OF BEHAVIORAL HEALTH SERVICES?

Behavioral health conditions can be treated by many different medical and social service providers in a variety of settings. Each year, psychiatrists, non-psychiatric physicians, psychologists, nurse practitioners, physician assistants, licensed clinical therapists, other licensed and certified clinicians, behavioral health paraprofessionals and technicians, and case managers and peer support specialists provide mental health and substance use services to more than 33 million Americans. These services are provided at inpatient facilities (hospitals and residential treatment facilities), outpatient clinics (e.g., community mental health centers), and substance abuse treatment facilities, through crisis mobile services, in a person’s home or in other informal settings.

Specialty mental health providers include psychiatrists, psychologists, and psychiatric nurses possessing formal graduate degrees in mental health. Mental health providers are also social workers, counselors, nurses, and therapists who either have received additional, specialized training in treating mental health problems and illnesses prior to their professional practice, or have chosen to practice in a mental health care setting and gained advanced knowledge in treating mental problems and illnesses through experience. These mental health providers may also provide substance use services. In the Institute of Medicine’s report on improving quality care for mental health and substance use conditions, the report cited SAMHSA’s most recent estimates of the numbers of clinically trained (CT) and clinically active (CA) mental health personnel and are shown in the following table.⁷

Discipline	Number	Reporting Year
Counseling	111,931 (CA)	2002
Psychosocial Rehabilitation	100,000 (CT)	1996
Social Work	99,341 (CA)	2002
Psychology	88,491 (CT)	2002
Marriage and Family Therapy	47,111 (CA)	2002
Psychiatry	38,436 (CT)	2001
School Psychology	31,278 (CT)	2003
Psychiatric Nursing	18,269 (CT)	2000
Pastoral Counseling	Data not available	n/a
Total Mental Health Providers	534,857	

Behavioral health services are also provided in substance abuse treatment facilities (e.g., outpatient, intensive outpatient, partial hospitalization, and residential settings). SAMHSA administers the National Survey of Substance Abuse Treatment Services and reports annually substance abuse facility information. The data in Table 3 is the result of a point in time survey in March 2007 and includes 94.5% of all substance

⁷ Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. The National Academies Press, 2006.

abuse treatment facilities in the United States in its survey results. The following table profiles substance abuse treatment by primary focus of the facility.

TABLE 3. Primary Focus of Substance Abuse Treatment Facility -- March 2007		
Primary Focus	Facilities Number	Facilities Percent
Substance abuse treatment services	8,360	61%
Mental health services	949	7%
Mix of mental health and substance abuse treatment services	3,957	29%
General health care	189	1%
Other/unknown	193	1%
Total Substance Abuse Treatment Facilities	13,648	100%

Given the fragmentation of and variability in behavioral health services, accounting for behavioral health spending at the national level is challenging. Many of the providers described by discipline in Table 2 are employed by other mental health organizations (hospitals, outpatient clinics, other sub-acute facilities), thus, the payer information by discipline is not readily available and is most likely part of facility-based provider information. Using the spending data by payer source in Table 1 above derived from the SAMHSA Preliminary Report on Financing Mental Health and Substance Use Services and the type of provider organizations described by SAMHSA in the National Expenditures on Mental Health and Substance Abuse Treatment 1993-2003,⁸ Table 4 provides a rough allocation of FY 2003 spending of \$121 billion by provider/location of services. Please note that the **number** of providers included in the allocation of behavioral health spending by provider/location type is not available. Table 4's data is derived by allocating the percentage of spending by behavioral health providers/location against the total behavioral health spending contained in Table 1 of \$121⁹ billion:

⁸ Mark, T.L., et al., 2007.

⁹ Percents are carried out to 1000ths place to reach total expenditures as illustrated in the SAMHSA spending reports.

TABLE 4. Estimated Distribution of Behavioral Health Expenditures by Provider/Location -- 2003*		
Provider/Location (from 2007 SAMHSA report)	Estimated Expenditures -- Dollar Amount (from 2010 SAMHSA report)	Expenditures -- Percent (from 2007 SAMHSA report)
Physicians and Other Professionals	\$26,654	22%
Specialty Hospitals	\$12,049	10%
General Hospitals, Non-Specialty Units	\$10,832	9%
General Hospitals Specialty Units	\$9,615	8%
Multi-Service Mental Health Organizations (OP)	\$14,483	12%
Specialty Substance Abuse Centers	\$8,398	7%
Nursing Home and Home Health	\$7,303	6%
Insurance Administration	\$8,520	7%
Retail Drugs	\$23,125	19%
Total Expenditures	\$120,979	100%
* Percents in Table 4 may not add to total in Table 1 due to rounding.		

INPATIENT PSYCHIATRIC FACILITIES -- INPATIENT PSYCHIATRIC HOSPITALS AND UNITS AND RESIDENTIAL TREATMENT CENTERS

Inpatient psychiatric facilities (IPFs) refer to all providers of 24-hour care for the diagnosis and treatment of behavioral health conditions. Facilities include non-governmental free-standing psychiatric hospitals, state psychiatric hospitals (these first two are often referred to Institutes for Mental Disease, or IMDs, under Medicaid), general hospital psychiatric units, and residential treatment centers (RTC). In 2008 the number of IPFs in the United States totaled 2,257 and had direct expenditures of \$20.6 billion.¹⁰

According to Code of Federal Regulations (CFR) 42 Part 482 Section 482.60, the term Medicare/Medicaid psychiatric hospital means an institution which:

1. Is primarily engaged in providing psychiatric services for the diagnosis and treatment of persons with a mental illness.
2. Satisfies the requirements of §§1861(e)(3) through (e)(9) of the Social Security Act, requirements for general hospitals.
3. Maintains clinical or other records on all patients as defined by the Secretary of HHS for individuals entitled to Medicare Part A hospital benefits (specified in §482.61).
4. Meets staffing requirements as defined by the Secretary of HHS in §482.62 to carry out active treatment for persons receiving services in the facility.

In addition, psychiatric inpatient hospitals are required to meet the conditions of participation (CoPs) specified for general hospitals (i.e., found in Sections: 482.1 through 482.23; 482.25 through 487.57). Notable psychiatric hospital CoPs include the following requirements:

1. Additional social service record keeping, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history (482.61(4)).
2. Each patient in a psychiatric inpatient hospital must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities including a substantiated diagnosis, short-term

¹⁰ Dobson, A., Da Vanzo, J., et al., 2010. *The Economic Impact of Inpatient Psychiatric Facilities*. National Association of Psychiatric Health Systems (NAPHS).

and long-range goals; specific treatment modalities used; responsibilities of the members of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities are carried out (482.61(7)(c)).

3. Psychiatric inpatient hospitals must employ adequate numbers of qualified personnel and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning (482.62).
4. Additional standards for the director of inpatient psychiatric services, clinical director, and nursing services (482.62(b)(c)(d)).

An RTC, also known as a psychiatric residential treatment facility (PRTF under the federal Medicaid laws and rules) is any non-hospital facility that holds a provider agreement with a state Medicaid agency to provide inpatient services benefit to Medicaid-eligible individuals under the age of 21. These facilities must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or any other accrediting organization with comparable standards recognized by the state. PRTFs must meet the requirement in Sections 441.51 through 441.182 of the CFR. PRTFs must comply with CoPs on the use of restraint and seclusion as well as the reporting of serious occurrences to the state Medicaid agency and to the state-designated Protection and Advocacy Organization per Section 483.374(b).

Institutes for Mental Disease -- Medicaid IMD Exclusion

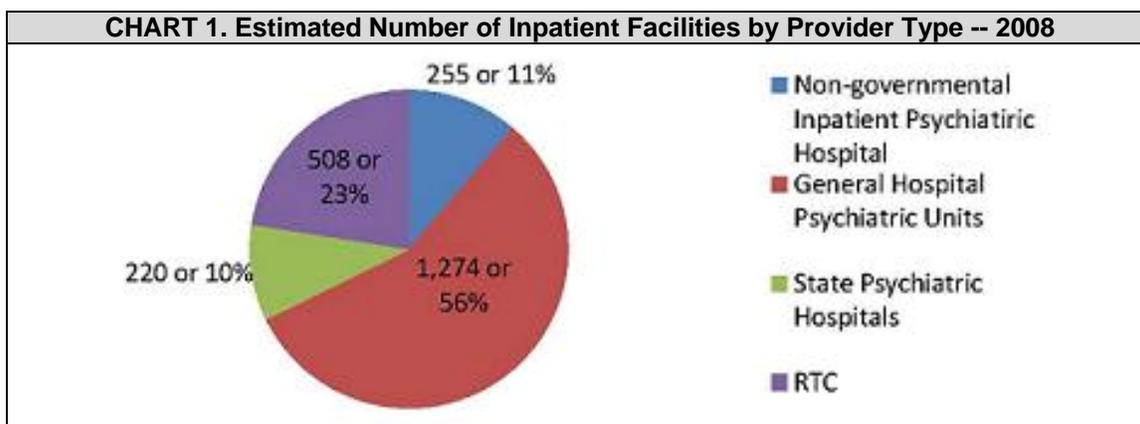
The IMD exclusion is one of the few instances in which federal Medicaid law prohibits federal contribution to the cost of medically necessary behavioral health care by licensed medical professionals for Medicaid recipients.¹¹ The 1965 law that established the exclusion for all Medicaid recipients was later amended to allow federal financial participation for persons under 21 years of age and 65 years and over who stayed in stand-alone governmental and non-governmental psychiatric hospitals (thus maintaining the exclusion of Medicaid beneficiaries between the ages of 21 and 64). The law was also amended to allow free-standing psychiatric hospitals with less than 17 beds to receive federal Title XIX contributions. Two categories of inpatient facilities remain affected by the Medicaid IMD exclusion: non-governmental inpatient psychiatric hospitals and state psychiatric hospitals.

¹¹ *An Analysis of the IMD Exclusion*. Sara Rosenbaum, JD, Joel Teitelbaum, JD, LLM, D. Richard Mauery, MPH, DrPH (Cand.). Center for Health Services Research and Policy, Department of Health Policy, GWU School of Public Health and Health Services. December 19, 2002. On-line at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_22CE3B02-5056-9D20-3DFE8F13074D0E21.pdf.

Number of Inpatient Psychiatric Facilities

Dobson and Da Vanzo's recent report to NAPHS concluded that approximately 2,257 IPFs are located throughout the United States. The following table displays the IPF by inpatient provider type.¹²

Inpatient Psychiatric Hospitals			Residential Treatment Centers (RTCs)	Total Inpatient Psychiatric Facilities
Non-governmental Inpatient Psychiatric Hospitals	General Hospital Psychiatric Units	State Psychiatric Hospitals		
255	1,274	220	508	2,257



Sources of Public Payment

Payment sources differ from one type of IPF to another. For this report, it is important to illustrate the role of Medicare and Medicaid as a payer of inpatient services. According to the 2008 member survey of the NAPHS reporting on inpatient expenditures by payer in 2007, non-governmental free-standing psychiatric hospitals and psychiatric units of a general hospital rely on commercial insurers, Medicare, and Medicaid as payers for more than 78% of their admissions.¹³ Medicare and Medicaid paid for 39.8% of all admissions to non-governmental inpatient hospitals.¹⁴ State psychiatric hospitals payer mix is comprised of 66% state general fund, 27% Medicaid, 3% Medicare, and approximately 4% from commercial insurers and state/local government resources.¹⁵ RTCs primary payer sources include Medicaid (45.2%) and

¹² Dobson and Da Vanzo, page 6.

¹³ NAPHS. *2008 Annual Survey of the National Association of Psychiatric Health Systems*, 2009.

¹⁴ NAPHS. *2008 Annual Survey of the National Association of Psychiatric Health Systems*, 2009.

¹⁵ National Association of State Mental Health Program Directors, NRI Inc.

commercial insurance (28.3%). Table 6 summarizes IPF Medicaid, Medicare and all other spending amounts by admission.

TABLE 6. Inpatient Psychiatric Facility Payers, 2008 -- Dollars in Billions							
Facility Type	Total Estimated Payments by Payer Upon Admission	Medicare Spending	Medicare %	Medicaid Spending	Medicaid %	All Other Spending	All Other %
Non-Governmental Free-Standing Psychiatric Hospitals and Acute Care Units	\$7.6	\$1.54	20.2%	\$1.49	\$19.6%	\$4.58	60.2%
State Psychiatric Hospitals	\$8.5	\$0.26	3.0%	\$2.30	27.0%	\$5.95	70.0%
Residential Treatment Centers	\$4.5	not a payer	not a payer	\$2.03	45.2%	\$2.47	54.8%
Total Expenditures by Admissions	\$20.6	\$1.79	8.7%	\$5.82	28.2%	\$12.99	63.1%

Other sources of information contain different spending patterns by payer. For example, Medpac estimates Medicare made payments to psychiatric hospitals, acute care units, and state psychiatric hospitals in the amount of \$4.2 billion, or 30% of revenue for these facilities, in 2008. The data contained in Table 6, based upon expenditures, conveys a lesser amount of 23.2% or \$1.8 billion. For 2003, SAMHSA reported total behavioral health spending of \$25.6 billion in inpatient and residential settings for a difference of \$5.0 billion from FY 2008 spending as illustrated in Table 6. This underscores the difficulty and complexity of ensuring reliable spending estimates among multiple payers of inpatient behavioral health services.

Aggregate Public Spending By Payer/Program

Non-governmental Free-standing Psychiatric Hospitals and General Hospital Psychiatric Units -- The National Research Institute (NRI Inc.) of the National Association of State Mental Health Program Directors (NASMHPD) reports on non-government free-standing and general hospital psychiatric unit spending by State Mental Health Authorities (SMHAs) as part of their annual revenue and expenditure survey.

Sources of payment to the SMHA for inpatient hospital services are primarily Medicaid, Medicare and state general funds. Of the \$7.6 billion spending in 2006 for non-governmental free-standing psychiatric hospital services and general hospital psychiatric units, SMHAs reported \$2.6 billion of inpatient, non-state hospital spending.

State Psychiatric Hospitals -- State psychiatric hospitals provide for the care of children, adults, older persons, and people who have entered the behavioral health system via the court system. For FY 2006, the NRI Inc. reported that \$8.5 billion was spent by SMHAs for the operations of 220 state psychiatric hospitals throughout the

United States. The sources of payment to these hospitals are included in the following table.¹⁶

State General Fund	Medicaid	Medicare	Other Federal Funds	Local and Other Funds	Total SMHA Revenues
\$5,620.7	\$2,278.9	\$289.7	\$6.8	\$350.4	\$8,547.0
65.8%	26.7%	3.4%	0.1%	4.1%	100.0%

Residential Treatment Facilities (RTC) -- The 2008 NAPHS Annual Survey indicated that the primary payer of RTC services is Medicaid, paying for 45.2% of all admissions to RTCs due to a high number of child and adolescent admissions and stays. Other payers included commercial insurers (28.3%), state/local government (15.5%), and other payers (11%).

Inpatient Hospital Payment Rate Setting, Adjustments, and Updates -- Medicare and Medicaid

Payment methods vary greatly among payers of IPFs. For this report, of particular interest are the different methods used by Medicare to set inpatient psychiatric non-governmental free-standing and specialized hospital-based unit rates and state Medicaid programs for IPFs (government and non-government), and RTC facilities.

Medicare

CMS sets rates for Medicare IPFs. Effective January 2005, Medicare implemented an IPF prospective payment system (PPS). This method of payment is applicable to Medicare-certified free-standing government and non-government psychiatric hospitals and psychiatric units of general hospitals and critical access hospitals (CAHs). The IPF PPS is based on a standardized Federal per diem base rate calculated from IPF average per diem costs and adjusted for budget-neutrality in the implementation year. The federal per diem base rate is the standard payment per day under the IPF PPS adjusted by the applicable wage-index factor, and the patient and facility-level adjustors that are applicable to the IPF stay (42 CFR § 412.428). Further, the per diem adjusted rate (inclusive of geographic, facility and patient characteristics) is multiplied by the variable per diem adjuster which is higher for the first day when an emergency department is present (i.e., multiplier is equal to 1.31) and lower when a emergency department is not present (i.e., multiplier is equal to 1.19) or patient's length of stay is beyond one day (day two multiplier equals 1.12; 22 or more days multiplier equals 0.92).¹⁷

¹⁶ NASMHPD on the web at http://www.nasmhpd.org/state_hospitals.cfm.

¹⁷ Psychiatric Hospital Services Payment System, Medpac, October 2009. On-line at <http://www.medpac.gov>.

For rate year (FY) 2010, the base payment rate is \$652, based on the national average of daily routine operating, ancillary, and capital costs in IPFs in 2002. The base rate is adjusted for patient characteristics of age, diagnosis, comorbidities and length of stay. Facility adjustments include wage-index, rural location, teaching (interns and resident ratios), cost of living, and emergency department adjustments. IPFs also receive additional payment for each electroconvulsive therapy treatment furnished to a patient. An outlier payment policy and payment pool of 2% of total payments is available for extraordinarily high cost cases.¹⁸

Current law does not define a mechanism for updating the base payment IPF rate. According to MedPac, CMS has stated that it intends to update the IPF payment rates annually by the increase in CMS's hospital market basket, which measures the price increases of goods and services hospitals buy to produce patient care.

Most recently, the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, amended the inpatient psychiatric PPS annual update process by revising the hospital market basket reduction. This, in addition to the productivity adjustment and are as follows: -0.3 in FY 2014, -0.2 in FY 2015-2016, and -0.75 in FY 2017, FY 2018 and FY 2019.

A limited number of psychiatric patients are cared for in non-specialized medical/surgical beds located in general hospitals, referred to as scatter beds. Scatter beds are used for voluntary psychiatric admission, meet medical necessity requirements, and rely on the education and training of general medical staff. Under Medicare, hospitals are reimbursed under hospital diagnostic related group (DRG) rates and are not reimbursed under the IPF PPS for scatter bed stays. A June 2010 joint SAMHSA and Agency for Healthcare Research and Quality study of general hospital psychiatric admissions (which does not include stand-alone state or private psychiatric facilities or RTC admissions) found that more than 93% of psychiatric patients received care in specialty units of general hospitals while less than 7% of psychiatric patient admissions were cared for in scatter beds of general hospitals.¹⁹

Medicaid

Medicaid inpatient facility rates are set by each state operating under their Medicaid state plan, waivers, amendments and options. States Medicaid unit rates for IPFs are often, but not across the board, per diem pre-determined rates. One exception includes payment to RTC facilities whereby there is pre-payment or block purchase of RTC beds to ensure adequate RTC capacity. Reconciliation to the block purchase or pre-payment is completed at the end of a state's fiscal year.

Under Medicaid FFS, inpatient hospital payment rates are adjusted according to state's Medicaid plan provisions. State Medicaid agencies who administer the state

¹⁸ Ibid, Medpac, 2009.

¹⁹ See <http://www.samhsa.gov/newsroom/advisories/1006025215.aspx>.

plan must make findings and assurances to CMS that the rates paid to inpatient hospitals are adequate and reasonable to meet the costs incurred of an efficiently and economically run facility and that Medicaid recipients have reasonable access to inpatient settings that provide quality services. States provide this assurance to CMS upon review of state plans, amendments or waivers.

More than 65% of the total Medicaid population is enrolled in some form of Medicaid managed care program.²⁰ Under Medicaid managed care, state Medicaid agencies must comply with 42 CFR § 438.6 and ensure actuarially sound capitation rates are paid to MCOs. “Actuarial sound capitation rates” are rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the contract; and have been certified as meeting the requirements of the regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. Payments to inpatient facilities are often included in the capitation rates established for MCOs.

Medicaid rates for inpatient facilities can be determined in a number of ways. As of April 2010, payment methods used by state Medicaid agencies for many types of inpatient settings (acute and psychiatric) include:

- Per Stay Medicare-DRG (Colorado, Iowa, Illinois, Kansas, Kentucky, Minnesota, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Utah, Vermont, Wisconsin, West Virginia).
- Per State -- Medicare Severity DRGS by state (Michigan, New Hampshire, New Mexico, Oklahoma, Oregon, South Dakota, Texas).
- Per Stay -- All-Patient Refined DRG's (Montana, New York, Rhode Island).
- Cost Reimbursement (Alabama, Arkansas, Connecticut, Idaho, Maine).
- Per Stay -- All Patient (District of Columbia, Georgia, Indiana, Nebraska, New Jersey, Virginia, Washington).
- Per Diem (Alaska, Arizona, California, Florida, Hawaii, Louisiana, Missouri, Mississippi, Tennessee).
- Per Stay -- Other (Delaware, Massachusetts, Nevada, Wyoming).

²⁰ National Health Policy Forum. Medicaid and Mental Health Services Background Paper No. 66 on the web at http://www.nhpf.org/library/background-papers/BP66_MedicaidMentalHealth_10-23-08.pdf.

- Other regulated charges (Maryland).²¹

States may assign a modifier or “tier” to the type of hospital stay (for example, psychiatric stays). This results in a different payment rate for the psychiatric hospital or for a psychiatric stay in a specialty unit or scatter bed of a general hospital.

A recent policy brief from the Center for Health Care Strategies calls out the need for Medicaid payment reform for both hospital inpatient and hospital outpatient care as more and more low-income individuals become eligible for Medicaid services under the PPACA (P.L. 111-148, March 23, 2010 as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, March 30, 2010). With expansion of Medicaid eligibility it is expected that more individuals with mental health and substance use conditions will be entitled to insurance coverage. In addition, the national health reform legislation calls for development and testing of innovative payment methods in Medicaid; multiple demonstration projects that increase federal medical assistance percentages or combine funding authorities (Medicaid and Medicare); and bundled payments to accountable care organizations that provide financial incentives for cost containment across multiple patient care sites.

Health Information Technology Implementation

In a 2009 behavioral health information systems survey, close to 50% of hospital and RTC respondents reported their hospital or RTC has either fully or partially implemented some of the major components of a HIT system. These components include billing, scheduling, clinical assessment, and treatment planning. Most hospitals and RTCs reported that they have yet to implement the quality improvement and outcomes functionality of an HIT system. More than 90% of the psychiatric hospitals surveyed reported that cost was a barrier and more than 55% reported that insufficient reimbursement was a barrier. Of the RTCs surveyed, more than 70% reported that cost was a major barrier to implementing HIT and 56% responded insufficient reimbursement was also a factor.²²

In the American Hospital Associations’ 2008 Annual Survey Information Technology Supplement, 76% of psychiatric hospitals reported that their hospital does not participate in any regional arrangements for the exchange of electronic health information. Additionally, the non-participation by psychiatric hospitals is significantly less than that of medical/surgical hospitals (57.6% non-participation rate). Furthermore, psychiatric hospitals (mean = \$.5 million) spend significantly less than medical/surgical hospitals (mean = \$6.9 million) on operating and capital information technology (IT).²³

²¹ Bachrach, D., JD, May 2010. Center for Health Care Strategies, Inc. *Payment Reform: Creating a Sustainable Future for Medicaid* (policy brief).

²² Paul M. Lefkowitz, Ph.D., June 2009. *Behavioral Health/Human Services Information Systems Survey*. Software Technology Vendors Association, National Council for Community Behavioral Healthcare, and NAPHS (permission granted by the National Council for Community Behavioral Healthcare).

²³ Information compiled by HHS, Office of the Assistant Secretary for Planning and Evaluation.

OUTPATIENT PROVIDERS -- PARTIAL HOSPITALIZATION, COMMUNITY MENTAL HEALTH CENTERS, OUTPATIENT SUBSTANCE ABUSE PROVIDERS

Outpatient behavioral health providers refer to providers of less than 24-hour care for the diagnosis and treatment of behavioral health conditions. For the purposes of this report, outpatient providers include partial hospitalization (hospital-based outpatient treatment centers), community mental health centers (CMHCs), outpatient substance use treatment centers, and other mental health organizations for which data is available. Independently licensed practitioners and other licensed or certified provider information are described in the next two sections of this report.

Partial hospitalization is a type of treatment program that is used to treat behavioral health conditions. An individual who is being treated in a partial hospitalization program is living at home, but commutes to treatment center up to seven days a week. Partial hospitalization services are affiliated with a hospital and may be licensed as part of the hospital or a separate free-standing program. Group therapy, individual therapy, medication management and other services are provided in the partial hospitalization setting.

CMHCs are publically and privately operated and funded. CMHCs provide a variety of behavioral health services to persons living in the community. CMHCs fulfill a treatment need to provide community-based care as an alternative to institutional care provided in large psychiatric hospitals and asylums throughout the United States. Initial funding for many CMHCs came from Community Mental Health Act of 1963 to build and develop behavioral health facilities and programs throughout the United States. Prior to the passage of the 1963 Act, CMHCs served multiple purposes for a community, including treatment of mental retardation and the provision of other low-income services and were known as multi-service mental health organizations. The 1963 Act concentrated CMHC efforts to fund federal priority populations including adults with serious and persistent mental illness and children under 18 who exhibited severe emotional or social disabilities. With the passage of the 1981 Omnibus Reconciliation Act, mandatory federal funding ceased to federally qualified CMHCs (thus, eliminating the federal designation of CMHC) and funding was block granted to states for the delivery of behavioral health services to multiple provider organizations, including CMHCs and other multi-service mental health organizations.

Outpatient substance use treatment centers may provide intake, assessment, referral, detoxification services, psychoanalytic therapy and counseling services among the many types of substance use treatment services. Outpatient substance use treatment services can be provided by specialty substance abuse centers, CMHCs or other providers of substance abuse services.

CMHCs and outpatient substance use treatment centers can be operated through large health care organizations that provide a continuum of mental health and substance abuse services including residential treatment, outpatient treatment, day treatment services, detoxification services, and other clinic services. Annual behavioral health budgets for these organizations can be millions or tens of millions of dollars and can be provided to clients from all across the state and sometimes from clients living outside a particular provider’s state. In contrast, some behavioral health providers that provide mental health and substance abuse services are small, have annual behavioral health budgets below \$1.0 million dollars and provide very specific treatment services to a population.

Number of Outpatient Providers by Provider Type

There is not a clear designation process for determining if a provider is as an “outpatient provider” or other type of provider that provides less than 24-hour care. Outpatient providers are often synonymous with community-based providers. At other times, however, a RTC or PRTF is considered community-based, although it is considered an inpatient provider for payment purposes.

This contradictory use of terms creates different methods for counting providers, thus, results in a variety of outpatient provider counts being categorized under the umbrella term of outpatient providers. Table 8 estimates the number of outpatient providers by the three outpatient provider types discussed in this section.

Outpatient Provider Type	Total Providers
Partial Hospitalization and Multi-Service Mental Health Organizations	1,561
Community Mental Health Centers	672
Outpatient Substance Use Treatment (includes day treatment aka partial hospitalization)	11,078
Total Outpatient Providers	13,311
<p>* The federal designation of CMHCs ended in 1981 and the last publicly available CMHC count was published in 1991. The data included in this table is from a variety of sources from 1991 to 2007. Partial hospitalization and multi-service mental health organizations = 1,561, source is <i>Mental Health, United States, 2000</i>: Chapter 14, Table 1 can be found at http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3537/chp14table1.asp. CMHCs = 672, Hadley & Culhane (1993) quoted in <i>The Role of Community Mental Health Centers as Rural Safety Net Providers</i>, Maine Rural Health Research Center, University of Southern Maine, November 2002. Outpatient Substance Use Treatment = 11,078 source is <i>SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS) Profile -- United States 2007</i>. A more recent survey estimated similar provider entity types totaled 10,448 throughout the United States (see Paul M. Lefkowitz, June 2009). The biggest differences can be attributed to outpatient substance abuse treatment count of 13,311 versus 2,000 and the addition of an “other” category of 5,000.</p>	

It is important to note that CMHCs and partial hospitalization providers are both considered “multi-service mental health organizations” depending on the source of the

data. According to data published in 2000 by SAMHSA,²⁴ there were 5,722 mental health organizations in 1998, including inpatient and RTC. Using the data in Table 5, there were 2,257 inpatient hospitals and RTCs in 2008. According to the data in Table 8, there were 2,233 the partial hospitalizations and CMHCs for a total of 4,490 mental health organizations sometime between 1991 and 2008, leaving a difference of 1,232 facilities (5,722 less 4,490) not accounted for in this report. The difference could be attributed to:

1. Veteran's Administration Medical Centers of \pm 145 facilities are included in the 2000 SAMHSA report (not included in this report).
2. Other multi-service mental health organizations \pm 1,087.
3. Other organizations not defined in the source data.

The 11,078 outpatient substance use treatment facilities illustrated in Table 8 is a subset of the 13,648 facilities reported in Table 3.

Sources of Public Payment

Outpatient providers receive payment from a variety of payers. Payer information by the three outpatient providers by payer is not available. However, Table 9 provides estimates of spending for outpatient provider types by payer, substance use services, mental health services, and behavioral health services. These estimates assume that: (i) expenditures are distributed across the Medicare, Medicaid and other payers in the same way as was described for all behavioral health services (see Table 1) ; and (ii) the distribution of spending on substance abuse and mental health services is the same for outpatient providers as was reported in the SAMHSA 2007 spending report.

As illustrated in Table 1, Medicare (6.8%) and Medicaid (24.7%) paid for 31.5% of all behavioral health spending in 2003 for a total of \$38.4 billion. As reported in the 2007 SAMHSA spending report, 49% of all substance use spending went to outpatient settings (\$10 billion) while 31% of all mental health services were provided in outpatient settings (\$31 billion). Additionally, Medicare accounted for 5% of all substance use treatment spending and Medicaid accounted for 18% of all substance abuse spending. Likewise, Medicare accounted for 7% of all mental health spending and Medicaid paid for 26% of all mental health spending. Applying these same percentages across outpatient provider settings, a total of \$12.6 billion can be attributed to Medicare and Medicaid spending for outpatient services. The following table illustrates this estimate for Medicare and Medicaid outpatient spending.²⁵

²⁴ On the web at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3537/chp14table1.asp>.

²⁵ Figures may not add due to rounding. See footnote 4 for additional clarification.

TABLE 9. Estimated Outpatient Spending by Medicare and Medicaid Dollars in Billions (All Outpatient Provider Types) -- 2003						
Payer	Mental Health OP \$	Mental Health OP %	Substance Use OP \$	Substance Use OP %	Total Behavioral Health OP \$	Total Behavioral Health OP %
Medicare	\$2.2	7%	\$0.5	5%	\$2.7	6%
Medicaid	\$8.1	26%	\$1.9	18%	\$9.9	24%
All Other	\$20.8	67%	\$8.0	77%	\$28.8	70%
Total Outpatient Provider Spending	\$31.0	100%	\$10.4	100%	\$41.4	100%

Aggregate Public Spending by Payer/Program

In FY 2003, outpatient spending for partial hospitalization, CMHC and other mental health organizations, and outpatient substance use treatment centers accounted for \$19.5²⁶ billion of behavioral health care spending and are included in the following table.

TABLE 10. Outpatient Spending by Provider Type -- Partial Hospitalization, CMHC, Outpatient Substance Abuse Treatment Facility -- 2003	
Outpatient Provider Type	Total Expenditures, 2003
Partial Hospitalization	\$7.1
Multi-Service Mental Health Organization (CMHC and other providers)	\$7.8
Outpatient Substance Use Treatment	\$4.6
Total Expenditures	\$19.5
* Mark, T.L., et al., 2007.	

Outpatient Payment Rate Setting, Adjustments, and Updates -- Medicare and Medicaid

Payment methods vary greatly to outpatient providers. For this report, of particular interest are the different methods used by Medicare and state Medicaid programs for partial hospitalization, community mental health centers and outpatient substance use treatment facilities. As described below, Medicare and Medicaid payments to eligible outpatient providers follow different statutory language and rules.

Medicare

Medicare covers mental health care given by a doctor or qualified mental health professional. Medicare covers mental health services on an outpatient basis by a doctor, clinical psychologist, licensed clinical social worker, clinical nurse specialist, nurse practitioners or physician assistant in an office setting, clinic or hospital outpatient

²⁶ The \$19.5 billion figure is not included in Table 9. Table 9 represents all outpatient provider types, not just the three provider types found in Table 10.

department. Medicare also covers substance abuse treatment in an outpatient treatment center if they have agreed to participate in the Medicare program.

Medicare does not recognize CMHC as a provider type and thus does not set a payment rate for CMHC services. Instead, Medicare may pay for services by a qualified professional practicing in a CMHC, as long as the qualified professional is billing individually for services provided.

General provisions of the Social Security Act (the Act) govern Medicare reimbursement of all services, including mental health services. Section 1862(a)(1)(A) of the Act states that no payment may be made for services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."²⁷

Providers of mental health and substance abuse services must be qualified to perform the specific mental health services that are billed to Medicare. For services to be covered, mental health professionals must be working within their state scope of practice act, be licensed or certified to perform mental health services by the state in which the services are performed, and have a Medicare provider agreement.

Payment to Medicare outpatient providers follows the established Medicare Physician Fee Schedule (MPFS). Pursuant to Section 1861(s)(2)(A) of the Act; 42 CFR § 410.26, Medicare allows physicians to bill for mental health services performed by their staffs and furnished to patients if the services are rendered "incident to" the physicians' professional services. Under Medicare, psychologists receive 100% of the MPFS and licensed clinical social workers receive a portion of the MPFS for procedures defined in the CPT/Healthcare Common Procedural Coding System code sets.

The MPFS and corresponding Medicare payment is affected by three key factors: (i) the resource-based relative value scale (RBRVS) which includes adjustments (units) for physician work, practice expense, and professional liability insurance; (ii) geographic practice cost indexes, and (iii) the Medicare conversion factor.²⁸ This process has been in place since 1992 and replaced usual and customary charge payments previously used by CMS.

Medicaid

States establish their own payment rates for Medicaid providers. Federal regulations require that these rates be sufficient to enlist enough providers so that covered benefits will be available to Medicaid beneficiaries at least to the same extent they are available to the general population in the same geographic area. Qualified outpatient providers must be working within their state scope of practice act and

²⁷ See http://www.ssa.gov/OP_Home/ssact/title18/1862.htm.

²⁸ See <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-medicare-physician-payment-schedule.shtml>.

licensed /certified to perform mental health and substance abuse services by the state in which the services are performed and documented in the state Medicaid plan.

Medicaid outpatient provider rate setting, adjustments, and updates follow a similar course to that of inpatient providers. State laws and rules may determine the method by which rates are adjusted, or absent state laws or rules, Medicaid rates may be set administratively. For example, states may update rates annually following Medicare rates for psychiatric procedure codes, provide a cost of living adjustment to an already established rate, re-base rates with new updated adjustments, or do nothing at all. Some state Medicaid programs use variations of the Medicare RBRVS to determine physician reimbursement rates. Because the RBRVS fee schedule was created originally for Medicare only, many behavioral health CPT codes do not have a corresponding MPFS rate (physicians are not the primary provider of behavioral health services) and thus requires states to develop its own rate setting methodology beyond the use of RBRVS and the MPFS.

Health Information Technology Implementation

During FY 2009, community behavioral health providers reported average spending of approximately \$485,000 on IT including hardware, software, maintenance, personnel, training and other IT expenses. Substance use and addiction treatment providers reported significantly less IT-related expenses totaling slightly \$140,700 per year.²⁹

More than 93% of community behavioral health providers have partially implemented (14%) or fully implemented (79.1%) electronic billing capacity as part of their electronic clinical information system and approximately 56% of community behavioral health providers have partially implemented (32.7%) or fully implemented (13.5%) quality improvement and outcomes measurement. Of substance use and addiction treatment providers, more than 90% of treatment providers have electronic billing capacity while 40% have either partially implemented (10%) or fully implemented (30%) a quality improvement and outcomes measurement component of their information system.³⁰

²⁹ Paul M. Lefkowitz, Ph.D., June 2009.

³⁰ Ibid.

INDEPENDENT LICENSED PRACTITIONERS

The types of independent licensed or certified practitioners (other than physicians) who can provide behavioral health services vary from state to state and from payer to payer. Independent licensed or certified practitioners become licensed or certified by the state in which they practice. The license or certification may require accreditation by a national accreditation organization.

Number of Independent Licensed or Certified Practitioners by Provider Type (Excluding Physicians)

Table 2 provides an estimate of more than 534,000 CA and CT behavioral health practitioners throughout the United States. These clinicians work in inpatient, outpatient, schools, and criminal justice facilities and/or in independent practice settings and therefore it is almost impossible to determine how many practice independently.

Sources of Public Payment -- Independent Licensed Practitioners (Including Physicians)

While both Medicare and Medicaid pay physicians, clinical nurse specialists, nurse practitioners and physician assistants that otherwise provide physician services, Medicare coverage of non-physician services performed by non-physician practitioners is more limited compared to Medicaid. Medicare pays for services performed by clinical psychologist and certified social workers but does not reimburse marriage and family therapists or licensed professional counselors. Medicaid policy does not prohibit these latter two professions from independently billing for services and allows for Medicaid reimbursement according to states scope of practice acts.

Pastoral counseling (PC) is a type of behavioral health discipline that may be licensed by a state. Six states have licensure or certification for PC and 37 states license them under another counseling discipline. Medicaid may reimburse PC services provided to eligible Medicaid members if it is defined in the Medicaid state plan.³¹

³¹ Hartley, D., Ziller, E., Lambert, D., et al., 2002. *State Licensure Laws and the Mental Health Professions: Implications for the Rural Mental Health Workforce, Executive Summary*. Muskie School of Public Service, University of South Maine.

Aggregate Public Spending By Payer/Program

Research findings from the 2003 SAMHSA report indicates that 22% of behavioral health payments went to physicians and other professionals operating independently of inpatient, multi-service mental health organizations or specialty substance abuse centers. Using the 2003 SAMHSA data, it is possible to estimate Medicare and Medicaid payments to physicians and other licensed or certified professionals. Table 11 illustrates the estimated amount that was paid to these providers.

TABLE 11. Estimated Medicare and Medicaid Payments to Physicians and Other Professionals -- 2003 (dollars in billions)		
Physicians and Other Professionals	Behavioral Health Spending \$	Behavioral Health Spending %
Medicare	\$1.8	7%
Medicaid	\$6.6	25%
All Other	\$18.2	69%
Total Physicians and Other Professionals	\$26.6	100%

OTHER LICENSED OR CERTIFIED PROVIDERS

Behavioral health services may be provided by other providers in other settings not previously described in this report. For example, nursing homes may provide behavioral health services provided by any number of health care professionals (e.g., physicians, psychologists, nurse practitioners, behavioral health technicians, and others). Similarly, home health agencies may provide behavioral health services through registered nurses, family support workers, and social workers. Behavioral health services can be delivered through other organizations that may be covered by Medicaid, depending on a state's Medicaid plan. For example, in Arizona, there is a Medicaid provider type known as a Community Service Agency. It has to meet certification (not licensing) requirements and is restricted to Medicaid and state-only non-emergency transportation, peer support, and skills training among other medical support/rehabilitative services and payments.

Sources of Public Payment

Other licensed or certified providers and related payments may or may not be included in the information contained throughout this report. For example, nursing home and home health agencies accounted for 6% (\$7.26 billion) of \$121 billion in behavioral health spending reported by SAMHSA for 2003. However, it is almost impossible to determine whether peer support, respite providers or other providers are included in the figures for outpatient provider spending. We do know, however, that Medicaid and state funds are a primary payer of other non-nursing home/non-home health licensed or certified behavioral health providers and their services.

Very limited information is available concerning the numbers of other licensed or certified providers that provide behavioral health services, the aggregate public spending by payer/program, and payment methods and rates for behavioral health services delivered by these other provider types.

BEHAVIORAL HEALTH ELIGIBLE PROVIDERS QUALIFYING FOR CMS NRPM EHR INVENTIVE PAYMENTS

The CMS NPRM for EHR Incentive Program (*Federal Register*, January 13, 2010) includes definitions of eligible professionals (EPs) for the Medicare FFS, MA and Medicaid programs. Certain behavioral health providers are eligible to receive incentive payments under the CMS NPRM.

Medicare Providers -- Fee-For-Service and Medicare Advantage Eligible Professionals and Hospitals

The following non-hospital-based providers qualify for Medicare FFS or MA EHR incentive payments if they meaningfully use a certified EHR product as described in the NPRM:

- doctor of medicine or doctor of osteopathy,
- doctor of dental surgery or dental medicine,
- doctor of podiatric medicine,
- doctor of optometry,
- chiropractor.

The following eligible hospitals qualify for Medicare FFS or MA EHR incentive payments if they meaningfully use a certified EHR product as described in the NPRM:

- Acute Care Hospitals;
- CAHs.

Other requirements must be met for qualifying MA-employed EPs and qualifying MA-affiliated hospitals to be eligible for Medicare incentive payments under the CMS NPRM. The requirements specific to MA Organizations can be found in the *Federal Register*, §495-200, page 1998.

Doctors of medicine and doctors of osteopathy (physicians) who practice psychiatry, addiction, or other behavioral health specialties are EPs and may qualify for Medicare EHR Incentive Payments if they “meaningfully” use a certified EHR product as described in the CMS NRPM.

The NPRM specifies that physicians who provide “substantially all” of their professional services in inpatient and/or outpatient hospital settings are ineligible for Medicare EHR payment incentives. The NPRM defines EPs who provide “substantially all” professional services in these settings as EPs providing 90% or more of their

services in these settings. The ineligibility of hospital-based EPs for EHR incentive payments applies to all physician specialties.

However, the CMS NPRM proposes to use Place of Service (POS) codes 21, 22, and 23 to determine whether/where the EP delivers services. As stated in the NPRM, POS code 21 is defined as: “Inpatient Hospital – is a facility, **other than psychiatric**, which primarily provides diagnostic, therapeutic...and rehabilitation services by or under the supervision physicians....” (page 1906, emphasis added). Other POS codes for psychiatric services, including POS code 51 for services delivered in IPFs, are not included in this NPRM definition. Thus, at this time per the NPRM, EPs practicing in IPFs should be eligible for EHR incentive payments, presuming the EPs meet the meaningful use requirements. Thus, per the NPRM, physicians who practice psychiatry, addiction or behavioral health specialties in IPFs may qualify of EHR payment incentives. It is important to note that this outcome treats EPs practicing in IPFs differently than EPs practicing in other inpatient settings. Whether EPs practicing in IPFs will qualify for EHR payment incentives or will be ineligible for such incentives should be reevaluated when HHS publishes the Final EHR Payment Rule.

Medicaid Providers -- Medicaid Eligible Professionals and Hospitals

The following non-hospital-based Medicaid EPs may qualify for Medicaid EHR incentive payments if they use a certified EHR product as described in the NPRM:

- physician,
- dentist,
- certified nurse midwife,
- nurse practitioner,
- physician assistant practicing in a FQHC or a RHC, led by a physician assistant.

The following eligible hospitals qualify for Medicaid EHR incentive payments if they meaningfully use a certified EHR product as described in the NPRM:

- Acute Care Hospitals;
- Children’s Hospitals.

Physicians and nurse practitioners who practice psychiatry, addiction, or other behavioral health specialties are EPs and may qualify for Medicaid EHR Incentive Payments if they meaningfully use a certified EHR product as described in the CMS NPRM. Other requirements must be met for qualifying Medicaid EPs to qualify for incentive payments under the CMS NPRM (i.e., certain Medicaid patient volume requirements). The requirements are specific to Medicaid EPs and can be found in the *Federal Register*, §495.304, page 2001.

The NPRM uses the same definition of “hospital-based” EP for the Medicaid EHR incentive program as used in the Medicare EHR incentive program, (page 1930). Physicians and nurse practitioners who practice psychiatry, addiction, or behavioral health specialties and provide “substantially all” of their services at a Medicaid-eligible inpatient/outpatient hospital are considered hospital-based EPs and are ineligible for the Medicaid EHR Incentive program. In determining whether a Medicaid EP provides substantially all of their professional services in a hospital setting, the NPRM uses the same set of POS codes to determine whether or not a Medicaid EP is a hospital-based professional as is used for Medicare EPs. Thus, per the NPRM, similar to Medicare EPs, Medicaid EP’s who provide substantially all of their services in IPFs would also be eligible for EHR incentive payments, presuming EPs meet the EHR meaningful use requirements.

Medicaid EP’s who do not provide substantially all of their services at a Medicaid-eligible hospital must meet one of the following requirements to be eligible for the Medicaid EHR incentive program if they meaningfully use a certified EHR product:

- Have a minimum 30% patient volume attributable to individuals receiving Medicaid.
- Be a pediatrician and have a minimum of 20% patient volume attributable to individuals receiving Medicaid.
- Practice predominately in a FQHC or RHC and have a minimum 30% patient volume attributable to needy individuals as defined in §495.302.

Physician assistants providing mental health or substance use disorder services and in an FQHC or RHC in which the facility is led by a physician assistant also qualify for Medicaid EHR incentive payments if they use a certified EHR produced described in the CMS NPRM.

The NPRM defines Medicaid-eligible hospitals as an acute care hospital that has at least 10% Medicaid patient volume (each year for which incentives are sought) or a children’s hospital that has an approved CMS certification number and predominately treats individuals less than 21 years of age. The NPRM excludes children’s hospitals from meeting the volume requirements.

BEHAVIORAL HEALTH PROVIDERS: Expenditures, Methods and Sources of Payment, Electronic Health Record Incentive Payments for Certain Behavioral Health Providers Policy Descriptions

Main Report

HTML: <http://aspe.hhs.gov/daltcp/reports/2010/behhp.htm>

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Attachment: ***Federal Register***, Wednesday, January 13, 2010, 42 CFR Parts 412, et al.

HTML: <http://aspe.hhs.gov/daltcp/reports/2010/behhp-attach.htm>

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