

The American College of Mental Health Administration (ACMHA)

Using Qualitative and Quantitative Data To Tell Us About Integration and Outcomes

Danna Mauch, PhD

17 March 2007

Solving problems, guiding decisions – worldwide



Qualitative and Quantitative Data Use Methods

- Qualitative Study of Barriers to Integration of Mental Health in Primary Care Settings: Data Sources
 - Literature Review
 - Policy, Program, Bioepidemiological, Clinical, Reimbursement and Regulatory
 - Key Informant Interviews
 - Policymakers, academic researchers, providers, consumer advocates
 - Expert Panel
- Quantitative and Qualitative Study of Fragmentation in a Public Mental Health System: Data Sources
 - Services Utilization and Cost Data
 - Stakeholder Input
 - Literature Review
 - Expert Consultants
 - Expert Panel
 - Budget, Legal, Regulatory and Judicial Review

Rationale for Examining Mental Health Reimbursement Practices in Primary Care Settings

- The President's New Freedom Commission, in its groundbreaking Report: *Transforming Mental Health Care in America*, focused two of its six goals on 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”, and
 - SubGoal 4.4: the need to “screen for mental disorders in primary health care across the lifespan and connect to treatment and supports” (The President's New Freedom Commission, 2003).
- The Federal Action Agenda prescribed steps to achieving these goals which led SAMHSA and HRSA, with CMS participation, to form an interagency collaboration to identify barriers and solutions to the provision of mental health services in primary care settings.

The Larger Significance of Reimbursement for Mental Health Services in Primary Care Settings

- Mental disorders impact 1 in 5 Americans each year (Office of the Surgeon General, 2001).
- Despite scientific evidence that mental health treatment is as effective as treatment for other medical disorders, the average delay in identification and onset of treatment for mood disorders is 6 to 8 years (Wang et al., 2005).
- Adolescent depression is “under-recognized and under-treated despite its poor long-term outcomes, including risk for suicide.” (Stein et al., 2006).
- Untreated mental illness is associated with higher use rates and increased costs in child welfare, homeless, criminal justice, medical and disability benefit programs (Wang et al., 2005).
- 5.6 million adults reported unmet need for mental health treatment in the 2004 National Survey on Drug Use and Health, identifying cost and insurance issues as the major barrier to care (SAMHSA, 2005).

Defining the Purpose and Scope of the Study

- Prevalence and Early Onset of Mental Illnesses Argue for Primary Care Integration
- Medical Illnesses in Patients with Serious Mental Illnesses
- Mental Illnesses in Patients with Major Medical Illnesses
- Barriers to Access
- Financial and Reimbursement Barriers
- Financial and Reimbursement Barriers in Medicaid and Medicare

Purpose and Goals of the Project

- Purpose of the Project:

- Identify barriers to integration of mental health services in primary care settings
- Document challenges in Medicare and Medicaid reimbursement for providers of mental health services in primary care settings
- Outline and review proposed solutions with policy, practice and research experts
- Recommend actions to address barriers

- Goals of the Project:

- Implement the Federal Action Agenda to address reimbursement issues
- Provide key information to assist in achieving New Freedom Commission Goals 1 and 4
- Engage experts and stakeholders in framing the issues and actions
- Produce usable reports to enable SAMHSA, HRSA and CMS to improve access to timely care

Approach to and Methodology for Environmental Scan

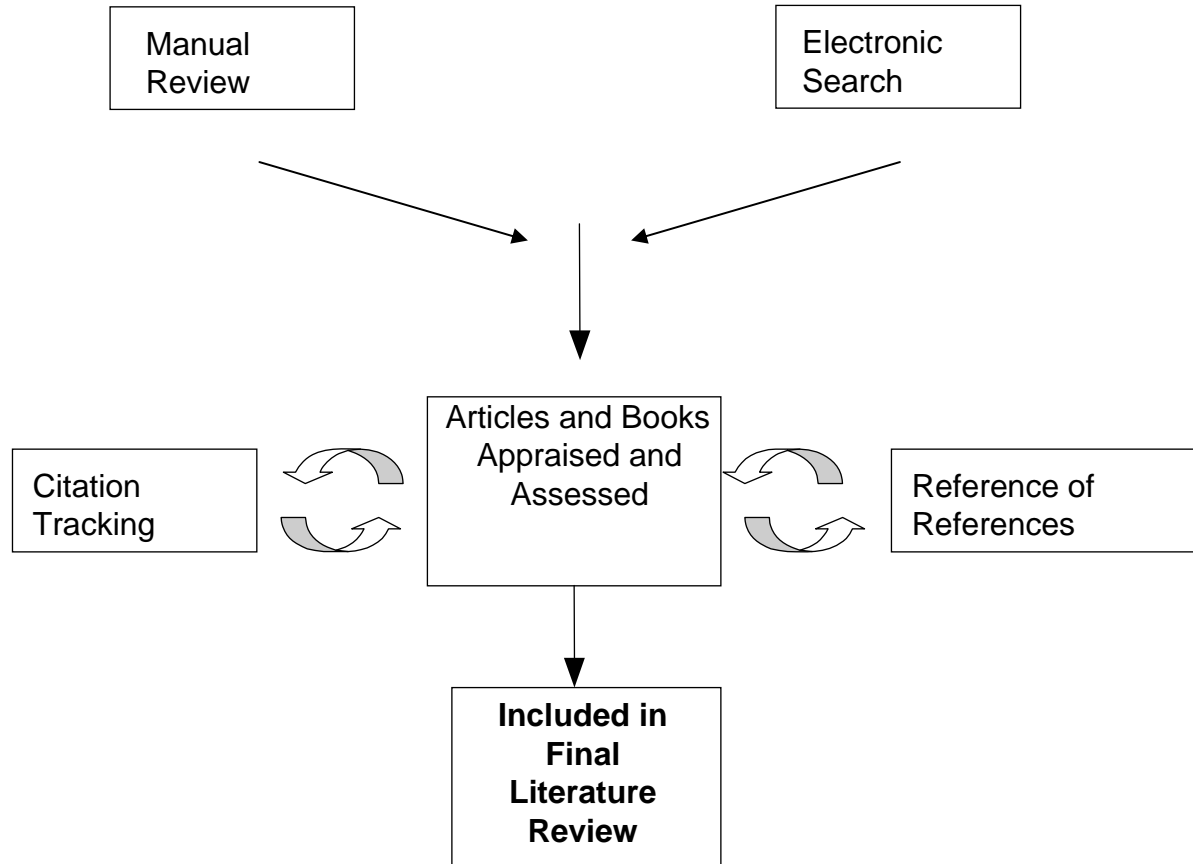


- Used defined key issues/research questions and carefully established selection criteria.
- Identified relevant studies through a computerized literature search of thousands of health and mental health-related journals, newsletters, and trade journals.
- Focused on articles published after 1995; however, the document also incorporates highly relevant articles published prior to 1995.
- Through this process, we reviewed 342 articles and included 148 articles, reports, memorandums, and other documents in the Environmental Scan.



Approach to and Methodology of Environmental Scan (continued)

Literature Review Process



Approach to Methodology for Key Informant Interviews

- Consumers: users and advocates
- Providers: individual and institutional
- Payers and Insurers: private and public; managed care plans and fee-for-service; state and federal
- Researchers: clinical, program, evaluation
- Policymakers: local, state and federal

Approach to Identifying Expert Panel Members

- Leading Policymakers and Decision makers from the Federal Work Group and State Agencies
- Policy and Research Experts from the Published Literature
- Leaders of Mental Health and Primary Care Provider Organizations with integration experience in a range of community settings – schools, MH and PC clinics and organizations, hospital networks, systems of care
- Leaders of national consumer, provider, policy and advocacy organizations

Preparation of the Expert Panel Members

- Results of Environmental Scan
 - Scope of the issue and need
 - Identification of key barriers
 - Zeroing in on reimbursement barriers
 - Findings on poor outcomes from split systems
 - Findings on results of integration
 - Identification of best practices in integration of mental health in primary care settings
- Results of Key Informant Interviews
 - Refining the Literature Review
 - Framing the Environmental Scan
 - Focus on the significant barriers
 - Understand the impacts in a range of settings from school clinics to community clinics to health systems
 - Identify best practices not yet in press

Barriers Evaluated and Ranked by Expert Forum

1. State Medicaid restrictions on payments for same day billing (20 votes)
2. Lack of reimbursement for collaborative care and case management related to mental health services (15 votes)
3. Absence of reimbursement for services provided by non-physicians, alternative providers, and contract providers (15 votes)
4. Medicaid policy disallowing reimbursement when primary care providers submit bills listing only a mental health diagnosis and corresponding treatment (11 votes)
5. Reimbursement rates in rural and urban settings (11 votes)
6. Difficulties in getting reimbursement for mental health services in school-based health center settings (9 votes)
7. Lack of reimbursement incentives for screening for mental disorders and providing preventive mental health services (9 votes)

Solutions Recommended by Expert Forum

An Expert Forum comprised of key policymakers, stakeholders, and researchers was convened on June 19, 2006 to review identified barriers and formulate suggested actions:

1. Clarify statements, policies, definitions, and services that are incorrectly interpreted, causing unnecessarily key reimbursement barriers; broadly disseminate clarifications
2. Collaborate among DHHS agencies and key national stakeholder organizations to achieve effective implementation and adoption of clarified information
3. Provide education and technical assistance across providers, settings, and payers to improve reimbursement
4. Approve, authorize, and support additional services and performance measures

Forum Suggested Action 1

Clarify statements, policies, definitions, and services that are incorrectly interpreted, causing unnecessarily key reimbursement barriers; broadly disseminate clarifications.

Forum Suggested Action 2



Collaborate among DHHS agencies and key national stakeholder organizations to achieve effective implementation and adoption of clarified information.



Forum Suggested Action 3

Provide education and technical assistance across providers, settings and payers to improve reimbursement.

Forum Suggested Action 4

Approve, authorize, and support additional services and performance measures.

Summary

- Project identified areas where the Federal government, States, provider organizations, and commissioner associations can
 - Clarify
 - Collaborate
 - Disseminate
 - Support
- to improve the reimbursement of, thereby increasing access to, mental health services in primary care settings.

Massachusetts' Unified Behavioral Health System Planning

- **Phase I Strategic Planning:** Pursuant to New Freedom Commission Mental Health System Transformation, Massachusetts Department of Mental Health identifies through Strategic Planning the need to integrate Medicaid/MassHealth Behavioral Health to reduce fragmentation in the system of care by integrating silos of financing, program benefits and eligibility on behalf of state residents with and at risk for emotional disturbance and mental disorders
- **Phase II Implementation Planning:** Using data from multiple sources to define the fragmentation problem and design the integration solution

Implementation Planning Methodology

- Build from the Strategic Plan framework of Vision, Mission, Goals, and Principles for System Redesign
- Gather data from multiple qualitative and quantitative sources to accurately define the scope of the system's strengths and problems
- Ground Redesign Solutions in the data and desired outcomes
- Frame implementation in measurable steps and objectives

Methodology for Data Gathering

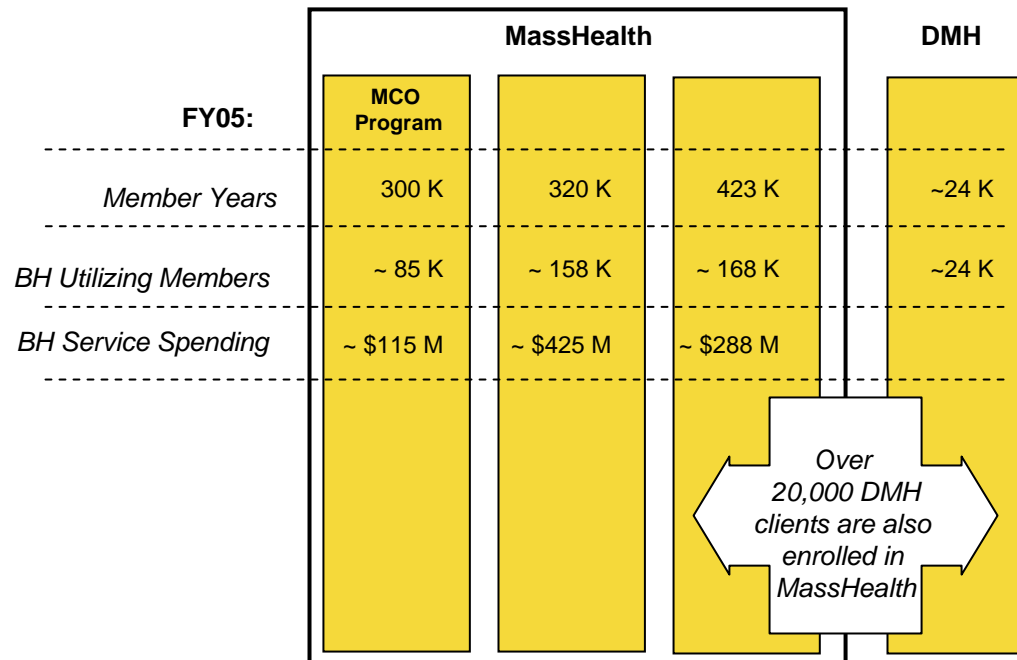
- Cross checking and validation of findings from the qualitative and quantitative data sources to identify fragmentation and plan integration for improved outcomes
 - Stakeholder Input through geographically dispersed forums for consumers, families, providers, program staff
 - Key Informants from policy, program, provider and consumer organizations, including sister state government agencies
 - Program and Policy Reviews in Mental Health, Medicaid and Managed Care entities
 - Review of Evidence-Based and Promising Practices
 - Clinical, Services and Cost data analyses of need for and utilization of services

Examples of Data Findings

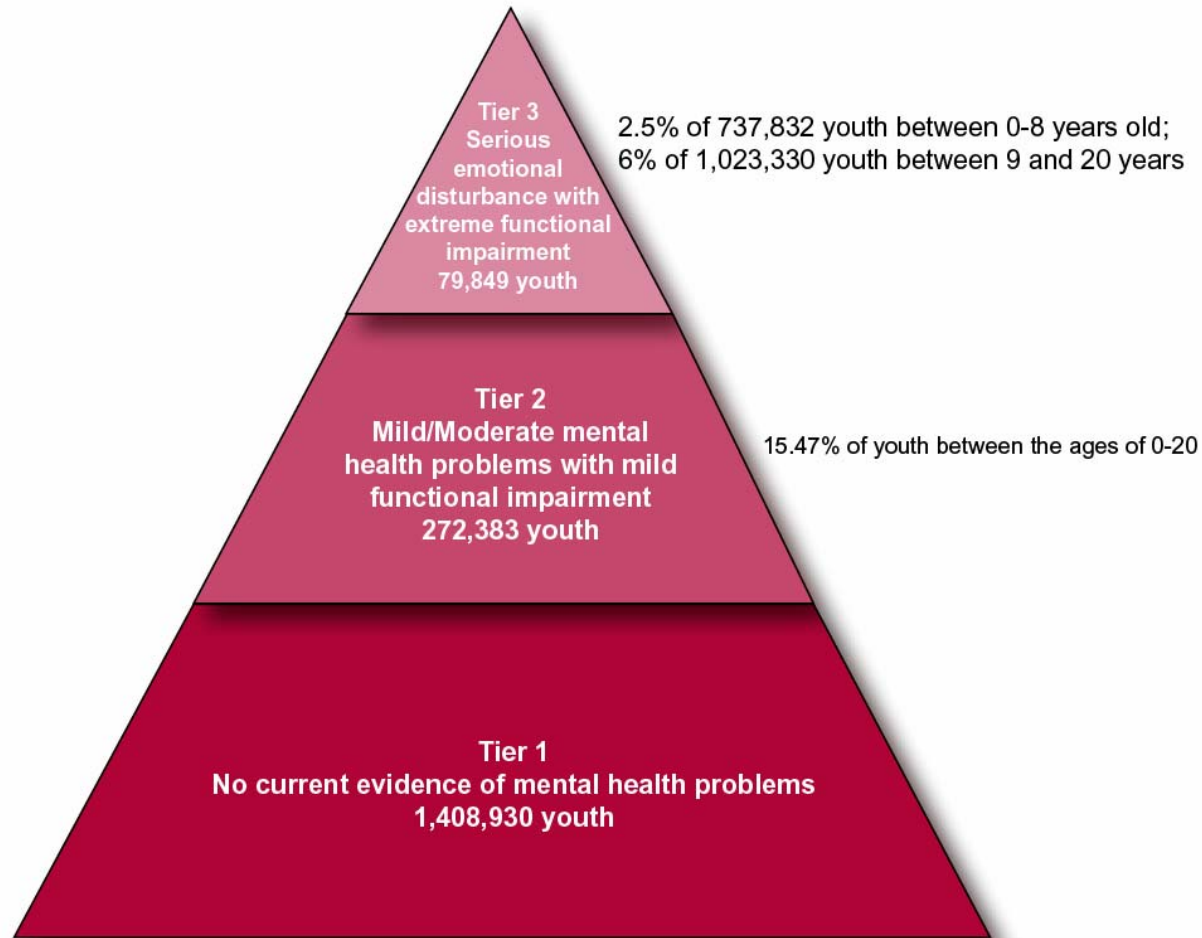
- Qualitative Results produce strong consensus across all stakeholder groups on system strengths and problems
 - Fragmentation and limited access are the greatest problems
 - Access limitations are exacerbated by fragmentation
 - Solutions can be built on the tradition of innovation and current adoption of evidence-based practice
 - Adopt a Public Health Model
- Quantitative Results are still in development, but as the following slides illustrate, these are contributing to:
 - Illustrating the silos of lives and reimbursement that are key to understanding the nature of the problem
 - Illustrating the scope of a Public Health Approach
 - Illustrating the issues of multiple diagnoses and treatments that demand an integrated approach to care

Massachusetts Behavioral Health System

- The public behavioral health system is funded through multiple mechanisms. Main two:
 - State Mental Health Authority appropriations
 - Medicaid

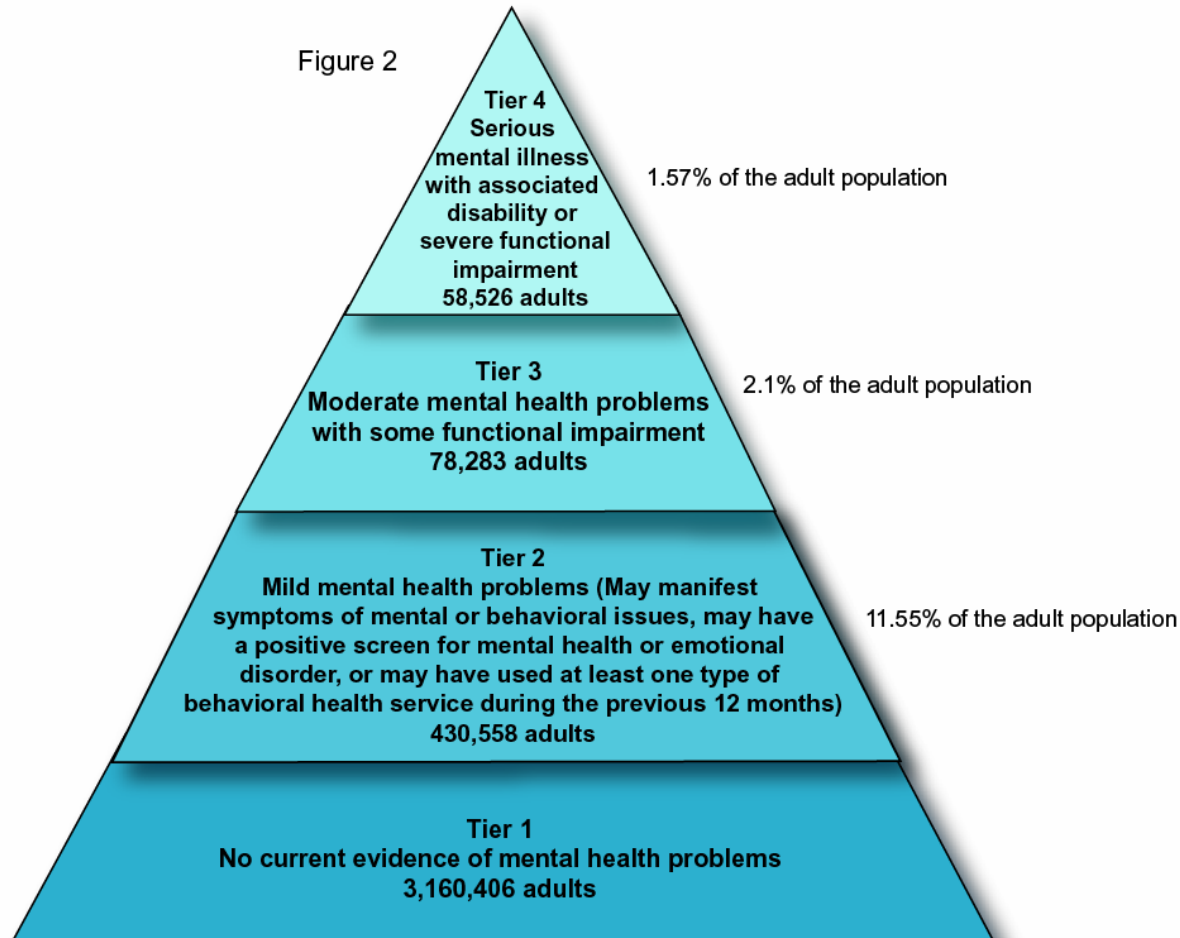


Estimated Level of Mental Health Need in MA: Children, Youth and Young Adults (Ages 0 to 20)



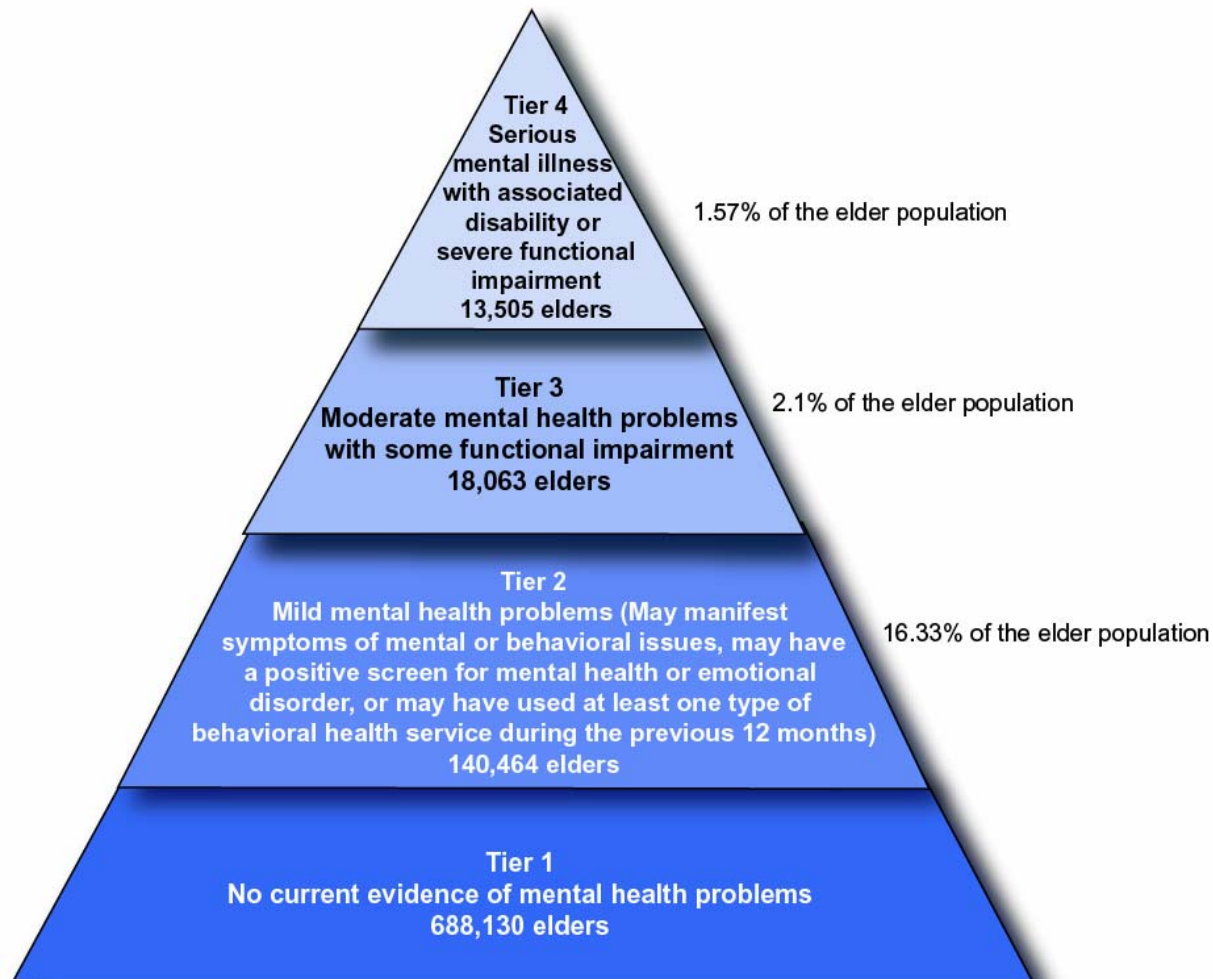
An estimated 1,761,162 youth between the ages of 0 and 20 are living in Massachusetts (27.7% of the total population). Tiers 3 and 2 represent 20% of the youth in Massachusetts based on the Surgeon General's report of any diagnosable mental disorder during childhood and adolescence.

Estimated Level of Mental Health Need in MA: Adults (Ages 21 to 64)



An estimated 3,727,773 individuals between the ages of 21 and 64 are living in Massachusetts (58.7% of the total population); 567,367 are potentially living with a mental illness (15.22% of individuals based on DMH prevalence estimates of adults with a diagnosable mental illness).

Estimated Level of Mental Health Need in MA: Elders (Ages 65 and Above)



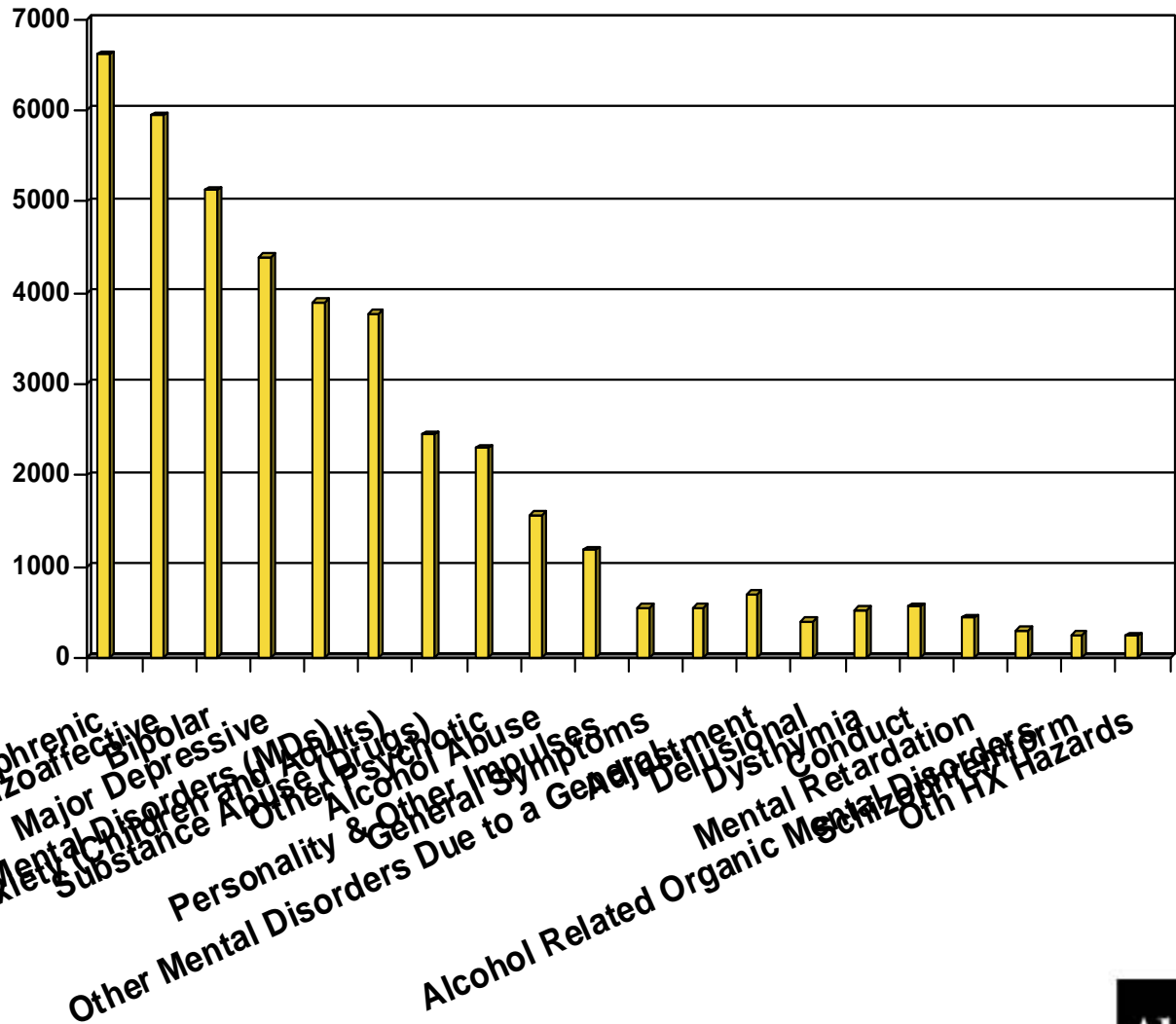
An estimated 860,162 elders live in Massachusetts (13.5% of the total population); 172,032 are potentially living with mental illness (20% of elders based on the Surgeon General's estimates for individuals aged 55 and over who will experience mental disorders that are not part of normal aging).

Diagnoses in MA DMH Client Population

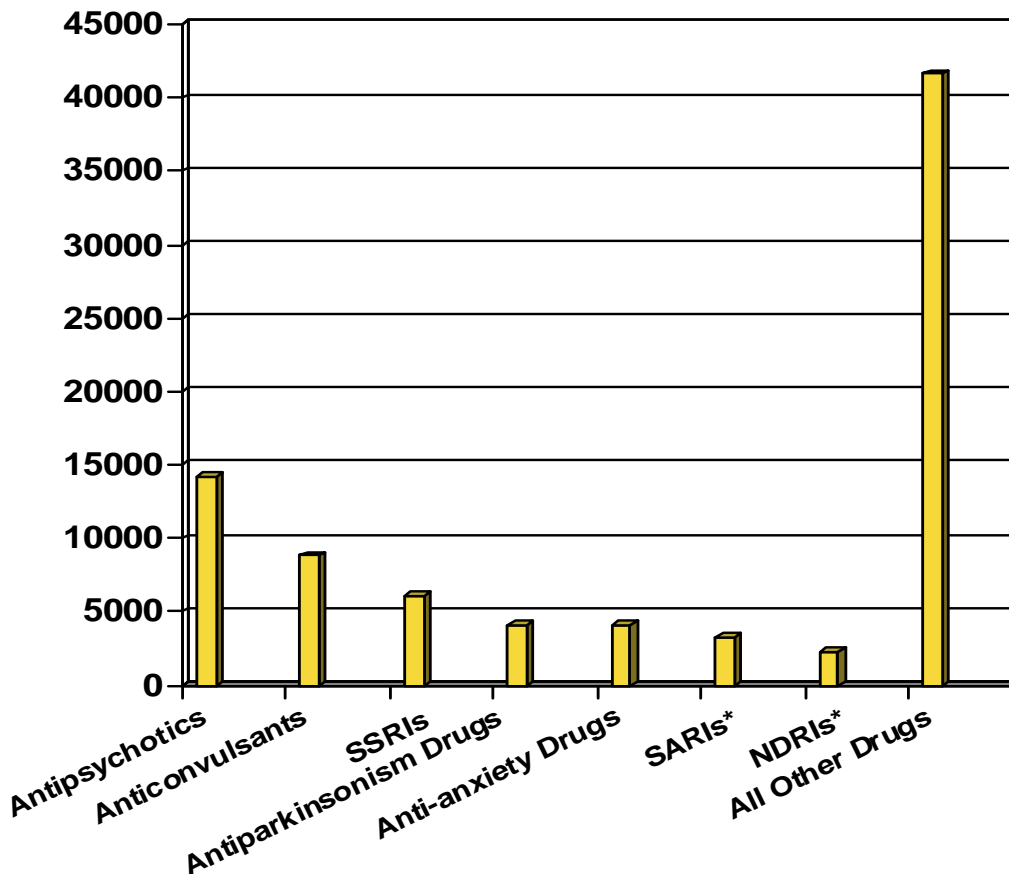
Average Number of Diagnoses per Client = 3

Unduplicated Client Count = 16,388

Client Diagnoses Count = 47,760



All Prescriptions by Drug Class for MA DMH Clients



**Average Number
of Prescriptions
per Client = 5**

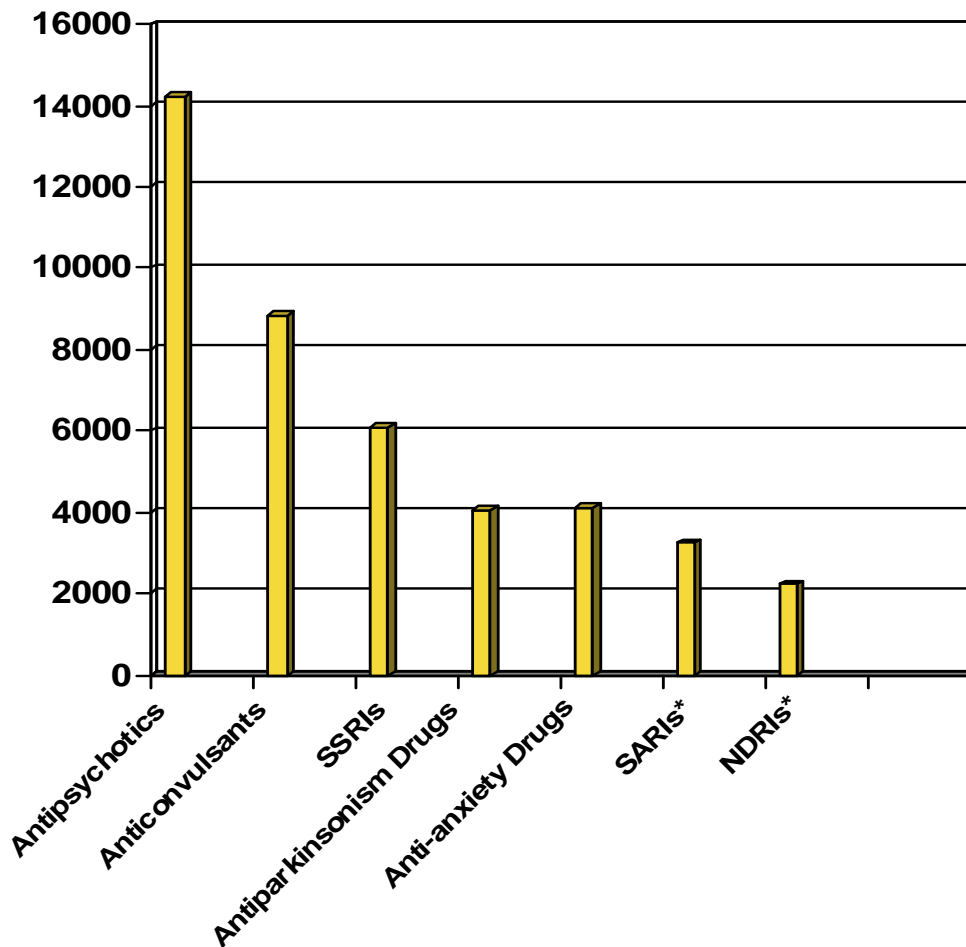
Total Number of
Clients = 16,388

Total Client
Prescription Count =
84,403

* Serotonin-2 Antagonist/Reuptake Inhibitors

* Norepinephrine and Dopamine Reuptake Inhibitors

Psychiatric Prescriptions by Drug Class for MA DMH Clients



Average Number of Prescriptions per Client = 5

Total Number of Clients = 16,388

Total BH Prescription Count = 42,736

Total non-BH Prescription Count (not represented in graph) = 41,667

Total Client Prescription Count = 84,403

* Serotonin-2 Antagonist/Reuptake Inhibitors

* Norepinephrine and Dopamine Reuptake Inhibitors

Significance of Analyses

- Understanding the scope of need
- Defining the solutions
- Justifying change to stakeholders
- Seeking support from stakeholders
- Securing budget and material resources from the Governor and Legislature



Abt



Abt

Abt Associates Inc.