PANEL 4 – HEALTH CARE CLAIM OR EQUIVALENT ENCOUNTER INFORMATION (Part 1)

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Thank you for the opportunity to provide testimony today around mental health and health care claim or equivalent encounter information. As someone who works quite closely with many practices around mental health, I believe this is a timely topic in the age of health reform. I will structure my remarks today around what I see as some of the most innovative and promising models for mental health emerging in our communities.

As the Institute of Medicine has written:

"Effective treatments (for mental health) exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences--for people who have the conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for our nation as a whole.[1]"

With a recognition that mental health must be better addressed, there comes an understanding that this cannot occur in isolation; that clinical, operational, and financial mechanisms must all simultaneously change to bring about a new model of care that better tackles mental health.[2] To this end, more seamlessly integrating mental health into the larger healthcare milieu holds promise for improving outcomes, decreasing cost, and enhancing our patient's experience. The data is clear, when we integrate mental health with certain dominant facets of delivery, like primary care, we have an opportunity to better treat, and in some cases prevent, mental illness.[3,4]

According to the Agency for Healthcare Research and Quality Lexicon for Behavioral Health and Primary Care, integration is defined as:

"The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, ineffective patterns of health care utilization.[5]"

This definition and framework was created in response to an emerging field that has attempted to close a gap between mental health and primary care. Central to the topic for my testimony on mental health and health care claim or equivalent encounter information, I want to focus on this new model of care and how the claims process may change when payment reform combines with clinical reform and what this means for healthcare.

Historically, the mental health field has predominately been paid through traditional fee for service mechanisms.[6] In fact, until recently there has not been much emphasis placed on quality or outcomes in this field. As a newer facet of the healthcare delivery system, traditional mental health services were often seen as requiring lengthy sessions or visits and continue for an extended period of time. However, when claims were submitted, these mental health benefits and payments were (and in many cases still are) adjudicated through a separate financial channel than that of a medical visit. To this end, a separate system for claims was created to manage the "mental health" benefits.

Needless to say, having two separate systems to address mental health and medical only exacerbated the already stymied fragmentation felt by patients and clinicians. On the medical side, many times the codes used by non-mental health clinicians for patients with a mental health need were not paid or, in some cases, the desire of the patient to not be labeled as having a mental illness led the medical

clinician to code the symptoms differently to hide the mental health issue. For example, instead of a diagnosis of depression given to a patient, the medical clinician may code symptoms of lethargy, stomach pain, insomnia, or others. In essence, stigma was somewhat perpetuated by a separate process for mental health codes and claims making it different than medical codes or claims.

With more medical practices, like primary care, recognizing the inseparability of mental health from medical, approaches that integrate mental health providers are emerging. These new approaches combined with new and novel payment methodologies challenge the antiquated notion that mental health is separate and that volume driven care improves quality and outcomes. Healthcare's increased emphasis on efficiency and value based care opens up new doors to address the role of claims in our system.

For example, in primary care practices where mental health is onsite, and that practice is held to some value based arrangement that includes mental health quality and outcomes, the entire idea that coding or billing a separate mental health encounter may become different. Add to this fact that many of these practices may wish to integrate a mental health clinician on the team and a new paradigm emerges for how we think about claims for multiple providers, on the same team, in the same practice. For an alternative payment methodology like capitation or global budgeting, primary care practices may not have their mental health clinician code or drop any bill since their service may be seen as part of the overall primary care visit.

Value based payments will also likely usher in the need for different types of data sets. Specifically in the area of mental health, we may start to see clinicians, offer up different types of data to the payer for the services delivered. Mental health visits, like most other healthcare services, has been encountered at each patient visit. In the context of value based payments, there is a need to recognize that under some financial arrangements, like a global budget, payers may not collect data from every encounter, but

rather come back after a specified period of time (e.g. six months, 12 months). Based upon patient outcomes or functional status, the payment to the clinician may be given out at the end of the time frame contingent on certain outcomes. The notion that not all payment will come through an encounter but be based on other data is relatively new and novel and the committee may wish to consider how these alternative payment methodologies impact on historical claims and encounter information.

Most mental health systems and clinicians do not have as robust electronic health record technology as their medical colleagues. Some of this may be due to mental health not being included in the HITECH Act as eligible for financial incentives; however, even if there were incentives, most of these systems are still collecting a very different kind of data than the rest of healthcare (e.g. process data, limited outcome data). Add to the fact that these systems operate under different rules around data exchange, and often are not easily able to share their data with others in healthcare (e.g. primary care). Mental health clinicians and practices, outside of larger integrated delivery systems, may not have the electronic infrastructure to support certain transactions. Simply put, stand-alone mental health providers may not have the information technology and systems infrastructure to rapidly adopt electronic health record utilization of the standard transactions and operating rules except for billing. When we consider clinical integration (e.g. bringing mental health into other settings), we must also consider where these data will be collected, stored, and how they will be shared as well as how these data will shift under non fee for service payment arrangements.

Claims, based on codes, seem to be an artifact of fee for service. As our healthcare system moves away from individual claims to larger more connected data sets built off a value proposition rather than a volume proposition, we must consider the impact this will have on mental health. If mental health is integrated into more medical settings, how we track or manage our mental health encounters will change dramatically. Separate specialty mental health services, still working to come into value based

arrangements, may have need to operate under the older approaches to claims; however, this will likely shift dramatically as more practices integrate care.

I encourage the committee to consider studying how the claims process will shift as more novel payment reform methods are applied to our practices. Specifically, looking at the role of mental health, in integrated and non-integrated practices, may help better elucidate the impact of integrated models and what role, if any, claims should play in holding the practice accountable for value based care. I also encourage the committee to recognize that regardless of where mental health services may be delivered, the mental health system has historically been behind their medical colleagues on systems infrastructure to rapidly adopt electronic health record and utilization of the standard transactions and operating rules.

References

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