Medical Homes and Integration of Mental Health

This is one of a series of issue briefs by the Bazelon Center on the integration of mental health in healthcare reform. They offer policy recommendations for:
♦integration of mental health in primary care;
♦medical homes;
♦chronic care management;
♦integration of mental health in the public health system;
♦the role of public insurance programs (Medicaid, SCHIP and Medicare); and
♦improving the quality of care.
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The concept of a "medical home" that is responsible for overseeing and coordinating a person's healthcare has gained in popularity since it was first introduced in 1967 by the American Academy of Pediatrics.[1] Medical homes are now considered a model of care widely applicable to adults and children. The value of medical homes for people with mental illnesses, and the value of mental health treatment for those enrolled in medical homes, is also well demonstrated by projects around the country that integrate mental health and physical healthcare services.

Background

Individuals need a healthcare provider who is accountable for their overall health and wellness. In a medical home, primary care providers not only provide traditional diagnostic and therapeutic services, but also coordinate care and link individuals to other providers and community services as necessary.[2]

Today, medical homes have been endorsed through policies in thirteen states[3] and by leading healthcare groups and organizations of primary care professionals.[4] These organizations and others, such as the National Committee for Quality Assurance (NCQA), have sought to achieve optimal results by more clearly defining the concept and setting high standards.[5] Research has shown that medical homes are a cost-effective approach.[6]

Collaborative-care models, such as medical homes, have also been found in more than 35 randomized controlled trials to be effective in treating mental illness.[7] Public mental health policies have long endorsed organized systems of care as critical in improving the quality of care. Such systems offer an opportunity for prevention and early intervention and can form a basis for improving quality and making care more affordable.

In an ideal medical home model, primary care and behavioral health professionals can be co-located and offer enhanced services in several ways. Among the benefits are:

- Improved behavioral outcomes that bear on wellness issues, such as obesity and smoking. The mental health specialist can address these issues in collaboration with the primary care provider.
- Easy access to mental health treatment for people with other serious or chronic illnesses, such as diabetes or cardiac conditions, whose recovery is impaired by a co-occurring mental health disorder, such as depression.
- Greater access to appropriate treatment for mild or moderate mental health disorders, either through direct services from the co-located mental health specialist or through improved treatment of these disorders by primary care providers as a result of the ease of consultation.

- Improved referral and linkage with community mental health specialty care for more complex cases.

To foster the growth of medical homes and other organized systems of health and mental health care, private health plans and public systems need to coordinate to avoid fragmentation and undue complexity. It will be important to ensure that a single person or entity is responsible for each individual's overall care and that access to all needed services is assured. There may be individuals with coverage under both Medicaid and a private plan, for whom coordination is critical. Other individuals covered only by a private plan may wish to purchase some of the less traditional services offered through the public mental health system. Duplication of effort should be avoided.

Medical Homes in Public-Sector Systems

Federally qualified health centers (FQHCs) are in a strong position to meet any standards set for medical homes. They should be encouraged to provide basic mental health services, screen individuals and make referrals to outside mental health specialists. One way to facilitate such referrals is through collaboration with public mental health programs. Collaborations between community health centers and behavioral health specialists, including community mental health centers, have been fostered by a number of state Medicaid programs.[8]

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Organized systems of care are also the basis for much of the public mental health system and have been supported with federal grant funds. For example, some community mental health centers are organized to furnish all mental health care for low-income people in their community, while some children's system of care programs engage in interagency collaboration to provide coordinated and effective care.

Community mental health agencies often act as the primary or only source of care for individuals with severe mental illnesses. There must be incentives to incorporate primary care services within their programs so that they become medical homes for that population. One way to accomplish this might be to link them with an existing FQHC. Missouri is currently piloting seven integrated-care partnerships between mental health centers and FQHCs. In other areas, constructs are being built that result in the merger of an FQHC and a mental health agency into a single entity.

A three-year demonstration project of the medical-home concept for improving the physical health of adults with severe mental illnesses was funded by the Robert Wood Johnson Foundation through the Medicaid program in Vermont. The medical homes reduced hospitalization for type II diabetes in this population to zero.[9]

Reimbursement Structures Should Support Medical Homes

Current health insurance reimbursement structures create barriers to the collaboration inherent in a medical-home concept and to the co-location of health and mental health providers. Policies that undermine the medical-home concept should be swept away. At present there are confusing policies in Medicare, and some state Medicaid programs

and private insurers have specific policies that deny payment for two visits to be billed on the same day by the same entity—even when one is with a primary care provider and the other is with a mental health professional. This is counterproductive, given the evidence that such a practice is the most effective and efficient approach and one that avoids the risk that an individual will fail to follow up on a referral**.** Insurers also should pay for consultation between two practitioners around the needs of a particular patient.

Financing policy should promote strategies that create a locus of accountability and offer incentives for improved performance and integration. Payment structures that allow provider flexibility in service delivery, while at the same time encouraging evidence-based practices, would greatly support the concept of a medical home with broad responsibility for a person's health.

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Medical homes should be paid through bundled rates, such as capitation or case rates. However, when entities are paid through these bundled rates, as opposed to fee-for-service reimbursement, they may be reluctant to take on the more difficult and therefore more expensive clients. This adverse selection could seriously impair access to these organized systems by individuals with a chronic illness and co-occurring mental health disorder or a severe mental illness. Risk-based reimbursement schemes may be one way to protect against this tendency. Health plans should also be prohibited from arbitrarily dropping such individuals. If a plan remains responsible for their care, it might bring its leverage to bear to ensure that they can access a medical (clinical) home where more integrated and comprehensive care can be provided.

Recommendations

The quality and availability of mental health care would be enhanced with a national policy that encourages the provision of care through medical homes that incorporate mental health expertise.

- Individuals should be encouraged to use a medical home where they can receive a full range of primary care services, including basic mental health care, and be effectively linked to specialist care and appropriate social support services.
- Community mental health agency providers should be allowed to become medical homes for their patient population, individuals with severe mental illnesses, by adding a primary care component.
- Medical homes should be paid in a manner that facilitates flexibility in service delivery, such as through capitation or case rates.
- Protection against adverse selection should be in place, including risk-based reimbursement to encourage medical homes to accept individuals with complex health problems.
- Research is needed to measure performance and outcomes in integrated practices, as compared with primary care practices without mental health expertise, to assess the value of various approaches to integrating mental health within primary care.

1 A medical home is defined by the American Academy of Pediatrics as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.

2 Keckley, P.H & Underwood, H.R. (2007). The medical home: Disruptive innovation for a new primary care model. Washington, DC: Deloitte Center for Health Solutions.

3 California, Connecticut, Florida, Idaho, Iowa, Louisiana, Maryland, Mississippi, North Carolina, Rhode Island, Texas, Washington and West Virginia.

4 American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association, representing 333,000 physicians.

5 National Council for Quality Assurance (NCQA) Physician Practice Connection Standards, available at: http://www.ncqa.org/Default.aspx?tabid=141

6 North Carolina Medicaid saved $195 million to $215 million in 2003 and between $230 and $260 million in 2004 through the use of medical homes operated by community physicians, hospitals, health departments and social services.

7 Thielke, S., Vannoy, S. & Unützer, J. (2007). Integrating mental health and primary care. *Primary Care: Clinics in Office Practice, 34*, 571-592.

8 American Public Human Services Association & National Association of State Medicaid Directors. (2008). *Serving the Needs of Medicaid Enrollees with Integrated Behavioral Health Services in Safety Net Primary Care Settings*. Washington, DC: National Association of State Medicaid Directors.

9 Mastal, M.F, Reardon, M.E., English, M. (2007). Innovations in disability care coordination organizations: Integrating primary care and behavioral health clinical systems. *Professional Case Management, 12*, 27-36.