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THERE COULD BE MORE MONEY FOR GERIATRIC MENTAL HEALTH IN NYS

By Michael B. Friedman

As the Geriatric Mental Health Alliance has explored barriers to providing services to meet the mental health needs of older adults, we have heard over and over again that there just isn't enough money. Everyone agrees that we need:

- Funding for a broad range of basic programs such as screening, assessment, and treatment; prevention of institutional placement; family support; bilingual/bicultural services; public education; workforce development; and more.
- Special Medicare and Medicaid rates for home visits
- Funding for more satellites in community settings such as senior centers and NORCS*
- Funding to support integration of mental health, health, and aging services
- Funding for innovative programs
- Major reform of Medicare, including parity of mental health and health coverage
- Release from NYS's Medicaid neutrality requirement

That is why one of the Alliance's major goals is to advocate for more funding.

But we have also learned that many providers in New York State are not taking full advantage of the funding Medicare would provide if services were designed and billed in accordance with Medicare rules.

That is why The Alliance and several co-sponsors** recently provided three training sessions on optimizing Medicare.*** One was for mental health organizations, one was for private practitioners, and one was for government officials. Derek Jansen, Ph.D., a national expert on Medicare, Medicaid, and other sources of federal funding provided the training. He made it quite clear that there are major opportunities for New York State to bring in more Medicare funding for mental health.

Here's the gist of what we learned.

1. Medicare is a disproportionately low payer for mental health services. It funds only 7% of all mental health expenditures in the United States, although it covers 14% of Americans. In addition, only 3% of Medicare expenditures are for mental health and substance abuse services, significantly lower than the proportion of behavioral costs of all health spending—roughly 10%.

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* A "NORC" is a naturally occurring retirement community, a building or neighborhood with a large concentration of older adults. Some have supportive service programs, which are referred to as NORC-SSPs.

** The Coalition of Behavioral Health Agencies, Inc. and the Mental Health Associations of Nassau, NYC, and Westchester.

*** The training sessions were funded through a grant from the van Ameringen Foundation.

2. Providers frequently do not take advantage of mental health funding opportunities in Medicare. For example, although Medicare only pays 50% for psychotherapy as compared to 80% for physical health care, consultation and certain evaluation and management services by psychiatrists and some other medical providers may be reimbursed at 80%. In addition, although for the most part Medicare will not accept bills for more that one service per day, there are circumstances under which it will pay for more. And although social workers must hold a special license (LCSW in NYS) to bill Medicare using their own provider identification number, services provided by social workers without the clinical license or their own Medicare provider number may be billed as "incident to" services provided under proper supervision in certain settings.

   Dr. Jansen gave many more examples, but the point is clear. NYS's mental health agencies, hospitals, and private practitioners could bring in more Medicare funds if all of them knew what is allowable and how to bill.

3. Medicare can also be used to fund mental health services in community settings such as senior centers and NORCs. One way to do this is to establish a satellite clinic in a senior center, NORC, or other community setting. The clinic then bills both Medicare and Medicaid as it does ordinarily. Several organizations in NYS currently do this. The problem is that it is not easy to establish a licensed satellite—in part because of Medicaid neutrality provisions. This problem could be overcome by NYS OMH easing the process of approving licenses for satellites for older adults.

   Another way to overcome the problem is to encourage private practitioners or private practice groups to establish offices in community settings as many currently do in nursing homes. They could bill Medicare and, for people also eligible for Medicaid, they could receive "crossover" payments that cover part of what Medicare does not cover. Dr. Jansen pointed out that this has to be done carefully with help from a health care attorney and that there are issues of quality assurance to be addressed. But it is doable.

4. Dr. Jansen also spoke about emerging opportunities to integrate mental health and health services—a major goal for all geriatric mental health advocates—by providing services in "federally qualified health centers" (FQHCs). These are community health centers that receive federal funding to cover the costs of serving people with no health coverage. They also can bill Medicare and Medicaid. Until recently community health centers were not permitted to provide mental health services except for psychological conditions linked to a physical illness. Now the FQHCs are permitted—even encouraged—to provide mental health as well as physical health care.

   Dr. Jansen noted two possible approaches. The FQHCs can hire mental health professionals to serve on their staff or they can partner with mental health organizations, an approach many seem to prefer. Either way more older adults with mental illnesses could get the treatment they need.

What needs to happen? To take full advantage of these federal funding opportunities, we believe that:

- Providers should work with health care lawyers and knowledgeable consultants to make sure that they are billing properly and are getting as much Medicare funding as is allowed under law.

- Providers should explore opportunities to provide services in community settings, and local departments for the aging and for mental health should help them.

- Mental health and community health providers should explore ways to integrate health and mental health service delivery in community health centers.

- New York State and local governments should develop expertise regarding all of the opportunities to generate federal funding support through Medicare and FQHCs.

- Then state and local governments should provide technical assistance to providers to optimize Medicare, to develop services in community settings, and to integrate health and mental health services.

- NYS OMH should facilitate the expansion of clinical services for older adults, including the development of more satellites in community settings. This should include relief from the Medicaid neutrality requirement.

To move ahead on some of these opportunities there is no need to wait. Expertise is available now. Private practitioners should look to their professional associations for help. Mental health organizations, community health organizations, and hospitals should look to their trade associations. And, to repeat Dr. Jansen's caveat, everyone should consult with a good health care attorney and with experts on Medicare rules.

As a final note I want to be clear that the Geriatric Mental Health Alliance does not believe that pursuing these avenues will produce *all* the funding that will ultimately be needed to meet the mental health needs of our growing population of older adults. Not by a long shot. We do need to press for basic geriatric mental health services. We do need to press for Medicare reform. We do need to press for parity. We do need to press for reasonable funding for home and community-based services. We do need to press for funding for community-based residential services. But in the meantime let's all find out what we can do within the current system and do it.

(Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of NYC and Westchester and The Chairman of the Geriatric Mental Health Alliance of New York. The opinions expressed in this column are his own and do not necessarily reflect the positions of the MHAs. Mr. Friedman can be reached at center@mhaofnyc.org.)