Funding mechanisms for depression care management: opportunities and challenges

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Abstract

Objective: Inconsistent third-party reimbursement for depression care management is a significant economic barrier to the utilization and sustainability of the chronic illness care model in primary care practice settings. We review common mechanisms used to procure payment for depression care management services, discuss obstacles encountered and suggest future directions.

Method: We describe several extant models for funding depression care management services in use at the demonstration sites of the Robert Wood Johnson Foundation funded Depression in Primary Care project and similar programs. We derived this information from ongoing discussions with the sites’ project directors and through an extensive electronic literature search on care management, funding mechanisms and depression.

Results: Funding mechanisms include (a) practice-based care management on a fee-for-service basis, (b) practice-based care management under contract to health plans, (c) global capitation, (d) flexible infrastructure support for chronic care management, (e) health-plan-based care management, (f) third-party-based care management under contract to health plans and (g) hybrid models.

Conclusions: While substantial obstacles remain in the way of fully implementing these depression care management funding mechanisms (e.g., variations in care managers’ credentials and work locations and third-party payer concerns about overutilization and transaction costs), several recent policy advances provide some optimism for the potential adoption of financial mechanisms to support and disseminate these evidence-based practices.

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1. Introduction

Optimal primary care for a variety of chronic illnesses, including major depression, is achieved through the use of the chronic illness care model developed by Wagner et al. [1–4]. This model reorients primary care from its focus on treating acute conditions to managing chronic diseases more effectively. Care management services provided by behavioral health-care professionals (i.e., psychiatric nurses, clinical social workers and masters-prepared counselors) through ongoing interactions with patients, physicians and behavioral health specialists are an integral component of this model. We define “care management” to mean “a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.”* Effective care management facilitates strategies and interventions incorporated in evidence-based guidelines (e.g., stepped care approaches). We avoid using the term “case management” because it can connote a set of utilization management techniques (e.g., preauthorization of services and concurrent review) employed by the managed care industry to prevent excessive use of services.

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This is the CMSA definition and is online at http://www.cmsa.org/AboutUs/CMDefinition.aspx.
and to contain health-care costs. Care management interactions take place through direct face-to-face meetings in primary care offices, in community settings or at the patient’s home, as well as via telephone, and occur throughout the acute and maintenance phases of treatment.

Several well-controlled studies have demonstrated the clinical efficacy and cost-effectiveness of care management for behavioral disorders in general [5,6] and for depression in primary care settings in particular [7–11]. In these studies, care managers provided combinations of the following services: (a) education about depression and its treatments to patients and family members; (b) development of treatment and self-management plans; (c) coordination of care with primary and behavioral health specialty providers; (d) assessment and monitoring of patients’ preferences, needs, barriers and progress; (e) encouragement of treatment adherence by patients and medication guideline compliance by physicians; (f) brief, structured forms of psychotherapy and (g) specialty referrals and hospitalizations as needed.

One of the significant challenges in providing depression care management services in an ongoing, consistent way is finding reliable mechanisms to reimburse them and compensate the staff that provides them. As with other chronic illness care management programs, care managers often expend a substantial portion of their clinical effort in activities that are typically not billable or reimbursed [12]. As a result, the use of care management services for the treatment of depression in primary care settings has not yet become a common practice [13,14]. In fact, Bodenheimer et al. [13] reported that care management services were most common for diabetes and least common for depression in the physician organizations they studied. Most of the depression care management interventions in research studies used grant funding to support the care managers; therefore, their sustainability has been limited.

Commenting on early Medicare demonstrations that utilized care management services for chronic medical illnesses, Berenson and Horvath [15] suggested that “the most straightforward and practical way to compensate physicians and their staffs for engaging in [care management] communications with patients would be with a monthly clinical management fee that would be made when beneficiaries have a high burden of chronic care that needs special coordination.” An example of this suggestion, albeit outside the depression arena, is Beck et al.’s [16] contracting approach with a state Medicaid third-party payer for a diabetes care management services fee. Through intensive patient/family education and immediate access to diabetes care managers, care management services reduced costs by reducing emergency room utilization and inpatient admissions. Similar third-party payer contracting strategies may prove to be cost saving for managing other costly and personnel-intensive chronic diseases, including depression.

A primary goal of the Robert Wood Johnson Foundation’s (RWJF) national program on “Depression in Primary Care” is to identify and implement economic and organizational strategies that, along with evidence-based clinical best practices, will sustain chronic illness care improvements in the primary care treatment of depression [17]. In this article, we describe common approaches to depression care management reimbursement methods and provide some examples of the innovative strategies currently under development at RWJF demonstration sites and elsewhere. Because fee-for-service remains the primary basis of provider reimbursement in the United States, we provide a more in-depth examination of this model. We also offer some broader cautions and concerns related to reimbursement for depression care management. We conclude with an overview of recent policy advances that offer some hope for the future emergence of depression care management from the backwater of third-party reimbursement into the mainstream of reimbursable best practices for the treatment of chronic diseases.

2. Funding mechanisms

Health-care expenses in the United States are remunerated by a combination of private and public third-party payers and via retrospective (i.e., fee-for-service) or prospective (i.e., capitated) payment contracts. Fig. 1 illustrates seven types of depression care management reimbursement methods. These are based on (a) the physical location of the care manager and (b) the specific mechanism(s) used for funding their services. Brief descriptions of these funding models follow, along with selected examples of their use.

2.1. Practice-based care management on a fee-for-service basis

In the fee-for-service model, care managers are employees of the primary care practice and are located within its
clinical site(s). Revenue flows from the insurer (e.g., a health plan or governmental payer) to the primary care practice upon the insurer’s receipt of properly coded billing statements and in accordance with the payer’s benefits’ structure and coverage policies. Few, if any, explicit care management billing codes are recognized by third-party payers, especially private insurers, thus making fee-for-service billing dependent on “medically necessary” services rendered “incident to” physicians’ care. Various fee-for-service billing rules and strategies are discussed in detail below to assist with billing and collection efforts.

For example, the RWJF-funded Massachusetts Consortium on Depression in Primary Care (MCDPC), a collaboration between the University of Massachusetts Medical School and the state Medicaid office (MassHealth), estimated how a practice-based, licensed independent clinical social work (LICSW) depression care manager might be self-supporting through Medicaid fee-for-service billing. As noted in Belnap-Hebeck et al. [18], MCDPC researchers calculated that a practice-based LICSW care manager who spent 25 h/week in reimbursable activities (using behavioral health assessment and therapy codes and payment rates) could generate enough funding to cover a full-time salary and fringe benefits. The thought was that an LICSW, enrolled on the behavioral health panels for the various MassHealth managed care plans, could function as an independent contractor for a range of types of primary care practices that did not have on-site behavioral health services. This model might be particularly useful for primary care physician practice groups with numerous small offices. The MCDPC is still in the process of determining if this approach is feasible while continuing to collect and analyze data from its RWJF demonstration, during which time pilot care managers were funded by grants.

The second approach the MCDPC is exploring is health plans fully funding depression care managers at sites where a high volume of Medicaid patients receive their primary care (such as community health centers (CHCs)). In this model, the depression care managers could have different types and levels of professional training, depending on the type of supervision and the practice model (e.g., RN, LPN, bachelors- or masters-level social workers or psychologists), as they would not be independently billing for services. A combination of some salary support with some fee-for-service billing has also been explored (e.g., billing for nursing visits when the care manager is a nurse). However, any fee-for-service care management billing from primary care would have to address current constraints on billing for patient telephone contacts (a large part of the care manager’s interactions with patients), as well as the inability of the sites to bill for multiple primary care provider encounters in the same day (e.g., a visit with a PCP followed by a visit with a depression nurse care manager cannot currently be billed as two separate encounters in a CHC as they receive a bundled rate for one encounter a day) for it to be a viable source of funding. Nevertheless, the MCDPC found that flexibility in the discipline and level of training for depression care managers is critical when trying to meet the needs of patients from different language and cultural groups. Providing full or partial salary reimbursement to practice sites for depression care managers is an example of practice-based care management under contract to health plans (see below).

2.2. Practice-based care management under contract to health plans

Health plans can contract with primary care practices to provide care management services to certain plan members with specified diseases, including depression. In these arrangements, care managers are typically located at the practice site(s) and may be employees of the practice, the health plan or another entity (e.g., a community mental health center or a disease management company). Revenue for their services is generally based on historical estimates of both the service costs and the number of members served and takes the form of monthly or yearly retrospective payments.

One example, though not focused on depression, has been developed by the Coordinated Care Network (CCN), a nonprofit organization in Southwestern Pennsylvania. CCN provides case management and pharmacy services to underserved populations in that region. CCN contracts with Medicaid HMOs and, through its proprietary claims surveillance and health risk assessment techniques, prospectively identifies high-risk Medicaid members before they become high cost. Identified members are voluntarily enrolled in CCN’s multidisciplinary practice-based case management program, referred for services through contracted agencies and tracked through a centralized data system [19].

2.3. Global capitation

Since they are generally fully capitated and have a relatively flexible capacity to allocate resources, group model HMOs can provide and fund care management services internally. For example, Kaiser Permanente’s Care Management Institute (CMI)2 funds research and demonstration projects designed to synthesize knowledge about evidence-based clinical guidelines and provide implementation, dissemination and evaluation support for effective and efficient chronic care programs [20]. The CMI has developed care management programs for patients with diabetes, coronary artery disease, hyperlipidemia, asthma, congestive heart failure (CHF) and, most recently, depression. The individual Kaiser regions typically fund ongoing care management programs from their own budgets. For example, the Colorado region has approximately 40 nurse care managers involved in three different care management programs: frail senior care coordination, chronic care coordination (patients with multiple chronic conditions) and disease-specific care management (e.g., depression care managers).

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2 Described online at http://www.kpcmi.org/.
2.4. Flexible infrastructure support for chronic care management

This funding model includes an allocation of money by health plans to practices designed to support specific quality improvement efforts, such as infrastructure developments (e.g., information system upgrades), provider training or care manager salaries that will improve clinical outcomes and patient satisfaction. The additional money is available to a practice either to meet specific, predetermined expenses or, more flexibly, for purposes of its own choosing. In the latter case, practices may choose to reward physicians for meeting or exceeding preselected clinical performance expectations, reinvest the money to enhance quality infrastructure (e.g., support care managers) or do both. An increasingly common form of this model is the “pay-for-performance” (P4P) approach in which reimbursement depends on demonstrable clinical quality improvements.

For example, the MaineHealth RWJF funded demonstration site has negotiated with certain local health plans to receive additional allocations if its physicians and hospitals exceed predefined clinical and quality performance targets. MaineHealth uses a percentage of this money to support practice-based, generalist chronic illness care managers who provide depression care management among other services to the chronically ill. MaineHealth’s leadership is convinced that the work of these care managers is critical to achieve performance targets.

2.5. Health-plan-based care management

Managed care and/or managed behavioral health-care organizations employ care managers in a variety of roles to perform multiple tasks, with a focus on utilization review and treatment planning with treating clinicians via telephone. These typical managed behavioral health-care care management services usually involve minimal or no contacts with patients or primary care providers. In the University of California San Francisco (UCSF) RWJF funded site (described below), health-plan-based care managers communicate with patients via telephone and with primary care physicians via telephone and fax. They also occasionally visit in person with primary care physicians and office staff in order to become acquainted, develop referral protocols and build trust. The visits are possible when the health plan and the practice are in close-enough geographical proximity. As health plan employees, care managers’ salaries and expenses are typically absorbed in the administrative costs charged to the health plan’s customers (i.e., purchasers). In some cases, health-plan-based care management targets specific diseases (e.g., asthma, diabetes, depression) or populations (e.g., the frail elderly).

At the UCSF RWJF funded site, health-plan-based care managers are employed by the managed behavioral health-care organization partner, United Behavioral Health (UBH), and work from its downtown San Francisco office, which is located several miles from the three UCSF clinic sites. The care manager provides education, support and coordination via telephone to all referred UCSF managed care patients, 70% of which are not covered by UBH. The care manager provides additional “enhanced care management” for UBH patients, which includes referrals to specific behavioral health clinicians and authorizations for treatment. It is unclear if and how UBH’s contribution of care managers, their supervision and the provision of a consulting psychiatrist will continue following termination of the demonstration project. Demand for enhanced, collaborative care by purchasers and consumers will be instrumental in managed behavioral health-care organizations’ commitment to invest in care management services to support primary care providers.

The RWJF-funded Colorado Access site has explored both health-plan-based and practice-based funding models of depression care management. A plan-based model was implemented at the Access Health Plan, and practice-based models were implemented at two federally qualified health-care clinics (FQHCs). Clinical and economic implementation at the health plan level was more easily and efficiently completed. Practice-based models were overly reliant on providers’ resources, workflow requirements, clinical priorities and effective administrative management in the larger FQHCs. However, care management in the other smaller FQHCs, which had existing depression protocols and dedicated resources, was much easier to implement than in the larger system.

2.6. Third-party-based care management under contract to health plans

Health plans may subcontract with disease management organizations, managed behavioral health-care organizations and/or community mental health centers to provide off-site care management services for specific patient populations (e.g., chronically ill elderly patients) and/or diagnostic classes (e.g., patients with depression). These arrangements are typically capitated wherein the subcontractor receives per-patient-per-month revenue for these services, which is generally based on historical estimates of both the service costs and patients served. As with the other funding mechanisms, consumer expectations and purchaser demands will exert clinical and economic pressure on health plans to extend support to third parties to provide care management services.

For example, Health Integrated,3 a behavioral disease management company, contracts with government and private health plans to provide depression care management services to the insurer’s members. Similarly, Blue Cross and Blue Shield (BCBS) of Minnesota and the disease management vendor American Healthways4 have started a disease

3 Company profile available online at http://www.healthintegrated.com/overview.html.
4 Company profile available online at http://www.americanhealthways.com/Home/Default.asp.
management program for 30,000 fully insured Minnesota BCBS members with depression.

2.7. Hybrid models

Combinations of these funding mechanisms result in various hybrid-funding models for care managers and their services. For example, community mental health center counselors can be placed in primary care practices and funded partly through fee-for-service billing and partly through health plan contracts. The RWJF-funded demonstration project in Oregon allows practice-based “qualified mental health professionals” (i.e., psychiatric nurse practitioners) to see patients with primary care mental health issues and to bill the health plan, CareOregon, for these visits. These nurse practitioners are employed by FQHCs that are under contract with CareOregon. Under the Center for Medicare and Medicaid Services (CMS) rules, FQHCs can generate revenue by billing a patient’s insurer (i.e., Medicaid in Oregon’s case) and through supplemental state “prospective payments” up to the average cost of a clinic visit for Medicaid patients. Such prospective payments are in addition to fee-for-service receipts received from Medicaid and can provide significant support for CareOregon’s FQHC-based primary care practices, including nurse practitioner services. These services overlap with and extend those of depression care managers. The extent to which this hybrid-funding model is exportable to other clinics, health plans and states is open to experiential exploration.

The RWJF-funded Vermont Community Depression Project, a partnership of the state’s Medicaid health plan, rural primary care practices, FQHCs and community mental health centers, collocates depression care managers in primary care practices. These care managers are employees of local community mental health centers and are funded via contracts with Vermont’s Medicaid agency, the Agency of Human Services.

3. Strategies for fee-for-service billing

Because the fee-for-service model represents the preponderant form of present-day health-care financing, it is a natural focus of attempts to generate reimbursement for care management services. However, several barriers impede such reimbursement. These include (a) rules concerning the medical necessity of care management services, (b) eligibility rules about who can provide reimbursable care management services and (c) the (inappropriate) use of diagnostic and procedural codes. Overcoming these obstacles requires a combination of informed trial-and-error learning and conscientious compliance with specific rules and codes in order to optimize the likelihood of successful reimbursement for care management services.

3.1. Medical necessity and “incident to” rules

Health insurance plans, whether public or commercial, require all covered services (including care management) to be “medically necessary” in order to be eligible for reimbursement [21]. Specifically, they must (a) be appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (b) be provided for the diagnosis or direct care of an illness; (c) be within the standards of good practice; (d) not be primarily for the convenience of the plan member or provider and (e) safely provide the most appropriate level of care. Payers typically determine the medical necessity of a clinical service on the basis of concurrent or retrospective reviews of medical charts and the billed services. Care management services performed by nonphysicians (e.g., care managers) that are “incident to” the licensed physician’s care and billed with the latter’s identification numbers will more likely be deemed “medically necessary” and, hence, reimbursable if they are (a) an integral part of the physician’s professional service, (b) provided under the physician’s direct personal supervision, (c) commonly rendered without charge or generally not itemized separately in the physician’s bill, (d) provided in the physician’s office or clinic and (e) described completely in the medical chart as a “stand-alone” entry.

3.2. Diagnostic and procedure coding

In addition to the medical necessity rules that govern eligibility for reimbursement of covered services, health insurance carriers vary widely in determining reimbursement eligibility for nonphysician clinicians who provide care management services. Licensed psychologists, social workers, nurses and other nonphysicians who typically work as care managers have strictly defined scope of practice limitations that can preempt third-party reimbursement of services delivered outside these boundaries. Given the absence of widely accepted care management procedure codes, these allied health professional care managers typically use procedure codes that fall within their scope of practice in order to increase the likelihood of third-party reimbursement.

Fee-for-service reimbursement for “depression” care management services requires explicit coding of both the patient’s diagnosis and the service or procedure administered by the provider, both of which are complex matters. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) [22] and the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) [23], which uses ICD-9-CM codes, are most commonly

5. See Dennis Smith’s, Director of CMS’ State Operations, discussion of FQHCs in his testimony before the House Energy and Commerce Subcommittee on oversight and investigations on community health centers, which is available online at http://www.cms.hhs.gov/media/press/testimony.asp?Counter=1471.

used to document diagnoses. Multiple diagnostic codes exist
for coding depression in its many presentations and
variations, including, for example, 290.43 (vascular demem-
tia with depressed mood), 296.3 (major depressive disorder,
recurrent episode), 300.4 (dysthymic disorder) and 648.44
(postpartum depression).

most commonly used to bill for office visits, procedures and
other encounters. Level II Health Care Common Procedure
System (HCPCS)7 codes are used to bill for services,
supplies and products not covered by the CPT codes (see
discussion below). As suggested above, fee-for-service care
management billing, especially in the absence of dedicated
codes and when provided by a nonphysician, stands a better
chance of reimbursement if done in compliance with
medical necessity and “incident to” rules.

There are several common CPT codes that primary care
practitioners and allied health-care staff might consider
using to bill for care management services on a trial-
and-error basis with various carriers. Evaluation and
Management (E&M) codes 99201 through 99215 are the
basic office visit codes for new or established patients.
Although generally not thought of as applying to care
management, these codes could be used for providing
depression assessment, antidepressant management and/or
counseling by physicians. Several CPT psychiatry codes
could be used to bill for care management services by
physicians and nonphysicians. These include the 90804
through 90809 series that refer to office or other outpatient
facility services for “insight oriented, behavior modifying
and/or supportive psychotherapy” and range from 20- to
30-min sessions up to 75- to 80-min sessions. When
psychotherapy is supplemented by some E&M service
(e.g., medication side effects assessment and dosage
adjustment blood level monitoring), 90805 supplants
90804 and 90807 supplants 90806. Each of these coding
“upgrades” carries a small, incrementally increased payment
amount over the psychotherapy without E&M codes. 90862
refers to pharmacologic management, including prescription
use and review of medication with no more than minimal
medical psychotherapy. 90885 refers to psychiatric evaluation
of hospital records, other psychiatric reports, psychometric
and/or projective tests and other accumulated data for
medical diagnostic purposes.

The CPT Health and Behavioral Assessment/Interven-
tion codes 96150 through 96155 refer to behavioral health
services provided for acute or chronic illnesses that are not
psychiatric in nature. The use of these latter codes requires
that patients have general medical diagnoses, but these may
be used by nonphysicians.

Because Medicare, Medicaid and other private insurers
cover a variety of services, supplies and equipment that are
not identified by traditional CPT codes, the CMS established
Level II HCPCS codes for submitting claims for these other
items. (Level I is composed of the CPT codes maintained by
the American Medical Association.) Level II “H” codes are
used by those state Medicaid agencies that are mandated by
state law to establish separate codes for identifying mental
health and alcohol/drug treatment services. State Medicaid
agencies use “T” codes to identify services for which there
are no permanent national codes but are necessary to
a Medicaid mandate. T codes are not used by Medicare but
can be used by private insurers. Some potentially relevant
H and T codes that may be considered to bill Medicaid for
care management services on a trial-and-error basis in-
clude H0002 — “behavioral health screening to determine
eligibility for admission to a treatment program”; H0025 —
“behavioral health prevention education service with tar-
get population to affect knowledge, attitude, and/or behav-
ior”; H0031 — “behavioral assessment by nonphysician”; H0032 — “mental health service treatment plan develop-
ment by nonphysician”; T1016 — “specialized wraparound
facilitated case management” and T1017 — “targeted
case management.”

The T codes identify Medicaid-based “targeted case
management services,” which include the following: (a)
assessment of the eligible individual to determine service
needs, (b) development of a specific care plan, (c) referral
and related activities to help the individual obtain needed
services and (d) monitoring and follow-up; however, they
do not include the direct delivery of the underlying service.
These activities clearly fall within the purview of depression
care management services. A Kaiser Commission Report on
Medicaid and the Uninsured provides a state-by-state
summary of targeted case management Medicaid benefits,
services covered, limits, copayments and reimbursement
methodologies for the 50 states, District of Columbia and the
Territories (as of January 2003). The description is
available online.8

In sum, licensed psychologists, nurses, clinical social
workers and other nonphysician allied health-care clinicians
(i.e., care managers), as permitted by their scope of practice,
may, depending upon the patient’s insurance company, use
selected CPT and Level II HCPCS codes when billing for
care management services. However, whether or not
nonphysician care managers’ services will be reimbursed
often depends on coverage interpretations by state Medicaid
offices, regional Medicare intermediaries or private insurance
companies. Primary care practices that provide fee-for-
service care management by nonphysicians are urged to
check patients’ insurance benefits. Physicians billing for
care management services should consider using E&M
codes. Psychologists cannot use E&M codes when treating
Medicare beneficiaries because the CMS currently restricts

7 See CMS’ “Health Care Common Procedure Coding System
(HCPCS) Level II Coding Procedures,” online at http://www.cms.hhs.gov/
medicare/hcpcs/codpayproc.asp.

8 Kaiser Commission Report on Medicaid and the Uninsured online at
http://www.kff.org/medicaid/bene fits/service.jsp?nt = on&so = 0&tg =
0&yr = 2&cat = 7&sv = 40.
the use of these codes to MDs. The American Psychological Association practice directorate reported that, as of August 2004, Medicare reimburses for Health and Behavioral Assessment/Intervention codes in all states, except Florida. Under Medicaid, only Colorado and Vermont reimburse for these codes. In the private insurance sector, 10 carriers in certain geographic areas recognize the codes.\(^9\)

4. Challenges in funding depression care management services

Ongoing efforts to design, implement and test innovative strategies for reimbursing depression care management services must account for and eventually overcome the substantial variation and complexity inherent in the depression care management process. Standardization of care managers’ credentials and clarification of their role in providing generalized versus specialized services for single versus multiple chronic illnesses will help satisfy purchasers’ concerns about what they are buying [15].

4.1. Variability in the training and credentialing of care managers

At present, national and state standards for the educational, training, supervision, licensure and scope of practice requirements for behavioral health clinicians, in general, and for depression care managers, in particular, are highly variable. Debates and discussions abound as to whether depression care managers should be advanced practice psychiatric nurses, clinical social workers, masters-level psychological counselors or physicians’ assistants. In one study of care management best practices, care managers were nurses with at least a bachelor’s degree in nursing [25]. Other proponents of the chronic illness care model emphasize the need for multispecialty care managers who can oversee the care of patients with multiple persistent disorders as a means of insuring third-party reimbursement [26]. Care managers in the Simon et al. [9] study of telephone psychotherapy and care management for patients beginning antidepressant treatment were mental health clinicians with bachelor’s or master’s degrees and at least 1 year of experience in depression assessment (including telephone assessment and triage). Additional training for the study included 6 h of didactic instruction and role-play followed by completion of at least five observed care manager contacts prior to any patient contact. Care managers received approximately 30 min of supervision each week from a psychiatrist and a psychologist.

However, as depression care management services expand from the highly regimented protocols of research projects to inclusion in a wide variety of clinical contexts, standardization of the “who” and the “how” will become increasingly expected as third-party payers consider reimbursement. Progress toward such standardization is under way at present through the work of organizations such as the Utilization Review Accreditation Commission (URAC),\(^10\) which certifies health-care organizations providing telephonic or on-site care management services, primarily to patients with chronic medical illnesses. Certification consists of URAC’s review and assurance that the organization’s care management services meet several critical operational standards including staff credentials, management and development; clinical information management; quality improvement processes; oversight and supervision of delegated functions; ethics and complaint processing.

4.2. Variability in care managers’ physical location and employee status

While it is recognized that effective depression care management depends on the centrality of care managers in patients’ care, their physical work locations can and do vary widely. In some cases, care managers operate as part of a permanent clinical team; in others, they operate independently. At the RWJF demonstration sites, depression care managers work on-site in single or group primary care offices, in multipractice clinics, in county and state health clinics or for managed behavioral health-care organizations [27]. These variations have implications for service reimbursement since payment depends in part on the location and position of care managers within organizations. Some are salaried employees while others must earn their income by providing reimbursable services.

4.3. Proliferation of alternatives to traditional face-to-face office visits

Current and emerging alternatives to traditional face-to-face office visits that are designed to improve the penetration of and access to behavioral and care management services further complicate these issues. Care-manager-initiated, periodic telephone contacts with depressed patients are highly effective and used extensively by the RWJF care managers. However, patient- or family-initiated phone calls to care managers could produce an expensive overutilization problem. In making office visits, patients experience “time-and-effort costs” (e.g., inconvenience), which mitigate excessive utilization. These hassle factors would not exist with telephone care management sessions. Prepaid phone cards, limited-use cell phones and/or specific time slots might lessen this overutilization risk. From an insurer’s point of view, though, the financial exposure could be problematic. In capitation or fee-for-service arrangements, where there are inherent spending limits (such as in

\(^9\) The American Psychological Association Practice Directorate discussion of H & B codes is online at http://www.apapractice.org/apo/insider/leg/epitcodes/practitioners_find.html#.

\(^10\) Described online at http://www.urac.org/prog_accred_CM_po.asp?navid=accreditation&pagename=prog_acred_CM.
the Medicare payment system for physicians), spending could shift among providers in politically unsustainable ways.

Newer non-visit-based communications, such as secure e-mails and “group sessions” via care-manager-supervised chat rooms, are currently being evaluated and have similar overutilization possibilities, in addition to raising significant privacy concerns and potential difficulties in maintaining appropriate utilization. Additional concerns include developing reliable methods to document that these nontraditional services actually occurred so that third-party payers’ utilization management activities do not become more intrusive than the oversight requirements currently in place for ordinary office visits.

To what extent third-party payers will reimburse traditional as well as alternative care management services remains unclear. If administrative costs associated with processing and paying care management claims add too significantly to health-care expenses already incurred by purchasers and health plans, there will be considerable resistance to reimbursing these services. Therefore, these costs should be tracked and analyzed carefully as care management services become more widespread. The University of Michigan RWJF funded site is tracking care managers’ clinical and nonbillable activities to determine the actual costs necessary to sustain the intervention.

5. Future directions and opportunities

Recent policy decisions to implement recommendations from the Final Report of the President’s New Freedom Commission on Mental Health, the Institute of Medicine’s (IOM) Crossing the Quality Chasm report and the Medicare Modernization Act (MMA) of 2003 offer possible precedents for including and reimbursing care management services as an integral part of the chronic illness care model. We discuss these future directions and opportunities below.

5.1. The New Freedom Commission

In 2002, President George W. Bush established the New Freedom Commission on Mental Health to study the problems and gaps in the U.S. mental health system and make concrete recommendations for immediate improvements that the federal government, state governments, local agencies, as well as public and private health-care providers, can implement. Among other things, this commission specifically recommended that the CMS, the Department of Veterans Affairs and other federal- and state-sponsored health insurance programs and private insurers identify and implement payment mechanisms for the core components of evidence-based chronic illness care, including care management services, supervision of care managers and consultations to primary care providers by qualified mental health specialists that do not involve face-to-face contact with clients.

5.2. The IOM report on Crossing the Quality Chasm

The original Crossing the Quality Chasm report laid out six aims for the health-care system. Specifically, the report endorsed the application and dissemination of the chronic care model and the implementation of incentives to sustain it. A new IOM committee was established with the charge of exploring the implications of the original Chasm report for the field of mental health and addictive disorders and for developing a blueprint for change. The report, released in November 2005, recommends making collaboration and coordination of patient care for better mental health, substance use and general health care the norm. The report specifically recommends that providers of general health, mental health and substance-use services establish clinically effective linkages within their own organizations and between providers and that stakeholders (e.g., providers, government agencies, purchasers, health plans and accreditation organizations) should implement policies and incentives to continually increase collaboration among providers to achieve evidence-based screening and care (e.g., care management models). Providers and practice organizations across all three groups should transition along evidence-based coordination models around integrated clinical practices of primary care, substance use and mental health care.

5.3. CMS developments

Recent developments initiated by the CMS have responded to the MMA of 2003. Section 721 of the MMA provides for the development and testing of the Medicare Health Support (MHS) program (formerly, the Chronic Care Improvement Program), a voluntary chronic care improvement program for patients with multiple chronic diseases. The goal of the program is to better manage and coordinate the care of these patients in order to reduce health risks, improve their quality of life and provide savings to the program and its beneficiaries. CMS will oversee the implementation of 3-year pilot programs in up to 10 sites and will target Medicare beneficiaries with CHF, complex diabetes and/or chronic obstructive pulmonary disease. Chronically ill patients with comorbid depression (about 15–25% of the MHS target population) have more severe medical illness, worse clinical outcomes and higher health-care costs than those without depression. These characteristics make them particularly important targets for disease management efforts. The MHS program represents a unique opportunity to learn more about the impact of comorbid depression and depression care management in the context...

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11 Available online at www.mentalhealthcommission.gov/reports/reports.htm.
13 Available online at http://www.cms.hhs.gov/medicarereform/.
14 Described online at http://www.cms.hhs.gov/medicarereform/ccip/.
of disease management for chronic medical conditions. If patients with comorbid depression and chronic medical illness have better clinical outcomes and lower costs when disease management programs include effective treatment of depression, programs that integrate depression and chronic disease treatment could be rapidly and widely disseminated to improve health outcomes and economic efficiency. A team of researchers from the RAND Corporation, the University of Washington and the University of Pittsburgh is working with CMS and participating disease management organizations to examine the role of comorbid depression in moderating the clinical and cost-effectiveness of the MHS programs. The team will assess the costs and benefits of strategies to manage comorbid depression as a component of programs to manage other chronic medical conditions.

Although not part of the MMA, CMS is also conducting the Care Management for High-Cost Beneficiaries (CMHCB) demonstration to study various care management models for high-cost beneficiaries in the traditional Medicare fee-for-service program. The CMHCB demonstration does not target or exclude specific diagnoses. Within the high-cost and/or high-risk Medicare population, applicants may propose any diagnostic, demographic or other parameters. CMS will assess how well each of these programs is able to reduce Medicare costs while improving the quality of care and quality of life for beneficiaries. In a personal communication, the CMHCB project officer informed us that six applicants have been selected for this project and three of them propose including behavioral health-care treatment (including care management services) in their projects.

Section 4105 of the Balanced Budget Act of 1997 provides a potential precedent for legislative action for depression care management reimbursement by permitting Medicare coverage of diabetes outpatient self-management training. Under a physician’s orders, such services as blood glucose self-monitoring instructions, diet and exercise education, insulin treatment planning and self-management motivational training are provided by certified practitioners who meet specified quality standards. The “incident to” rules do not apply to the reimbursement of these services. While this diabetes care management template does not include other care management services, it can be viewed as reflecting an evolving mindset among health-care decision makers and their political allies to reimburse care management-type services as a tool in the quality improvement box.

5.4. Other P4P programs

P4P programs link improvements in clinical outcomes, patient satisfaction and infrastructure enhancements with financial incentives that are paid to physicians and practices by health plans and purchaser consortiums. For example, the Integrated Healthcare Association’s (IHA) P4P program is the country’s largest quality-based physician incentive program with six California health plans, 7 million commercial enrollees and 215 physician organizations with over 35,000 doctors. Using a common measurement set, performance results are publicly reported and rewarded with health plan bonus payments. However, IHA was forced to drop the HEDIS antidepressant medication management indices when too many of the participating physician groups protested their inherently unreliable nature. The “Bridges to Excellence” P4P program utilizes the National Committee for Quality Assurance’s (NCQA) “Physician Practice Connections” and “Physician Office Link” to recognize and reward physician practices that improve chronic care for high-risk medical patients and reduce unnecessary hospitalizations by using care management services and patient education.

Very few of these incipient P4P projects currently underway include incentives for better depression care or behavioral health outcomes. To fill in this gap, the RWJF Depression in Primary Care program has funded several “value” grants designed to further evaluate the specific impact of P4P on depression care management. These projects include the following: (a) a study exploring the quality of depression care and the validity of the HEDIS quality indicators (PI: John Williams, Duke University Medical Center); (b) a project to identify and test the feasibility of methods for identifying high-quality depression care by primary care providers that could be used by the Bridges to Excellence program and other P4P programs (PI: Sarah Scholle, National Committee on Quality Assurance); (c) a project to determine whether performance and improvement over time on three HEDIS antidepressant medication management measures differ by how health plans organize, finance and administer behavioral health care (PI: Constance Horgan, Brandeis University) and (d) an evaluation of a PCP performance-based incentive program implemented by a health plan currently serving 550,000 members in which outcomes include HEDIS depression quality indicators and utilization patterns (PI: Lori Lackman-Zeman, Wayne State University). A systematic review of behavioral P4P initiatives by the RWJF Depression in Primary Care national program office is underway and will describe the components of extant programs.

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15 Described online at http://www.cms.hhs.gov/researchers/demos/cmhc.asp.
16 Personal communication with Randy Thomas, CMHCB Project Officer, at 410:786-6578 on 6/2/2005.
18 Description available online at http://www.iha.org/Ihaproj.htm.
19 Description available online at http://www.bridgestoexcellence.org/bte/index.html.
20 Descriptions available online at http://www.wpic.pitt.edu/dppe/value.htm.
Overall, these general medical and behavioral P4P developments establish the impetus for private and public third-party payers to increasingly fund linkages between care management services and improved behavioral health-care outcomes.

5.5. Other developments

Time constraints and other competing demands for primary care physicians’ attention can cause them to sacrifice interactions important to the doctor–patient relationship, mitigate shared decision making and minimize patient advocacy obligations. By absorbing some of the time-consuming, but clinically crucial tasks, care managers provide much-needed (and much-appreciated) services. Other recent developments may encourage funding of care manager positions and are described below.

5.6. NCQA’s revision of HEDIS antidepressant measure

The NCQA recently revised its definition of the “optimal practitioner follow-up contacts” measure for antidepressant medication management.21 This revision was based on findings that telephone calls from care managers are successful in improving outcomes [7–9]. The inclusion of telephonic care management contacts in the HEDIS definition helps make the case for these alternative encounters to be considered a bona fide reimbursable fee-for-service (even if simply to be able to include them in administrative data bases for reporting purposes).

5.7. Food and Drug Administration antidepressant warnings and clinical monitoring recommendations

The recent Food and Drug Administration warnings about the possibility of depression and suicidal thoughts worsening in people, particularly children and adolescents, who take certain antidepressants, emphasize the importance of systematic and longitudinal monitoring of depressive symptoms and the adverse side effects of these medications. These high-profile warnings may increase the impetus for assuring adequate monitoring of depression care, potentially encouraging care management funding.

5.8. Alternatives to traditional face-to-face office visits

As noted previously in the text, there are several emerging alternatives to traditional face-to-face office visits. These alternatives include secure e-mail correspondence, prescheduled time slots for “instant messaging” with a care manager, electronic “group sessions” via care-manager-supervised chat rooms, prepaid phone cards and/or limited-use cell phones. While they represent innovative ways of improving access to behavioral care management services, such futuristic possibilities raise significant privacy concerns and potential difficulties in maintaining appropriate utilization. Additional concerns include developing reliable methods to document that these nontraditional services actually occurred so that insurers’ utilization review activities do not become more intrusive than the oversight requirements currently in place for ordinary office visits.

6. Conclusion

Without the benefits bestowed by an established precedent, funding of depression care management currently resides in the backwater, rather than in the mainstream, of third-party reimbursement for health-care services. Because care management services fall outside the conventional margins of the health-care delivery system and are delivered by a potpourri of people whose professional identities cut across traditional boundaries, third-party payers require cogent demonstrations of their value in order to justify subsidizing them. A decade of well-controlled health services research now unequivocally demonstrates that depression care management effectively integrates primary and behavioral health care for depressed patients and produces significantly improved clinical outcomes. Economically, depression care management strategies add significantly to the cost-effectiveness of primary care interventions for depression [30].

With the clinical, economic and quality case for depression care management now well established, innovative blends of purchaser and consumer expectation, financial and nonfinancial quality incentives and the strong endorsement of major health policy institutions (such as the President’s New Freedom Commission, the IOM and the CMS) can drive greater utilization of evidence-based care models for depression.

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21 National Committee for Quality Assurance (NCQA). HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2003. HEDIS measures now include three face-to-face follow-up visits with either a non-mental health or mental health practitioner within 12 weeks (of treatment initiation) or two face-to-face visits and one telephone visit with either a non-mental health or mental health practitioner within 12 weeks.
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