Mental Health Screen Part Of Mass. Well-Child Visits

BY JANE ANDERSON
Contributing Writer

MassHealth, Massachusetts' Medicaid program, has begun requiring primary care doctors and nurses to use a standardized behavioral health screening tool at every well-child visit for children under the age of 21.

The new requirement, which took effect Dec. 31, resulted from a 2007 U.S. District Court decision in Rosie D. v. Romney. In its decision, the court ruled that Medicaid-eligible children with "serious emotional disturbances" were not receiving appropriate mental health screenings, service coordination, and home-based treatment services, and ordered MassHealth to implement a plan to improve care.

As such, MassHealth is setting up several initiatives to improve mental health services for Medicaid beneficiaries under age 21 years, said MassHealth spokeswoman Jennifer Kritz in an interview.

For the new standardized behavioral health screens by primary care physicians and nurses, Medicaid will ask providers to choose from eight standardized tools for the screening, depending on the patient's age, and will pay for the screening as well as the standard office visit reimbursement.

The goal is to help detect issues with behavioral health, social-emotional well-being, or mental health in the state's 460,000 children and young adults covered by Medicaid, Ms. Kritz said. If a potential problem is detected, the primary care provider will refer the patient to a mental health provider, according to the state. A parent or guardian can decline screening for a child if they wish.

Other measures prompted by the Rosie D. case will take effect over the next 2 years, Ms. Kritz said. Starting in late 2008, children who see a behavioral health provider will be assessed by that provider using the Child and Adolescent Needs and Strengths tool.

And, MassHealth expects to cover several new behavioral health services for beneficiaries under age 21 years, although the agency hasn't yet received federal approval for those new services, she added.

Massachusetts faces challenges in providing mental health services to those additional children and young adults who are expected to be identified as part of the stepped-up screening, according to the Massachusetts Medicaid Policy Institute.

"Massachusetts faces a shortage of qualified 'child-trained' providers … as well as an inadequate number of bilingual and multicultural providers," the institute said in a brief last year. "Existing providers also are not spread out evenly across the state, making access a problem in many areas. One of the state's biggest challenges will be to engage more qualified providers and train them in the new delivery structure, which is vastly different from the existing model of care that most clinicians are used to."

However, Ms. Kritz said MassHealth has a "robust" behavioral health system and is working with primary care physicians to streamline the referral process. It also is partnering with schools and professional organizations to recruit more people to the behavioral health field. ■

CMS to Cut Reimbursement For Fast In-Office HbA_{1c} Test

BY JANE ANDERSON
Contributing Writer

The Centers for Medicare & Medicaid Services will cut reimbursement for physicians who provide diabetic patients with point-of-care hemoglobin A_{1c} testing using a "glycosylated Hb home device" from about $21 a test to about $13.50 a test on April 1, a coding expert from the American Academy of Family Physicians said.

The reimbursement cut was mandated by a provision in the Medicare, Medicaid, and SCHIP Extension Act of 2007, enacted at the end of last year. That provision reverses a decision by CMS in late 2006 to increase reimbursement for the HbA_{1c} test, said AAFP coding specialist Cynthia Hughes, who noted that AAFP had lobbied hard for several years for the increase in reimbursement.

"It was slipped into SCHIP," Ms. Hughes said. "It would take another act of Congress to reverse it."

The language added to SCHIP legislation states that point-of-care HbA_{1c} testing using the kit and billed under CPT code 83037 should be paid at the same rate as HbA_{1c} testing done with an in-office analyzer in either a physician's office or laboratory setting and billed with CPT code 83036.

Ms. Hughes said that the average cost to physicians' offices for each test kit is about $13, but that costs also include shipping and handling of the kits themselves, staff time to administer the test, supplies, and additional overhead expenses. AAFP has suggested to CMS that an appropriate payment—one that takes into account all the costs of purchasing and administering the test—would be more than $34.

Providing the test at the point of care is more convenient for the patient and augments care because the test results are available in just a few minutes, in time for the physician to counsel the patient about those results, Ms. Hughes said.

The decreased reimbursement for the test kits could lead to fewer patients receiving the HbA_{1c} test at the point-of-care, Ms. Hughes said, adding that reimbursement for testing using the in-office analyzers—which cost about $2,700—is not affected. ■

POLICY & PRACTICE

Programs Cut Smoking Rates

State tobacco control programs are effective at cutting adult smoking rates, according to a study by researchers at the Centers for Disease Control and Prevention and RTI International. The researchers were able to quantify the link between comprehensive tobacco control programs and a decrease in adult smoking, observing a decline in prevalence from more than 29% in 1985 to less than 19% in 2003. Among individual states, declines in adult smoking prevalence were directly related to increases in state per-person investments in tobacco control programs, they wrote. Such programs use educational, clinical, regulatory, economic, and social strategies to establish smoke-free policies and social norms, to help tobacco users to quit, and to prevent people from starting to smoke. The study was published in the February issue of American Journal of Public Health.

Individual Mandates Necessary

Unless the United States adopts a single-payer health system, it will not be possible to achieve universal coverage without a mandate that requires individuals to purchase health insurance, a report from the Urban Institute concluded. A system that encouraged but did not require people to get health insurance would tend to enroll disproportionate numbers of individuals with higher cost health problems, it said. This could create high premiums and instability in the insurance pools that enroll those individuals. In addition, the government would have difficulty redirecting current spending on the uninsured to offset some of the cost associated with a new program without universal coverage, the report noted.

Recertification Could Improve Care

The quality of care provided to patients with hypertension seems to erode as the time since the physician's last board certification increases, a study published online in Circulation found. Researchers analyzed treatment of more than 8,000 patients with hypertension and comorbid diabetes who were treated by 301 internists, and looked specifically at patient visits with documented blood pressure equal or greater to 130/85 mm Hg. They analyzed the association between the number of years since the physician's last board certification and the probability of pharmacologic antihypertensive treatment intensification at a given visit and found that frequency of treatment intensification decreased from about 27% for physicians who were board certified the previous year to about 7% for those who were board certified 31 years before the visit. For physicians recertified more than 10 years previously, the treatment intensification rate was about 22%, compared with 17% for those recertified in the last decade.

Part D Costs Drop

The projected cost of providing Medicare beneficiaries with a prescription drug benefit through private health plans has dropped again, according to the Centers for Medicare and Medicaid Services. CMS said in its fiscal year 2009 budget documents that the overall projected cost of the Part D drug benefit is $117 billion lower over the next 10 years than it estimated last summer. The difference results from the slowing of drug cost trends, lower estimates of plan spending, and higher rebates from drug manufacturers, CMS said. Compared with original projections, the net Medicare cost of the drug benefit will be $243.7 billion lower over the 10 years ending in 2013.

Patient Safety Goals Updated

The Joint Commission has released a preliminary version of its 2009 National Patient Safety Goals for hospitals and critical care facilities, and is seeking to add several new requirements to its list of priorities. According to the draft, the commission would like to add a requirement highlighting the need to eliminate transfusion errors related to patient misidentification. It would also add a requirement that acute care facilities implement best practices to prevent the spread of multiple drug–resistant organisms. Last, the draft specifies new requirements for using best practices to prevent catheter-associated bloodstream infections and surgical site infections and refines points to work toward the commission's goal of reconciling patient medications across the care continuum.

Top 10 Cost Half a Trillion

The nation's 10 most expensive medical conditions cost about $500 billion to treat in 2005, according to the Agency for Healthcare Research and Quality. Heart disease topped the list at $76 billion, with trauma second at $72 billion, and cancer third at $70 billion. Mental illness, including depression, cost $56 billion, and asthma and chronic obstructive pulmonary disease cost $54 billion. Hypertension cost $42 billion to treat, type 2 diabetes cost $34 billion, and osteoarthritis/joint diseases also cost $34 billion. Back problems and normal childbirth rounded out the list at $32 billion each. The agency counted money spent on office visits, clinic and emergency department use, hospital stays, home health care, and prescription medicines.

CMS May Cover Artificial Heart

CMS has proposed covering artificial heart devices in Medicare beneficiaries enrolled in Food and Drug Administration–approved studies, reversing a 20-year-old policy. The use of artificial heart technology has not been available to Medicare beneficiaries because of a 1986 noncoverage policy. But since then, two artificial heart makers have run clinical trials studying the safety and health outcomes of using their devices, CMS said. The agency said it now believes there is sufficient scientific evidence on the use of artificial hearts to allow coverage of these devices for beneficiaries "in the carefully controlled clinical environment of an FDA-approved study." A final coverage determination is expected in May.

—Jane Anderson