Provision of Mental Health Services by Critical Access Hospital-Based Rural Health Clinics

Flex Monitoring Team
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KEY FINDINGS

- Mental health (MH) services provided by Critical Access Hospital (CAH)-based Rural Health Clinics (RHCs) can be financially sustainable, particularly when considering their impact on system performance rather than as a standalone "profit center."
- Although study participants reported that MH services were sustainable, only 9 percent of all CAH-based RHCs provide them.
- RHC providers are satisfied with MH services provided in their clinics and believe they help to overcome stigma and other barriers that discourage patients from accessing needed services.
- It is important that CAH-based RHCs understand third-party MH payment policies and regulations prior to developing these services.

INTRODUCTION

Residents of rural communities face longstanding access barriers to mental health (MH) services due to chronic shortages of specialty MH providers, long travel distances to services, increased likelihood of being uninsured or under-insured, limited choice of providers, and high rates of stigma.[1] As a result, rural residents rely more heavily on primary care providers (PCPs) and local acute care hospitals to meet their MH needs than do urban residents.[1] This reality highlights the importance of integrating primary care (PC) and MH services to improve access to MH care in rural communities. Critical Access Hospitals (CAHs) are ideally positioned to help meet rural MH needs as 60 percent manage at least one Rural Health Clinic (RHC).[2] RHCs receive Medicare cost-based reimbursement for a defined package of services including those provided by doctoral-level clinical psychologists (CPs) and licensed clinical social workers (LCSWs). This policy brief explores the extent to which CAH-based RHCs are employing CPs and/or LCSWs to provide MH services, describes models of MH services implemented by CAH-based RHCs, examines their successes and challenges in doing so, and provides a resource to assist CAH and RHC leaders in developing MH services. It also provides a resource for State Flex Programs to work with CAH-based RHCs in the development of MH services.

BACKGROUND

Of the numerous barriers that impede access to MH services in rural areas, stigma presents a unique problem in that the lack of anonymity in rural communities may discourage individuals from seeking MH services, even if they are available in specialty settings.[1] Instead, many rural individuals prefer to access MH services in PC settings. Reflecting this fact, the integration of MH and general medical care is widely promoted as a solution to increase MH access that enjoys substantial support among patients, providers, and policymakers.[3] Providing integrated care is not without challenges, however, including limited provider supply, low reimbursement rates, and differences in treatment cultures.[4-6]

For purposes of this paper, we use the term "mental health" to focus on a specific set of RHC services provided by CPs, LCSWs, licensed professional counselors, and other master's prepared

counselors for the treatment of depression, generalized anxiety disorders, and other mental health conditions that are reimbursed on a cost basis by Medicare.[7] We specifically use this term, rather than the term behavioral health which includes these mental health conditions as well as a broader set of conditions such as substance use, eating disorders, or gambling addictions. Although these terms are frequently used interchangeably, mental health is more accurately viewed as a subset of the larger category of behavioral health.

The basic model for integrating MH and PC services places psychiatrists, social workers, psychologists, or other MH counselors into PC settings to address depression, anxiety, and other low acuity MH conditions.[4,8-10] Integrated care can take many forms including referral agreements, shared space arrangements, contractual agreements with independent MH providers, and direct employment. Under basic models of integration, PCPs screen for MH conditions and prescribe necessary psychotropic medications, while social workers, psychologists, and counselors provide individual counseling and psychotherapy. In more advanced models, specialty MH clinicians are employed by PC practices to provide direct care services, consult with the medical staff, and accept "warm hand-offs" in which the medical providers introduce patients to MH providers to facilitate patient engagement.

Given the multiple ways in which practices have sought to integrate MH services, it is clear that no one model fits all practice settings.[8,10] An extensive body of literature on integrated care suggests a number of questions that can help providers to work through the process of deciding which approach to the delivery of MH services makes the most sense for their practices. These questions include:

1. What are the goals for developing MH services? To address the unmet MH needs of the practice's patients or to expand access more broadly within the general community?[7]
2. What is the target population? Adults, children, and/or geriatric patients?
3. What are the practice's clinical capacity, administrative resources, and space availability?
4. What are the needs of the practice's patients?
5. What MH resources and referral options exist in the community?

It is also helpful to understand the functional clinical and structural elements of integration when developing services: how care is delivered and coordinated across PC and MH providers, how clinical and administrative information is shared, and how and where patients are served (Figure 1).[9]

In addition to improving access to MH services, the provision of integrated MH services offers significant benefits to PC practices by reducing the demands on PCPs and improving practice efficiencies. One study in a rural pediatric PC practice found that the pediatricians spent an average of eight minutes with medical patients compared to 20 minutes for patients with MH and medical needs.[11] The integration of MH services in primary care settings improves PCPs' efficiency by allowing them to see more patients and providing access to MH clinicians who can spend more time addressing patients' MH needs.

FIGURE 1: Functional Elements of Integrated Mental Health Services

Clinical Integration	**Decision Points**
Roles for clinicians and staff	Are their roles clearly defined? Does the practice have a team-based culture? How will MH clinicians be integrated with the clinical team? How will MH clinicians be supervised? Is there a process to monitor and manage the quality of services?
Medical records	Shared vs. separate? Who has access?
Shared decision making	Is there a clear decision making process? How are team and patient input obtained? How are differences negotiated/resolved?
Common treatment plans	How are treatment plans developed? Who has oversight responsibility? Is there a process for teams to review and revise treatment plans?
Regular communication	How often? How is it facilitated? Is the process formal or informal?
Use of critical pathways or practice guidelines	How are these pathways/guidelines developed? Who is involved in their development? How often are they reviewed? How are staff trained on these pathways/guidelines?
Internal referral process	Are patients routinely screened for MH issues? How are internal referrals made? Warm-hand offs? Are referrals monitored to ensure that appointments are made? Is there feedback to the referring clinician?
Structural Integration	**Characteristics and Decisions Points**
Service location	Separate patient treatment space vs. shared?
Workspace	Shared clinician workspace/offices vs. separate? In what ways does it allow for interaction?
Engagement of MH staff	Employed by the practice? Contracted staff? Sub-contracted from another agency?
Billing and scheduling systems	Shared billing and scheduling systems vs. separate?
Clinical and financial risk	Who bears the risk for the provision of services – the practice, the provider, or both?

Source: Gale, JA, Lambert. Maine Barriers to Integration Study: Environmental Scan. 2008. Available: digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1153&context=healthpolicy.

Under the Medicare program, RHCs receive cost-based reimbursement for MH services provided by CPs and LCSWs.[12,13] Under Medicare regulations, RHCs are typically reimbursed for only one encounter per day, regardless of the number of times a patient is seen. MH services are an exception to this policy as Medicare reimburses for both a qualified medical visit and a qualified MH visit on the same day.[14] Under state Medicaid programs, RHCs may be reimbursed for MH services provided by CPs, LCSWs, and other master's-prepared clinicians through a per-visit, prospective payment system (PPS) or an alternative payment methodology (APM) (provided the amount paid under the APM is at least the minimum amount required under PPS).[13,15] Despite enhanced payment under Medicare and Medicaid and the significant need in rural communities, relatively few RHCs provide MH services.[13]

METHODS

Our study used Fiscal Year 2016 Medicare Cost Reports (Form CMS-2552-10) to identify provider-based RHCs with and without CPs and LCSWs. We linked the Cost Reports to the 2016 Centers for Medicare and Medicaid Services (CMS) Provider of Services file using CMS Certification Numbers to identify CAH-based RHCs and to obtain state and county Federal Information Processing Standards (FIPS) codes for the counties where CAH-based RHCs are located. We used the United States Department of Agriculture Economic Research Service's

2013 Rural-Urban Continuum Codes[16] to classify counties as urban, large rural, medium rural, and small/isolated rural, and the U.S. Census Bureau's four census regions to determine the regional distribution of CAH-based RHCs (Northeast, South, Midwest, West).

We identified 1,416 cost reports filed by CAH-based RHCs in 2016. To ensure comparability across our analysis, we excluded 26 cost reports with less than a full year of data, one of which reported employing CPs and LCSWs. Our final sample comprised 1,390 unique cost reports for CAH-based RHCs, with 126 indicating the provision of MH services by CPs and LCSWs. We performed chi-square tests of independence and two sample t-tests to compare clinic characteristics and to examine characteristics of communities where CAH-based RHCs with and without MH services are located. For the two sample t-tests, we assumed unequal variances and reported the results of the Satterthwaite t-test where the p-value of the Equality of Variances test was less than alpha ($p \leq .05$).[17]

For our qualitative analysis, we selected 12 of the 126 CAH-based RHCs providing CP and/or LCSW (here after referred to as MH) services for in-depth telephone interviews with their hospital and clinic administrators and clinical staff using semi-structured interview protocols. We sought geographic representation within the four United States Census Regions. Within each of the four census regions, we selected those CAH-based RHCs that employed the greatest number of full time equivalent (FTE) CPs and LCSWs and reported the highest MH visit volumes. We completed 11 of the 12 interviews (Appendix A) with seven independent and four system-affiliated CAHs. The average program had been in existence for approximately nine years. Study participants ranged from an 11-bed facility with a single RHC to a 25-bed facility with 14 RHCs. Staffing levels ranged from three to more than 12 MH clinicians. Of the six CAHs that reported their payer mix, the percentage of Medicare/Medicaid patients ranged from 45 to 90 percent. The remaining five did not provide percentage estimates of their payer mix but explained that payer mixes were heavily dependent on Medicare and Medicaid as payer sources.

FINDINGS

Clinic characteristics and locations: The percentage of CAH-based RHCs offering MH services was relatively small at 9 percent of all CAH-based RHCs. Of the 126 CAH-based RHCs with MH services, 72 percent employed only LCSWs, 19 percent employed only CPs, and 9 percent employed both CPs and LCSWs (Table 1). Our analysis of the distribution of CAH-based RHCs providing MH services across census regions, degree of rurality, and location in MH health professional shortage areas (compared to the overall distribution of CAH-based RHCs) revealed variations in the distribution of clinics providing MH services that warrant further study (Table 1). For example, a substantially higher percentage of CAH-based RHCs offering MH services are located in the Northeast and West census regions than would be predicted by the overall distribution, a slightly higher percentage are located in the Midwest (where almost 50 percent of all CAH-based RHCs are located), and substantially fewer are located in the South. As another example, over two-thirds of CAH-based RHCs offering MH services are located in medium size rural areas (compared to under 50 percent for all CAH-based RHCs). A lower percentage of clinics providing such services are located in urban, large rural, and small/isolated rural counties than the overall distribution would suggest.* The reasons for these variations warrant further investigation.

TABLE 1. Characteristics of Critical Access Hospital-Based Rural Health Clinics with and without Clinical Psychologists and/or Clinical Social Workers, 2016

Measure	With CPs/ LCSWs (n = 126)[a]	Without CPs/ LCSWs (n = 1,264)[a]	All CAH-based RHCs (n=1,390)[a]
Percent of RHCs by Type of Mental Health Providers			
Clinical Psychologists and Licensed Clinical Social Workers	8.7%	-	0.8%
Clinical Psychologists only	19.0%	-	1.7%
Licensed Clinical Social Workers only	72.2%	-	6.5%
Percent of RHCs by Ownership Status			
Non-profit/governmental	97.6%	94.1%	94.4%
For-profit	2.4%	5.9%	5.6%
Percent of RHCs by Region***			
Northeast	12.7%	3.4%	4.2%
South	5.6%	28.7%	26.6%
Midwest	51.6%	49.1%	49.4%
West	30.2%	18.8%	19.8%
Percent of RHCs by County Rurality***			
Urban (Metro areas)	11.1%	16.7%	16.2%
Large Rural (≥20,000 residents)	7.9%	9.3%	9.1%
Medium Rural (2,500-19,999 residents)	67.5%	45.7%	47.6%
Small/Isolated Rural (≤2,500 residents)	13.5%	28.4%	27.1%
Percent of RHCs by Mental Health HPSA**			
Whole county	77.0%	87.0%	86.1%
Partial county	21.4%	11.6%	12.5%
Not HPSA	1.6%	1.4%	1.4%

Source: Medicare Cost Report Data, 2016

Differences between RHCs with and without CP/LCSW services significant at p≤.01** and p≤.001***

[a] Columns may not total due to rounding

Overall, CAH-based RHCs offering MH services tended to be larger clinics and/or clinic systems with more FTE primary care staff (physicians, physician assistants, and nurse practitioners) than those that do not offer such services (Table 2). As would be expected given the higher number of FTE providers, clinics offering MH services report a substantially higher number of visits (18,894 compared to 8,265).

CAH-based RHCs offering MH services employed an average of 0.64 FTE Medicare reimbursable clinicians (CPs, LCSWs, or some combination of the two) with a 95 percent confidence interval of 0.52 FTEs to 0.76 FTEs (data not shown). Those clinics providing MH services reported a relatively wide variation in the number of CPs and/or LCSWs with a range of 0.1 FTEs to 2.9 FTEs. In terms of visits, these clinics reported an average of 949 visits provided by CPs and/or LCSWs with a 95 percent confidence interval of 752 to 1,146 visits (data not shown). As with staffing rates, these clinics reported a wide range of visit levels from 6 to 6,143 CP and/or LCSW visits.

*Although RHCs are required to be located in non-urbanized areas at the time of their designation, there is no process to de-designate a clinic if the rural classification for the area in which it is located changes over time.

TABLE 2. Staffing and Visits by Critical Access Hospital-Based Rural Health Clinics with and without Clinical Psychologists and/or Clinical Social Workers, 2016

Measure	With CPs/LCSWs (n = 126)[a]	Without CPs/LCSWs (n = 1,264)[a]
Average Number of FTE Staff[b]		
Physicians***	2.7	1.1
Physician Assistants and/or Nurse Practitioners***	2.4	1.4
Visiting Nurses	0.02	0.03
Clinical Psychologists and/or Licensed Clinical Social Workers***	0.6	-
Total Staff***	5.8	2.5
Average Number of Visits by FTE Staff		
Physicians***	10,728	4,292
Physician Services Under Agreement	406	232
Physician Assistants and/or Nurse Practitioners***	7,298	3,965
Visiting Nurses	18	8
Clinical Psychologists and/or Clinical Social Workers***	949	-
Total Visits***	18,994	8,265

Source: Medicare Cost Report Data, 2016
Differences significant at p≤.001***
[a]Columns may not total due to rounding
[b]The number of FTE physicians under agreement is not reported on the Medicare Cost Report

Reasons for developing MH services: Respondents reported a variety of internal and external factors that contributed to their decisions to develop MH services. In terms of external factors, the majority reported that a primary motivation for implementing these services was to address community needs based on feedback from community members. Four respondents noted that poor access to MH services was a priority health issue identified through their community health needs assessments. In two cases, services were developed in response to cuts in services at local MH programs. Five respondents identified gaps in access for specific populations with comorbid MH conditions, suicidality, or insufficient support following deinstitutionalization.

In terms of internal factors, six respondents explained that they developed MH services in response to requests from their PC providers who were having difficulty referring patients to MH services. These respondents reported that their PCPs were feeling overwhelmed by the added burdens associated with their patients' MH needs, which often took more of their physicians' time and stretched the boundaries of their expertise. For example, providers at one RHC regularly expressed concern about the high number of MH patients in their practices and their ability to address their patients' concerns.

A number of respondents reported additional internal factors that influenced their development and/or expansion of MH services. One CAH hired its own MH staff to improve care coordination for its patients. Another expanded its MH services when it acquired an RHC that already employed a MH specialist. This same hospital uses the proceeds from its 340B drug program[18] to support its MH services thereby satisfying the requirement that profits from the 340B drug program be used to benefit the community. Yet another CAH developed MH services when a local psychologist asked to be hired by its RHC as his services were difficult to sustain under traditional fee-for-service fee schedules. Two respondents highlighted the contribution of MH services in supporting "whole person wellness" for their PC patients.

All CAHs were accepting new MH clients at the time of the interviews, although not all were accepting referrals for individuals who were not existing patients of their systems. Some respondents reported that a greater need existed in the community than they could possibly meet and thus limited access to MH services to existing patients of their clinics. Others reported opening their services to patients from outside their systems. Either approach can be valid, with the choice driven by the ability to hire sufficient staff and the availability of space and other organizational resources.

Mental Health Staffing Patterns: Among our 11 study subjects, LCSWs were the most commonly employed type of MH clinician, with 10 of the 11 study RHCs having one or more LCSW on staff. CPs were the next most commonly employed MH clinician, with six of the 11 RHCs having one or more psychologists on staff. The primary reasons for this are that LCSW and CP certifications are nationally recognized and Medicare reimburses RHCs on a cost basis for services provided by these provider types. Respondents also reported employing a variety of state-level licensed MH clinicians such as licensed professional counselors (LPCs), licensed mental health counselors (LMHCs), and licensed alcohol and drug abuse counselors (LADACs). Although Medicare does not recognize these state-licensed clinicians for reimbursement, they are reimbursable by many Medicaid programs and/or commercial payers. The scope of practice for LCSWs, LPCs, LMHCs, CPs, and LADACs includes diagnostic evaluations, individual and group counseling and, for CPs, psychological testing.

Other types of MH staff employed by RHCs included psychiatrists, psychiatric nurse practitioners (PNPs), and, in one case, a physician assistant (PA) with mental health training and experience. These clinicians have a broader scope of practice that focuses on the evaluation, diagnosis, and treatment of mental diseases including the prescribing and management of psychiatric medications for new and/or complex patients, psychotherapy, and psychosocial interventions. Once a patient's medications are under control, PCPs may assume day-to-day medication management responsibilities in consultation with these prescribers. PCPs are also essential members of MH teams as they can screen for MH issues, identify patients for referral to MH services, manage medications for less complex patients, and attend to patients' physical health needs. In addition, five respondents employed support personnel including case managers, registered nurses, and administrative assistants. These staff coordinate care for MH patients; provide case management; assist patients with housing, transportation, and other needs; and follow up with patients to ensure they are adhering to their medication routines.

MH services provided by CAH-based RHCs: Core MH services provided included MH screenings, medication management, and individual counseling. Respondents reported using a variety of screening tools and scales such as the Patient Health Questionnaire for depression, the Generalized Anxiety Disorder scale for anxiety, and/or the Strengths and Difficulties Questionnaire for MH symptoms in children and youth. A smaller subset also reported routine screenings for behavioral health conditions such as substance use as well as the social determinants of health (e.g., employment status, access to food, and housing).

Based on their screenings, PCPs treat less acute patients through psychoeducation or basic medication management and refer more complex patients to MH specialists, such as psychiatrists

or PNPs. When available, psychiatrists or PNPs typically assume responsibility for managing patients' medications, but when their patient rosters grow too large, as is often the case, they prioritize more complex cases for their own care and offer consultative support to PCPs for patients with stabilized or episodic needs.

LCSWs, CPs, LPCs, and LMHCs offer short-term individual counseling and psychotherapy for episodic concerns (e.g., mild to moderate anxiety and depression, ADHD). Programs that employ support staff, such as case managers, reported they are able to address the more complex needs of patients with higher acuity conditions. For patients requiring more extensive services than available through their RHCs, study participants developed referral relationships with local or regional providers. Referral locations for inpatient psychiatric care were often several hours away.

Services are typically provided in the RHC clinic setting, although respondents described a variety of other service settings as well. For example, six participants provide services in nursing homes, patients' homes (for housebound patients), and schools.

Five respondents reported the use of telepsychiatry in their emergency departments (EDs), clinics, and other settings to provide direct care to complex patients; to provide access to specialty MH services (child psychiatry); or to consult with their PCPs and MH clinicians. One participant reported his belief that the use of telepsychiatry to support MH clinicians helps with staff retention.

Reimbursement for MH Services: Respondents emphasized the importance of selecting clinicians that best meet their patients' needs and are reimbursable by their clinics' most common payers. LCSWs and CPs were reported to provide the greatest flexibility as their services are reimbursed by Medicare, state Medicaid programs, and commercial payers. For those participants with large Medicaid and/or commercially insured populations, LPCs, LMHCs, and other master's-prepared clinicians may be appropriate choices as respondents reported that their state Medicaid programs and commercial payers reimbursed for their services. Respondents reported that physicians, nurse practitioners (NPs), and PAs are reimbursed for providing MH services by Medicare, state Medicaid programs, and commercial payers. Respondents expressed concern that supportive services such as case management are, with limited exceptions, not typically directly reimbursed by third party payers, although a portion of the costs for providing these services may be recovered through the Medicare cost-reporting process.[†]

Sustainability of Mental Health Services: The sustainability of MH services varied across study participants. Six participants reported their MH services were generally sustainable given Medicare's cost-based reimbursement of RHCs. Respondents explained, however, that assessing sustainability can be complicated as not every service line is equally profitable. Generally, reimbursement for counseling services and medication management provided by PCPs covers the cost of providing these services. In comparison, psychiatrists may not generate sufficient revenue to cover their costs. Nonetheless, respondents reported that the availability of psychiatric

[†]Medicare, Medicaid, and some commercial payers reimburse for care management services that meet the definitions established for these codes. Medicare reimburses for chronic care management and general behavioral health integration services provided by RHCs under the Medicare Physician Fee Schedule.[19]

consultation improved the efficiency of PC staff and the service as a whole, which contributes to the overall sustainability of their programs. Respondents also noted improvements in access to MH services led to benefits for their systems. Two respondents explained that their MH programs eased the clinical burden on their PCPs; lowered costs by reducing repeat visits, unnecessary hospitalizations, and psychiatric holds in their EDs; and generated referrals and ancillary services for their hospitals. Others noted that RHC cost-based reimbursement contributed to the sustainability of their programs. Given these benefits, several respondents reported that MH services may not be sustainable on their own but are sustainable when viewed in the overall context of their RHC services. In these cases, respondents drew a clear distinction between MH as a sustainable component of their overall systems as opposed to a standalone "profit center."

Strategies for integrating MH services: RHCs wishing to develop MH services have a number of decisions to make regarding employment status, location of services, use of electronic health records (EHRs), and interactions between providers. The 11 study participants all employed MH clinicians directly through their RHCs. This is not surprising given that clinical staff must be employed by, or under contract to, an RHC for their costs to be reflected on their cost reports.

Similarly, these services were consistently co-located in their clinic facilities. Respondents reported numerous benefits to co-location. One participant described improved convenience for patients with easier access to the ED for high-risk patients and improved communication and collaboration between providers. Another explained that the provision of MH services in their general medical settings reduced the stigma of receiving such care due to increased patient anonymity and reported cost savings resulting from shared reception and waiting space and staff. Yet another explained that co-location on-site allowed MH services to be embedded within their broader wellness programming.

Another functional element of integration involves the sharing of EHRs, scheduling, and management information systems. Eight respondents reported that records for MH services are tracked using their EHRs. Respondents varied in their description of how well their EHRs met the needs of their MH services. Four reported little difficulty, and one reported that they had to build out the component parts of their EHR to get them to work as desired. Another explained that many primary care-focused EHRs do not have a MH component built into their systems and, as a result, their clinicians have to manually enter some of their clinical information. The ability to share clinical information internally using their EHRs was consistently viewed as an important benefit to the study participants. Two respondents, however, noted that the ability to share information across partner organizations using their EHRs was less easily accomplished. Most reported using common scheduling and billing systems.

The final functional element of integration we examined involved the extent to which MH and PC clinicians function as part of an integrated team. Three respondents explained that it took time before their PCPs came to accept the inclusion of MH clinicians in their clinics and to appreciate their contributions to their systems. This transition did not take long in most cases and now the services are viewed as an integral component of their clinics. Two respondents described the importance of developing a culture that values MH by focusing on communication and the development of team-based care by holding combined staff meetings, soliciting input from

the MH team, having the MH team present on topics of interest, and developing a consulting relationship between the PCPs and MH clinicians. A number of respondents reaffirmed that the co-location of services on-site contributed to improved communication and interaction between PC and MH staff.

CHALLENGES OF PROVIDING MENTAL HEALTH SERVICES

Although all respondents were consistently pleased with the development of their MH services, they described challenges that had to be overcome. These challenges included recruitment and retention of MH clinicians, limitations on Medicare reimbursement for certain types of MH clinicians, difficulty integrating services into their primary care settings, patient access issues, and Medicare regulations that require that primary care services comprise at least 51 percent of services provided by RHCs.

Recruitment and retention of mental health staff: Nearly all respondents reported that their RHCs had struggled at times to recruit and retain MH staff. To enhance their abilities to recruit MH clinicians, respondents noted that it was important to offer competitive salaries and other benefits. Toward that end, one CAH offered relocation and rental assistance and, to the extent possible, loan repayment support. Another respondent noted that the first hires were often the hardest, further noting that while the use of recruiters and word of mouth was helpful, having existing MH clinicians greatly facilitated their recruitment efforts. When recruitment lagged behind demand, several respondents recommended ways to make the most of the providers available. In response to the shortage of psychiatrists, one respondent recommended maximizing psychiatric consultations with PCPs, connecting patients to psychiatrists via telehealth, or using PNPs to manage patient medications and consult with PCPs. To retain staff, one respondent highlighted the value of integrating MH providers into the primary care team and reported that the failure to do so can contribute to retention difficulties.

Medicare coverage limitations: One commonly identified challenge was that several types of MH providers (e.g., LPCs, LMHCs, and marriage and family therapists) are not eligible for Medicare reimbursement. The ability to receive Medicare reimbursement for these providers would broaden the pool of Medicare-reimbursable clinicians and reduce recruiting difficulties. Respondents affirmed the importance of understanding Medicare, Medicaid, and commercial payer billing policies and recruiting clinicians that are reimbursable by the primary payers for their patient populations. A small number of respondents reported that they were unaware of these limitations when beginning MH services, leading to later complications with hiring and billing. One hospital had to reimburse Medicare for RHC services rendered by an LPC to Medicare beneficiaries. For these reasons, respondents recommended hiring LCSWs or CPs to implement their services as they provide the most flexibility in terms of third party payment. As psychiatrists may be difficult to recruit, other respondents recommended hiring a PNP to provide medication management support. Respondents also explained that certain types of supportive services (e.g., case management or wraparound supports) are beneficial to their MH patients but are not reimbursed by Medicare and other third party payers.

Reimbursement issues: While respondents were satisfied with Medicare reimbursement for MH services, a small number noted that Medicaid reimbursement did not adequately cover the cost of services. Others explained that enhanced Medicare reimbursement helped to compensate

for lower Medicaid and commercial payer rates. Finally, four respondents noted that some of their patients are classified as "self-pay" and have difficulty paying their bills although, with the exception of one clinic, self-pay patients generally represented a relatively low percentage of their overall patient populations.

Integrating services into primary care setting: Three respondents reported that early resistance from PCPs was a challenge to setting up their MH programs. In response, clinics implemented inclusive staff meetings, routinely solicited MH provider expertise through consultations and staff presentations, and developed a clinic culture that promotes open communication through shared medical records. Another respondent explained that a key source of early friction after the launch of a MH program was due to PCP frustration at limited feedback on patients referred to the MH team. Staff resolved the matter by improving communication through the clinic's EHR, and now the PC and MH programs are working together well. Another respondent highlighted the value of growing the MH team over time to increase opportunities for mutual support and to reduce provider burnout. Four CAHs offered case management to their more complex MH patients with the goals of improving compliance with medication and treatment plans as well as reducing unnecessary clinic, ED, and inpatient utilization.

Patient access issues: Respondents consistently reported that issues related to transportation, time, and cost kept rural residents from receiving MH services. Several reported efforts to develop ancillary services to improve patient access to their MH programs. One CAH offered bus vouchers and shuttle rides to those with transportation barriers. Two CAHs reported having some of their MH clinicians split their time between multiple clinics, thereby improving access to services in outlying communities and reducing travel distances for patients who live in those communities and would otherwise have to travel to the home clinic for services. Others used telehealth to improve access to psychiatry and medication management. In lieu of bringing patients to the clinic, several providers brought services to patients at their homes, nursing homes, or schools.

The "51 percent rule": [20] Two respondents expressed concern about the Medicare regulation designed to ensure that RHCs are primarily engaged in providing primary health care, which is typically interpreted to mean that PC services are offered during at least 51 percent of the total operating schedule.[21] One CAH reported problems when a surveyor raised concerns about one of their clinics that provided buprenorphine services to patients with opioid use disorders. Due to the loss of a PC nurse practitioner, the percentage of visits for buprenorphine compared to PC rose above 51 percent. Ultimately, they were able to resolve the issue by splitting the service between two sites, but it did potentially threaten to disrupt this critical service. Another respondent also expressed concern about the potential impact of this rule on their clinic. Although only two respondents identified this issue, it is worth exploring the extent to which concerns about the 51 percent rule serve as a barrier that discourages more CAH-based RHCs from offering MH services. It is also worth exploring the extent to which the issue is a function of the overall Medicare policy or the interpretation of the policy during the survey process.

DISCUSSION

Despite the challenges noted above, respondents from the 11 CAH-based RHCs in our study expressed significant satisfaction with and support for the delivery of MH services in

their provider-based clinics. Almost all described their services as sustainable given that they contributed to increased access to necessary services, improved the efficiency of their PCPs, reduced the demands on their time, increased referrals to the hospitals, generated greater use of ancillary services, and minimized unnecessary repeat visits, inpatient admissions, and emergency department use. Further evidence of their success is the fact that most respondents were either in the process of expanding their programs or at least exploring the possibility of expansion. Respondents strongly encouraged other CAHs and their RHCs to consider the development of MH services.

Of concern is that only 9 percent of the 1,390 CAH-based RHCs in our analysis were providing Medicare-reimbursed MH services in 2016. Given that shortages of MH services are a long-standing problem for rural areas, it is somewhat surprising that more CAH-based RHCs have not chosen to offer MH services. Further study is needed to determine why this is the case and to identify opportunities to encourage more to do so. In particular, it would be important to explore the variations in CAH-based RHC MH services by geographic region, rurality, and MH HPSA designation (Table 2). Why, for example, do a higher percentage of CAH-based RHCs provide MH services in the Northeast and West census regions, while a lower percentage do so in the South? Similar questions should be asked about the observed variations in the provision of CAH-based RHC MH services across different rural areas and MH HPSAs. Understanding these variations would help to better target incentives and technical assistance to encourage more CAH-based RHCs to offer these services.

In terms of encouraging more CAHs to undertake work in this area, our respondents provided a number of suggestions. One highlighted the importance of identifying the system's goals and expectations for the service, considering the system's resources and capacity, and understanding its target patient population and their MH needs. Others explained that local needs were typically greater than they can serve so it is essential to understand what a system can and cannot do well, and to target those populations that can be served with quality. Another respondent noted that it is critical to understand Medicare, Medicaid, and commercial payer coverage and reimbursement policies and to tailor hires accordingly. Respondents also noted that MH services must be carefully managed in terms of payer mix and clinician productivity to ensure sustainability.

Finally, respondents stated that some of these challenges are outside of their control and require policy and/or regulatory changes to overcome them. Policy and regulatory changes requested by study participants included expanding Medicare reimbursement to additional licensed MH clinicians beyond LCSWs and CPs, improving Medicaid reimbursement rates, providing reimbursement for support services, and clarifying Medicare's regulation commonly known as the "51 percent rule."

THE ROLE OF STATE FLEX PROGRAMS IN SUPPORTING CAH-BASED RHC MENTAL HEALTH SERVICES

The relatively small number of CAH-based RHCs that have chosen to provide MH services and the chronic shortages of those services in rural communities suggest an opportunity for State Flex Programs to engage with CAHs and their RHCs to encourage the development of these important population health services. State Flex Programs can provide information to

CAH-based RHCs interested in the development of MH services as well as technical assistance on staffing models, regulatory and licensing issues in their states, coding and billing for MH services, and strategies to integrate services in RHC settings. They can also highlight and disseminate information on successful models of CAH-based MH services.

CONCLUSIONS

The reported experiences of these 11 respondents demonstrate that CAH-based RHCs can play an important role in providing needed MH services in their communities and that, with careful management, these services can be sustainable over time. This policy brief provides models and resources that CAHs can use to implement MH services in their RHCs. State Flex Programs can play an important role in assisting more CAH-based RHCs in developing MH services through the provision of technical assistance and support, and through the dissemination of models that can be adapted by CAH-based RHCs to their unique needs and resources. Appendix B provides a list of resources and tools that State Flex Programs can use in their work with CAH-based RHCs.

For more information on this study, please contact John Gale at john.gale@maine.edu.

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APPENDIX A. Study Participants

Abbeville Area Medical Center (Abbeville), Abbeville, SC: Abbeville is an independent CAH with two RHCs providing MH services. Abbeville's initial MH efforts involved providing group counseling to meet the needs of its Medicare population. In 2016, Abbeville hired its first licensed independent social worker (LISW) at the main RHC and acquired a satellite clinic that already employed an LISW. Its MH roster now includes these two LISWs, a board certified psychiatrist, and an administrative assistant. These staff provide traditional counseling and medication management services. The psychiatrist collaborates with the PC team to manage clients' medications by providing direct care for new clients or those with complex needs, as well as consultative support once a client's medications are stabilized. Abbeville's client base is largely adults and older adults, with occasional adolescents. PC and MH providers are co-located and participate in regular meetings together. Staff generally refer complex patients to a nearby state-run facility; patients presenting at the ED are evaluated and referred to external specialty MH services. Abbeville supports its MH program through savings from its participation in the 340B Drug Pricing Program, which stipulates that savings be used for community benefit.

Adventist Health Clear Lake (Clear Lake), Lake County, CA: Clear Lake is a faith-based system consisting of the CAH and eight RHCs. The largest RHC reported 110,000 visits annually for primary care, MH, and other specialty services. Clear Lake's RHCs serve a high proportion of Medi-Cal (Medicaid) enrollees and a large number of patients with pain management needs. The MH department, known as Live Well, launched in 2009 to address increasing local needs as other providers pared back their MH services. Live Well was developed as a comprehensive response to patient health needs and provides medical and MH screenings, psychiatric support, individual counseling, health coaching, nutritional counseling, pain management, and other psychoeducation and preventive supports. The MH program includes three psychiatrists, five LCSWs, and a PNP. Several case managers help patients address social determinants of health such as housing, transportation, and stressors in the home. Live Well primarily serves individuals with mild to moderate MH needs; the hospital refers more complex patients to specialty community providers. Patients needing psychiatric inpatient care are referred to inpatient facilities in Vallejo or Sacramento, each roughly two hours away.

Aspirus Ironwood Hospital (Aspirus), Ironwood, MI: Aspirus is located in the western Upper Peninsula of Michigan. Its RHC offers ambulatory specialty services with a primary focus on preventive medicine, common conditions, coronary disease, hypertension, and MH. Aspirus hired its first psychologist in 2008 to meet a growing need for MH services, in part due to the closure of local residential facilities. Aspirus employs two CPs, a psychiatrist, and a PNP, with patient demand that exceeds staff availability. The psychiatrist and PNP together see roughly 600 scheduled patients. These providers offer counseling, psychotherapy, and psychiatric medication management. Patients with urgent or complex needs are referred to a local community MH center, particularly after-hours. Children needing inpatient psychiatric care are referred to Grand Rapids, a 12 hour drive away. Aspirus is working to better integrate medical and MH services through improved communication and collaboration. It is also exploring the development of intensive outpatient services to meet the needs of its large geriatric population.

Bingham Memorial Hospital (Bingham), Blackfoot, ID: Bingham serves southeast Idaho and operates OB-GYN services, two surgery centers, a 10-bed geropsychiatric distinct part unit, physician offices, and RHCs throughout the Snake River Valley. Its outpatient MH services are co-located at its primary RHC on the hospital campus which offers services from primary care to neurosurgery. Bingham began its MH services in 2007, hiring a CP as part of its pain management program. Given the success of this multidisciplinary approach and ongoing community need, Bingham has since integrated several other service lines and developed a MH department that includes a psychiatrist, four CPs, and a number of licensed counselors. Services include medication management, counseling, and MH screenings. MH services are available 10 hours per day, Monday through Friday. The average wait time is one week for counseling/psychotherapy with longer waits for psychiatry. Given regional shortages in MH services, Bingham triages clients needing inpatient care to its geropsychiatric unit or to facilities in neighboring states. Bingham expects continued growth in its outpatient MH department with plans to expand services for children and youth.

Lakewood Health System (Lakewood), Staples, MN: Lakewood provides the majority of its outpatient MH services through its largest RHC and serves persons of all ages. These services began in 2008, based on local need and a drive among hospital leadership to improve the community's overall health by addressing MH concerns. The MH department employs five LCSWs, four CPs, a PNP, and a licensed practical nurse, along with a team of case managers and other support staff. The system is currently recruiting for two additional PNPs and a CP. Lakewood reports 450 MH visits each month, including individual counseling, psychotherapy, and medication management. Its PCPs screen for MH and substance use issues at every visit. Beyond these direct supports, Lakewood is involved in community-based MH initiatives to address social determinants of health such as poverty, housing, and law enforcement's response to MH needs.

Livingston HealthCare (Livingston), Livingston, MT: Livingston's RHC is located within the hospital facility and began providing MH services in 2016. The factors driving the development of MH services included local needs and the fact that the hospital's PCPs were struggling to keep up with increasingly high volumes of complex patients with MH needs. The RHC employs a psychiatrist, a psychiatrically-trained PA, two LCSWs, and a nurse care coordinator. The psychiatrist and PA provide medication management and consultation for patients deemed too complex for the clinic's PCPs; the LCSWs offer short-term individual psychotherapy and counseling; and the nurse care coordinator offers case management support to Livingston's more complex patients. Wait times for clinical services range from two weeks (psychiatry) to same-day or next-day (counseling). A patient's first contact with the hospital is generally through its PCPs who screen for MH issues and make "warm hand-offs" to MH staff. The RHC prioritizes services for episodic mental health needs, referring patients with more chronic and complex needs to other community providers. Those in crisis are referred to a system affiliate in Billings, MT, one hundred miles away.

Ozarks Community Hospital (Ozarks), Gravette, AR: Ozarks operates 12 RHCs and two other clinics in Missouri, Arkansas, and Oklahoma and serves primarily Medicare and Medicaid patients. Ozarks' early MH efforts were through an inpatient psychiatric unit in Springfield,

Missouri, which specialized in team-based care for patients with co-occurring disorders. To address a lack of local MH services, Ozarks launched the Solutions Program using this integrated model. Today, most of its RHCs house at least one LCSW, and five psychologists divide their time between the twelve clinics. System-wide, most MH patients are referred to Ozarks' MH services from external providers. At patient intake, staff conduct screenings and psychological evaluations and, as needed, refer patients internally to services that include play therapy; Eye Movement Desensitization and Reprocessing; family therapy; individual and group counseling; and physical, occupational, and speech therapy. Ozarks offers psychiatry through in-person visits or internal telehealth. Ozarks further integrates its services by encouraging shared appointments between primary care and behavioral health providers.

Pagosa Springs Medical Center (Pagosa Springs), Pagosa Springs, CO: Pagosa Springs is an 11-bed CAH with an RHC on the same campus. When the hospital opened in 2008, Pagosa Springs began contracting with an LPC for consultations and evaluations in its ED, and hired an on-site LPC in 2014. Two years later, it began providing outpatient MH services when the RHC moved to its new on-site facility. Today, the clinic's PCPs offer screenings for depression and suicidality as well as medication management for less complex MH needs. In addition, an LCSW, an LPC, and a CP offer scheduled counseling services. A second LCSW offers immediate clinical support to patients presenting with acute MH needs. For urgent needs (e.g., active suicidality, psychosis), its clinicians complete emergency evaluations via telepsychiatry with an external provider. The closest referral center for inpatient psychiatric care is in Denver, a six-hour drive away. In the near future, Pagosa Springs hopes to offer medication management to complex patients via expanded telepsychiatry through the RHC.

Regional Medical Center (Regional Medical), Manchester, IA: Regional Medical has an RHC on the hospital campus and four satellite facilities. Its PCPs screen for MH issues at each visit and refer, as appropriate, to the RHC's three LMHCs, its licensed independent clinical social worker (LICSW), or its PNP. These clinicians see persons of all ages and with all conditions, so long as presenting needs are episodic and manageable. The clinic's LMHCs and LICSW offer individual counseling and psychotherapy and the PNP provides medication management. Regional Medical's clinical staff generally refer locally to external specialty providers when patients present with chronic or complex needs. For urgent MH problems (e.g., acute suicidality), clinic staff refer patients to the ED, which then triages patients to an inpatient care facility or telepsychiatry through an external provider.

Weeks Medical Center (Weeks), Lancaster, NH: Each of Weeks' four RHCs provide primary care and MH services. Weeks hired its first LICSW in the early 2000s to support its primary care providers, who increasingly struggled to manage both the volume and complexity of their patients' MH needs. Today, the MH program may be the fastest growing department in the system, with three LADACs, two LICSWs, two PNPs and a number of support recovery workers and master's level mental health counselors on the roster. The clinic is actively recruiting additional staff. Weeks relies heavily on case management to ensure patient compliance with MH supports such as counseling and medication management. Weeks is currently building a new facility to house expanded MH and substance use services, with special attention to further growth in case management.

Western Wisconsin Health (Western Wisconsin), Baldwin, WI: Western Wisconsin is an independent CAH located midway between Saint Paul, MN and Eau Claire, WI. It operates two RHCs, one in Baldwin on the hospital's main campus and one in nearby Roberts, WI. Western Wisconsin's new facility was completed in 2016 and houses MH and PC services. It employs one psychiatrist, two PNPs, one CP, and six LCSWs and licensed counselors to provide short-term outpatient counseling, MH screenings, and medication management. Western Wisconsin integrates these services with preventive supports such as health coaching and nutritional counseling. Its MH clinicians provide consultative support to its ED and inpatient staff. The RHC serves between 30 and 50 MH clients daily. To address access barriers for some families, Western Wisconsin provides off-site school-based MH services billed at state Medicaid rates. Tele-behavioral health is available evenings and nights in the ED for those presenting with urgent needs. Patients requiring inpatient care are referred to one of Wisconsin's state-run psychiatric hospitals. Western Wisconsin plans to add outpatient substance use treatment in 2020.

APPENDIX B. Mental Health Resources for CAH-Based RHCs and State Flex Programs

Source	Resource Description	Links
Center of Excellence for Integrated Health Solutions (COE)	*Center of Excellence for Integrated Health Solutions*. This website provides resources to support the development of integrated services. COE recently migrated to a new host, the National Council for Behavioral Health. Not all tools have been migrated to the new site so both are provided.	thenationalcouncil.org/integrated-health-coe/resources/
Center of Excellence for Integrated Health Solutions (COE)	This is the original website for the *Center of Excellence for Integrated Health Solutions.* It provides additional resources not yet migrated to COE's new website including resources and tools on screening for MH conditions, clinical integration, billing and financing care, the business case for integration, etc.	integration.samhsa.gov/
Rural Health Information Hub (RHIhub)	RHIhub's *Mental Health in Rural Communities* toolkit provides tools and resources to help rural providers integrate mental health services into primary care settings.	ruralhealthinfo.org/toolkits/mental-health/2/primary-care-integration
Resources for Integrated Care (RIC)	RIC's *Behavioral Health* web page provides promising practices and tools to integrate and coordinate care for beneficiaries dually eligible for Medicare and Medicaid. It also houses technical assistance products and webinars to help providers integrate and coordinate care for this population.	resourcesforintegratedcare.com/concepts/behavioral-health
American Academy of Pediatrics	*Mental Health Screening and Assessment Tools for Primary Care:* This document lists mental health screening and assessment tools and summarizes their psychometric testing properties, cultural considerations, costs, and key references. It includes proprietary and public use tools.	aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf
Beidas, Stewart, Walsh, Lucas, Downey, Jackson, Fernandez, & Mandell	The article "Free, brief, and validated: Standardized instruments for low-resource mental health settings," published in the peer-reviewed journal *Cognitive Behavioral Practice*, provides assessment tools for low resource MH settings.	ncbi.nlm.nih.gov/pmc/articles/PMC4310476/pdf/nihms-589127.pdf
Integrated Behavioral Health Partners	*Integrated Behavioral Health Screening Tools for Primary Care:* This document provides resources and links to MH screening tools.	ibhpartners.org/wp-content/uploads/2015/12/Screening-Tool-Mandy.pdf
Integrated Behavioral Health Partners	The mission *of Integrated Behavioral Health Partners* is to advance integrated behavioral health care in California and nationally through capacity building, training, and technical assistance. This website provides resources and tools to support integration.	ibhpartners.org/