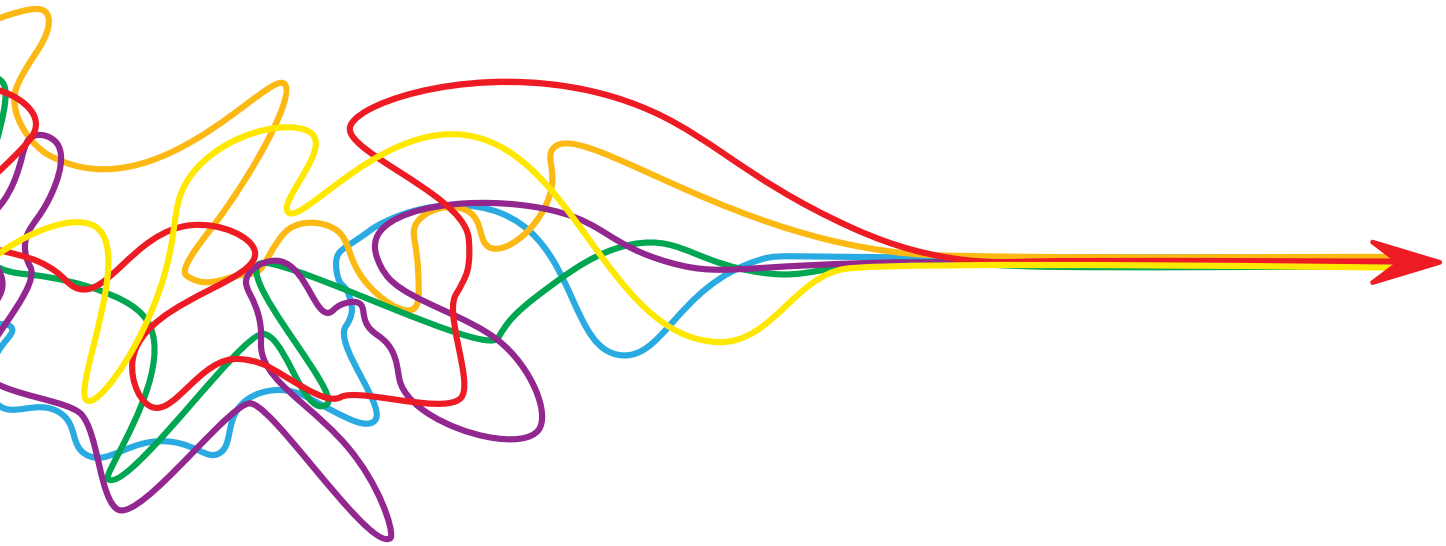
Mental Health Care Access for NH Youth:

A Comparison of Two Models



Institute for Health Policy and Practice

Authors & Funders

Authors

Katherine Lipp, LICSW, PMP, Project Director, IHPP
Maya Gelting, Research Associate, IHPP
Delitha Watts, Project Director, IHPP
Erica-Lyn Plante, MS, Senior Health Data Analyst, IHPP
Jeanne Ryer, MSc, EdD, Director of Delivery System and Payment Reform, IHPP
Felicia Brackett, MPH, Project Director, IHPP

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Contents

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Executive Summary

To improve access to behavioral health services in NH, we must expand the roles and settings that can effectively screen, assess, and treat children and adolescents with mild to moderate mental health conditions. Doing so would allow specialty behavioral health providers, an already limited resource, to focus on patients with severe or complex clinical needs. Both the Collaborative Care (CoCM) and Child Psychiatric Access Program (Access Program) models of care have been shown to improve access to behavioral health care while optimizing use of the limited workforce of child and adolescent psychiatrists (CAPs).

Both models have a role in improving care access in NH. An Access Program provides timely support for primary care providers managing youth with pressing mental health needs and can be implemented and used with few resources. CoCM, however, requires more resources to implement but provides systemic change that has been shown to improve care outcomes with a high return on investment. Financial modeling shows that an Access Program is not financially feasible through NH billing. While CoCM is financially feasible in NH, uptake across the state currently remains low- likely due to the challenges associated with implementation and billing.[2] This assessment identifies key strategies to improve the feasibility of implementing and sustaining these two complementary programs within NH:

Strategy 1: Pilot a low-cost, high-impact Access Program design and gather volume data to support policy change.

NH MCAP can utilize the next three years of PMHCA grant funding to pilot and evaluate the proposed program design.

Strategy 2: Incentivize and support uptake of CoCM by increasing opportunities for implementation support.

CoCM requires significant practice-level change that has hindered uptake. Implementation support, such as the provision of a no-cost registry tool and technical assistance, can provide the jump-start practices need. NH MCAP can pilot this process through the next grant funding period to better understand the needs of NH practices.

Strategy 3: Explore increased reimbursement for CoCM by increasing NH Medicaid rates and/or pay-for-performance metrics.

Although estimated CoCM reimbursement does cover projected costs when calculated with the full payer mix of NH youth, CoCM is less feasible for practices that serve higher rates of youth insured by NH Medicaid. NH Medicaid rates for CoCM are among the lowest in the country. By increasing rates to align with Medicare, practices may be more willing to implement the model. Pay-for-performance metrics associated with screening and enrollment in CoCM may also incentivize implementation.

Strategy 4: Explore a quarterly assessment fee on health insurance carriers and self-insured plans to fund an Access Program.

Current reimbursement is insufficient to cover the costs of an Access Program. By applying a calculated rate on the reported number of children and adolescents covered by the carrier or plan, as has been done in other states, an assessment fee could cover the costs of the Access Program.

Introduction

Background

The future well-being of New Hampshire is being determined right now by how we foster the health of the next generation. Currently, lack of mental health treatment and services for children and adolescents represents a major obstacle to the state's continued progress. Health outcomes are deeply connected to the environments in which we live and our access to resources and services that promote well-being, both of which are determined by larger systems of power and inequity. The work of these systems is clearly seen in NH, where almost a third of the state's youth (31.3%) were reported as having a mental, emotional, developmental, or behavioral problem in 2020 and 2021.[3] This number is 8% higher than the national average and, without intervention, will likely continue to increase beyond the 81,000 children already affected.[3]

Childhood and adolescence are a foundational period for brain development, and so it follows that it is a critical time for mental health care. Early identification and treatment have been shown to lead to better outcomes that persist into adulthood. Both early treatment and timely access to care reduce the impact of mental health conditions on quality of life by allowing providers to target symptoms before they reach a point of crisis.[4] However, early access to behavioral health care is not something that is available to many NH residents. When last recorded, less than half of children who needed mental health care in the state received treatment or counseling from a mental health professional.[3]

A variety of compounding factors have led to care access issues in NH: reluctance to seek help, long waitlists, inadequate insurance coverage, lack of scheduling flexibility, and a shortage of specialized providers.[5] Even before COVID-19, NH was ranked second among US states hit hardest by workforce shortages, and "the pandemic exacerbated both the need for and strain on health care personnel".[6-7] New Hampshire is experiencing a severe shortage of mental health professionals, with more than half of the need remaining unmet.[3] The State reports that there are only 5 full-time psychiatrists for every 100,000 people living in NH, with many areas coping with less.[8] Shortages are particularly acute for Child and Adolescent Psychiatrists (CAPs), with 9 of the 10 NH counties experiencing severe shortages and one county having no practitioners at all. Because of the systems of inequity discussed previously, adolescents in ethnic, racial, sexual, and other minority groups are especially hard-hit.[9] For example, a quarter of female students and almost half of LGBTQ+ students reported seriously considering attempting suicide.[10] Statistics like these demonstrate not only the need in New Hampshire, but how much of a difference it can make in our communities to have programs that increase access to behavioral health care.

As demand continues to grow, the existing behavioral health system lacks the capacity to provide timely services to young people in need. Through targeted interventions, however, we can empower Primary Care Providers (PCPs) to provide effective behavioral health care by giving them the resources they need to do so.

Potential Solutions

To enable the behavioral health system to meet the existing need, we must expand the roles and settings that can effectively screen, assess, and treat children and adolescents with mild to moderate health conditions. Most notably, this requires reinforcing the supports and services available through primary care.

PCPs in NH already view the diagnosis and treatment of depression, anxiety, and attention-deficit/hyperactivity disorder- the most common mental health issues seen in primary care- as within their scope of care.[1,11] In fact, PCPs prescribe nearly half of all mental health medications for NH children and teens.[2] While this does help to mitigate access issues, as 90% of children receive regular medical care from a PCP, only 1 in 3 pediatricians feel that they have sufficient training to diagnose and treat children with mental disorders.[5]

All stakeholders in New Hampshire's healthcare system need to work together to find ways to support pediatric primary care providers in caring for the mental health of their patients, especially for those issues that come up frequently. Creating and enhancing these supports would allow the state's health system to effectively manage the severely limited resource of specialty behavioral health providers, reserving their services for cases that are severe, complex, unsafe, or otherwise not responding to treatment.[11]

Behavioral health integration has been shown to mitigate care access problems.[12] It is based on a partnership of mental health specialists and PCPs but can be delivered in a variety of formats.[5] Different approaches to integrated care require varying combinations of care providers, activities, services, and other requirements to satisfy billing codes and fidelity. Given the significant behavioral health workforce shortages in NH, this feasibility study focuses on two models that have been found to increase access to care without volume-intensive or highly specific staffing requirements: the Collaborative Care Model (CoCM) and the Child Psychiatry Access Program model.

Both of these models have seen substantial growth nationwide over the last decade, due in part to the support of federal strategies such as HRSA PMHCA grants and 1115 waivers as well as advocacy and implementation support from notable organizations like the University of Washington AIMS Center (Advancing Integrated Mental Health Solutions) and the Massachusetts Child Psychiatry Access Project (MCPAP).[13-14]

Feasibility Study

This report summarizes the evidence base and structure of the Child Psychiatry Access Program and Collaborative Care models, as well as the costs of both models and how these costs could be financed. It also elaborates on how the models could be adapted to fit NH's needs and provides data-based estimates of net financial impact.

Child Psychiatry Access Program

Background & Rationale

A Child Psychiatry Access Program, or Access Program, is a model established in most states that provides PCPs with access to pediatric behavioral health experts virtually or by phone for consultation.[15] Access programs give PCPs the education and support they need to meet the behavioral health needs of their pediatric patients, specifically in areas with significant CAP shortages. In consulting with a CAP, PCPs can not only get answers about a specific patient or case, but also gain more generalized knowledge in areas such as diagnosis, treatment, and referral resources, which can be applied to future practice.[15]

Access Programs have been found to improve access to specialized behavioral health care for children.[16-17] By removing obstacles such as sitting on waitlists or traveling long distances from rural locations to see a specialist, more patients and their families are able to access care.[18] Evidence from the National Survey of Children's Health shows that children living in states with an Access Program were significantly more likely to receive mental health services than those in states without one.[16] Studies on a variety of Access Programs show that PCPs feel better equipped to meet their patients' mental health needs and that their confidence and skills increase after such a program is implemented.[16,19]

The costs associated with Access Programs vary considerably depending on the breadth and volume of the program. Most are implemented with grant funding and can be sustained by a variety of sources including grants, insurance mandates, Medicaid support, billing, and direct support from insurers.[19-20]

There are no formal requirements for an Access Program as a care model, but it makes sense to align the service model with billing requirements for interprofessional consultation codes which include obtaining patient consent and providing a written report to the treating provider.[21]

Access Programs in NH

In NH, there are two known Access Program pilots: NHMCAP and Dartmouth Health Children's Pediatric Mental Health Access Initiative. NHMCAP established an Access Program in 2019 that was available to all registered participants in the MCAP Project ECHO learning community and their associated practices. MCAP participant practitioners and their colleagues could request teleconsults using a web-based form that collected basic patient demographic information

and an explanation of the issue or question. Consultations with the requested behavioral health expert were made available within 48 hours. Consultants did not make written recommendations; there were no limits on teleconsult duration. Despite high engagement in the Project ECHO learning community and its case consultations, utilization of the teleconsult service was low. PCP feedback indicated high satisfaction with the consultations provided, but participants noted that forgetting about the service and the cumbersome workflow associated with the process impeded use.

The Dartmouth Health Pediatric Mental Health Access Initiative piloted an e-consult program in 2022 with three primary care sites external to the Dartmouth Health (DH) system. The pilot used a secure messaging system integrated with the DH Electronic Health Record (EHR) to communicate relevant patient data and facilitate an asynchronous exchange. The e-consults, initiated by the PCP, received a response within three days from a DH Child Psychiatrist. Surveyed PCPs reported satisfaction with response time and that the e-consults resulted in modifications to the treatment plan. Feedback also indicated that the administrative burden caused by working in two separate EHRs limited the effectiveness of the service; PCPs shared frustration with manually entering patient information and consulting CAPs struggled to provide effective consultation without access to the full record (F.C. Morgan, MBA, Dartmouth Health Children's, oral communication, June 21, 2023).

Financial Model

Costs

While there are some start-up costs associated with an Access Program, NH MCAP experience shows that the majority of costs are represented by the staff needed to operate the program.[22]

Training Costs	• For PCPs: marketing and recruitment, education on the purpose, process, and expectations of Access Programs • For psychiatric consultants: informal training on efficient and effective consultation strategies
Technology Costs	• Teleconsult modality: must provide way to contact Access Program, securely exchange patient data, and/or export program data • Data management (if separate from teleconsult modality) • Website maintenance
Staffing Costs	• Determined by program scope and call volume, as described below.

CAP: Available at designated times or on-call for teleconsults. Licensed in the state they are providing services. Able to document consultations and provide direct patient consultation when needed.

Administrative Support: Collects basic demographic and clinical data, schedules consultation, processes billing, sends records to requesting provider.

Program Manager: Develops and oversees day-to-day operations and financial management of the Access Program. Includes data management, state advocacy, grant writing, and stewardship.

Minimum (Core) Staffing Requirements

Care Coordinator: Manages database of potential referral sources, provides consultation on community-based services and providers. May directly consult with patients and follow up as needed. Can be combined with an administrative support role, depending on call volume.

Licensed Clinician: Provides consultation on diagnosis and therapy approaches and strategies. Directly consults with patients as needed.

Opportunities to Enhance Staffing & Services

Financing Strategies

Advantages and Disadvantages of Billing

The Center for Medicare and Medicaid Services (CMS) issued Interprofessional Consultation codes in 2019 and expanded them in 2023 to include a broader range of professional consultants.[21] These codes are used when a primary provider wants to confer with a specialist provider, or consultant, about a specific case without meeting in person. Consultations are usually used to get advice or an opinion from someone with specialty expertise that is not accessible to the patient because of factors like availability or location.[21] These consultations can happen via phone, the internet, or any other electronic platform.[23] The treating providers can also bill for time spent preparing the referral or communicating with the consultant.[24] Many insurance plans will require a patient co-pay, so it is important to obtain patient consent.[21]

While Interprofessional Consultation codes are reimbursed by Medicare and many private payers, NH has not yet implemented these codes in their Medicaid coverage.[25] This may be attributed to previous CMS guidance which prohibited coverage by Medicaid and Children's Health Insurance Program (CHIP) plans.[26] However, in January 2023 CMS issued a letter that acknowledged the administrative burden the previous policy created and provided new guidance allowing consultation codes. CMS notes that these "may be paid for under existing state plan benefits such as physician services, services of other licensed practitioners, rehabilitative services, and health homes".[26(p4)]

Nationally, most Access Programs do not bill interprofessional consultation codes. Use of these codes initiates a patient-provider relationship with potential liability implications Some programs experience barriers in credentialing consulting providers; others value providing a

no-cost service. Providers may be less likely to use an Access Program if they are concerned about a potential cost to their patient. Billing could also serve as a barrier to equitable access; if the Access Program will be billing for services, it should identify strategies to cover the cost of those who are under-insured or uninsured to avoid creating a barrier to program use.

Implementation Considerations

Service Demand & Capacity

In 2021, there were an estimated 292,506 children under age 19 living in NH and 1,268 full-time (FTE) pediatric PCPs working in the state.[27-28] Among those surveyed, over 97% of pediatric PCPs in NH self-report that they would use an Access Program at least once per month.[1]

Low PCP uptake of teleconsultation has been a significant factor thus far in NH, complicating the process of selecting a modality and staffing structure that supports scalability while minimizing waste and any undue administrative burden on the requesting PCP.

Staffing Considerations

If the Access Program will rely on billing for sustainability, CAPs must be licensed in their state and enrolled with NH insurance providers.[26] Health system-specific credentialing depends on the consultation modality used; if the CAP will access the EHR to review data, document the consultation, or submit a bill, they must be credentialed with the associated health system. For advantages and disadvantages to partnering with a CAP provider group, see Table 1.

Table 1. Pros and Cons of Contracting with Individual and Group CAPs

Contract Type	Pros	Cons
CAP Provider Group	• Having a larger group of providers mitigates impact of turnover • Credibility/Reputation of group • Likely to have established documentation and billing system	• Credibility/Reputation of group • Higher cost
Individual CAPs	• Cost effective • Flexible availability	• Disruption caused by turnover • Upfront effort to establish billing

Other Considerations

As compared to other integrated care models, an Access Program has a very small impact on practice workflows. PCPs can contact an Access Program as needed and receive a response within a designated period. Access Programs are not intended to be a crisis resource but must respond quickly enough that PCPs have a positive experience and are able to apply recommendations.

Despite psychiatric consultant concerns about the liability associated with teleconsults, a review of integrated care models did not find any instances of medical malpractice lawsuits.[29-30] The American Psychiatric Association recommends consulting with state medical boards, a risk management professional, and a liability carrier to review state-specific concerns.[31]

Collaborative Care Model

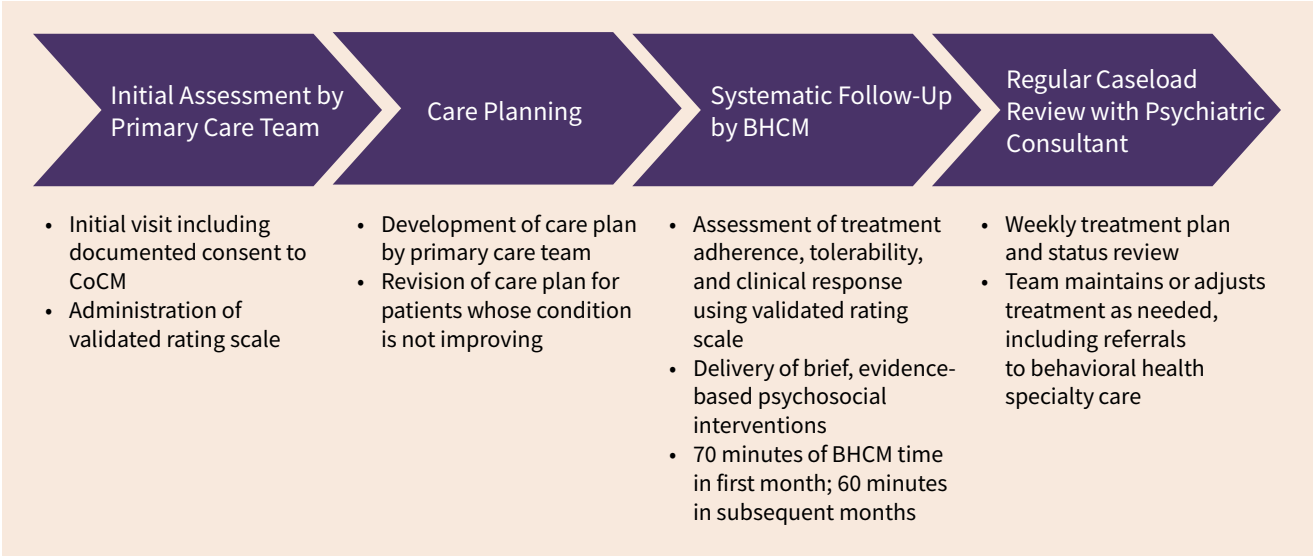
Background & Rationale

The Collaborative Care Model is an evidence-based approach to screening and treating mental health conditions within the primary care setting. In CoCM, pediatric PCPs work alongside a Behavioral Health Care Manager (BHCM) and psychiatric consultant to screen, assess, and manage common childhood mental health conditions. Pediatric patients are universally screened for mental health conditions like anxiety, depression, and behavioral concerns, and those who screen positive undergo further assessment to find out if CoCM is the right treatment approach for them. The team collaborates to develop a treatment plan which could include recommendations for medication and/or brief treatment by the BHCM. Patient response to treatment is tracked on a registry by the BHCM and used as part of a weekly caseload review with a psychiatric consultant to ensure patients get the care they need.

With its protocol-driven design, CoCM allows PCPs to effectively triage and manage the mental health needs of their pediatric population. They receive support in treating patients with mild to moderate symptoms and can readily identify those who require a higher level of care. The streamlined method of caseload review in CoCM also makes effective use of the psychiatric consultant's time, reserving the limited resource for patients who need more intensive care. The impact is especially meaningful in areas with staffing and provider shortages, like NH.

CoCM has the largest evidence base of all integrated behavioral health models.[13] More than 90 randomized controlled trials and several meta-analyses show that it is effective for treating depression, anxiety, and other behavioral health conditions across populations and ages[32-33]; furthermore, CoCM has been shown to reduce disparities in mental health outcomes (compliance, remission, or persistence of symptoms) for people of color.[32-34] It is also easier now to implement than it has ever been before, due to a proliferation of resources for implementation, billing, and legislative policy.

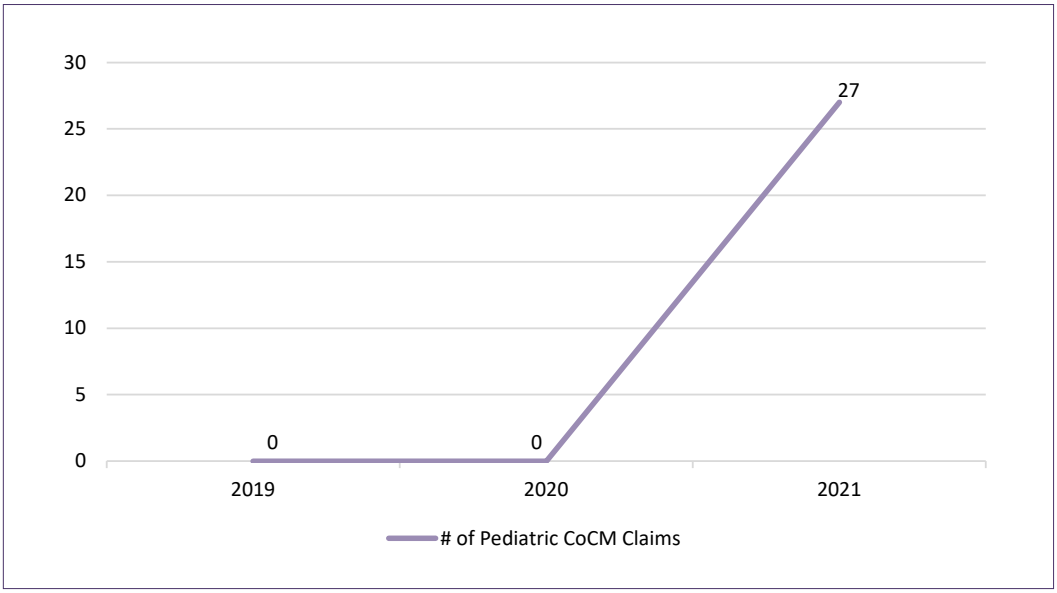
CMS outlines the following requirements to bill CoCM[35]:



Collaborative Care Model in NH

The most recent health care claims data shows that uptake of pediatric CoCM in NH is very low, but had a sharp increase in 2021, as can be seen in Figure 1.[2] This is likely attributable to the high effort associated with implementation and billing coupled with low NH Medicaid rates, described further below.

Figure 1. CoCM Uptake in NH 2019-2021



Data from the Center for Health Analytics claims analysis.[2]

Financial Model

Costs

CoCM requires practice-level change. Implementation costs vary considerably based on factors such as planning, staffing, and technology. In 2019, a study attempting to quantify implementation costs of collaborative care found the total planning and implementation costs for a site ranged from $39,280 to $60,575, including both salary and non-personnel costs.[36] They found that workflow development was the largest cost ($16,325-$31,375), with others including training and other planning activities. It is important to note that the study evaluated implementations in 2015 and that technical assistance resources available to streamline implementation have grown tremendously, including vendors who offer “plug and play” implementation that claim zero up-front costs.

Training	• There is no specific training required to bill CoCM, but training is needed • Practice level: broad understanding of clinical pathway, model delivery, documentation, billing (min. 1h release time) • BHCMs only: registry use, assessment, brief behavioral interventions • Psychiatric Consultants only: registry use, assessment, and treatment
Registry	• Required to bill CoCM • Must be accessible to BHCM, psychiatric consultant, administration (supervision/data) • Does not need to be connected to EHR—not considered clinical record • Options vary in "sophistication, functionality, cost and scalability" and include a spreadsheet, cloud-based application, and custom EHR build[37-38]
Billing	• No specific associated costs, but manual time-tracking processes contribute to staffing costs • No EHR modifications are required to provide and bill for CoCM • Services are bundled over the course of a month; common to use single longitudinal note

Staffing	• CoCM is delivered by collaborative team as defined by CMS[35]
	  • PCP – Physician, nurse practitioner, or physician assistant
	  • BHCM – Formal education or specialized training in behavioral health (including social work, nursing, or psychology). Must be available to deliver services face-to-face and engage patients outside of clinic hours as needed
	  • Psychiatric Consultant – Trained in psychiatry and qualified to prescribe a full range of medications

Flexibility of the Care Team

CoCM codes are billed under the PCP's National Provider Identifier (NPI) for the work of the entire care team. This allows for flexibility in hiring BHCM and psychiatric consultants, since billing does not require them to be empaneled with payers, credentialed within the practice, or licensed within the state. Practices are less impacted by the state's workforce shortages, as they can recruit consultants nationally, and are not limited to licensed clinicians for BHCMs. The billing structure also limits the impact of staff turnover, as practices can resume billing as soon as a position is re-filled. Services can be entirely telehealth as long as the BHCM can deliver face-to-face care as needed.[35] All of these factors allow for flexible staffing approaches, such as contracting with behavioral health organizations, splitting allocations across practices or health systems, or contracting with a CoCM vendor. Practices may choose to expand clinical pathways and associated billing potential by hiring BHCMs with additional training, as shown in Table 2.

Table 2. Comparison of Staff Cost and Billing Potential by Staff Credentials

Credentials	Average Salary[a]	Billing Potential by Code/Service Type		
		CoCM Codes	Psychotherapy Codes	Health & Behavior Codes
Master's Intern	Unpaid	Yes	Yes, with supervision by licensed clinician	No
Bachelor's level care coordinator	$49,790	Yes	No	No
Licensed mental health clinician	$71,200	Yes	Yes	Proposed in CMS 2024 physician fee schedule[39]
Clinical Psychologist	$79,270	Yes	Yes	Yes

[a]Based on 2022 NH salary estimates[40]

Financing Strategies

Billing Coverage and Capacity

CoCM coverage has rapidly expanded in the last few years. In 2020, only 17 states reimbursed CoCM codes under Medicaid; that number is now at 44 states and includes virtually all major commercial payers.[43] Despite widespread coverage, uptake of the codes has been slow nationwide. An analysis of 2019-2021, NH pediatric health care claims data shows that Collaborative Care codes were billed just 27 times across the three-year period.[2] Possible reasons include the administrative burden associated with billing requirements such as variation by plan and the challenge of time tracking.[44]

Billing capacity varies significantly by case load size, payer mix, and service mix. The AIMS Center offers a free, downloadable Financial Modeling workbook that allows practices to enter projections for staffing, caseload, delivery, and payer mix using benchmarks rooted in CoCM expertise.[45] This was used to generate the financial models used in this assessment (see Tables 7 and 8, Appendix 5).

CoCM codes are meant to reimburse the full care team but are generated by the total number of minutes spent by the BHCM only in a given month. Billable activities may be provided in person, by phone, or virtually, and include outreach to patients and families, completing and reviewing assessments, providing brief interventions, conducting case reviews with the psychiatric consultant, updating the registry, and relapse prevention planning.[41-42] Other requirements for billing under CoCM include use of a registry to track treatment, weekly caseload review with a psychiatric consultant, and using treatment monitoring tools. Some payers have additional requirements for care, qualifications, and reporting.[41]

As a benchmark, experts suggest that 90% of CoCM-enrolled patients should meet requirements to generate a bill each month under CoCM (V. Little, PsyD, oral communication, March 29, 2023). Depending on the credentials of the BHCM and the specific services provided, there are opportunities to bill for the remaining 10% of services provided such as screening, psychotherapy, General Behavioral Health Integration codes, or Health and Behavior Codes (see Table 2).

Policy Strategies

CoCM is reimbursed by the payers covering the majority of children in NH.[43] However, current NH Medicaid rates for CoCM are among the lowest in the nation, ranging from 39-115% of Medicare rates (see Appendix 2).[13] To expand availability of integrated care models, Medicaid rates should pay at least Medicare rates[46]; low reimbursement rates impact provide uptake and associated access to care for underserved communities.[13,46]

> *Alignment with Medicare guidelines can increase provider uptake by reducing administrative burden and improving financial viability, leading to better outcomes for kids.*[13,41]

Implementation Considerations

Registry Development & Management

A registry can be developed in a spreadsheet or caseload management application, or custom built into the EHR. It should be able to track clinical outcomes, patient progress, and engagement, and facilitate efficient and systematic caseload review.[38] The BHCM, psychiatric consultant, and supervisory staff must have access. Time spent managing the registry can be included in monthly billing totals, but an inefficient system will reduce time directly available to patients.

Workflow

Collaborative care requires significant revision of practice workflows like identifying appropriate clinical pathways, consent and referral to CoCM, communication across the care team, documentation, and billing procedures. A review of CoCM program implementation found that a common factor of the most successful teams was that they had sufficient time to build infrastructure and workflows.[36] Resources to support these changes are free and publicly available via the AIMS Center.[47]

Reimbursement

It is critical that the treatment team and billing staff have a strong understanding of the requirements associated with collaborative care codes. Several organizations have developed free written materials to help with the process, including the AIMS Center and American Psychological Association (APA).[43,48] Practices also need an effective system for time tracking, such as the EHR, a registry, or manual system.[41] Lastly, practices must have a process prepared to track denials and advocate with payers. Since CoCM codes have a relatively low uptake rate nationwide, many payers are inexperienced reimbursing the codes.[32,41]

Legal

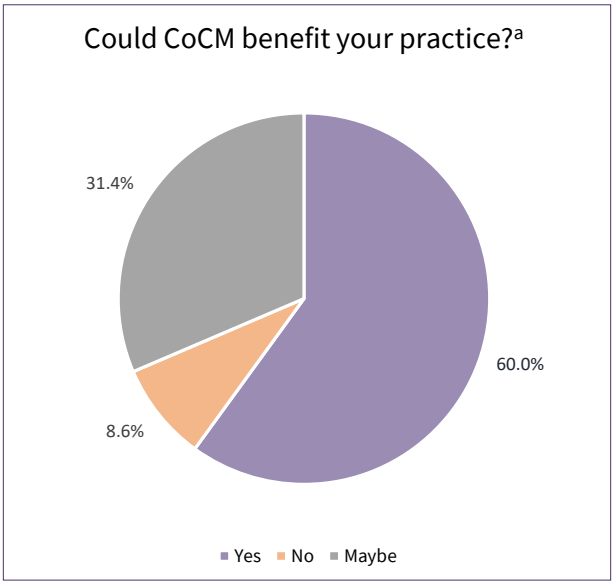
The APA released a document which outlines liability and risk management considerations for the delivery of CoCM.[31] These include review of state-specific regulations, privacy, security, safety, informed consent, documentation, contract, and the role of the psychiatrist. With reference to medical malpractice liability, psychiatric consultants are encouraged to use a disclaimer in their written recommendations explicitly stating that recommendations are based on consultations and available information and that the consultant has not personally examined the patient.[31]

Discussion & Recommendations

Broad changes are needed to meaningfully address mental health access in pediatric primary care across New Hampshire. To reduce the strain on specialty behavioral health, PCPs must be equipped to universally screen all pediatric patients for mental health concerns and have assessment and triage processes in place for those who screen positive. In addition, PCPs need training and support to manage mild to moderate presentations of common pediatric mental health disorders and the ability to refer more complex or severe presentations to specialty behavioral health practitioners.

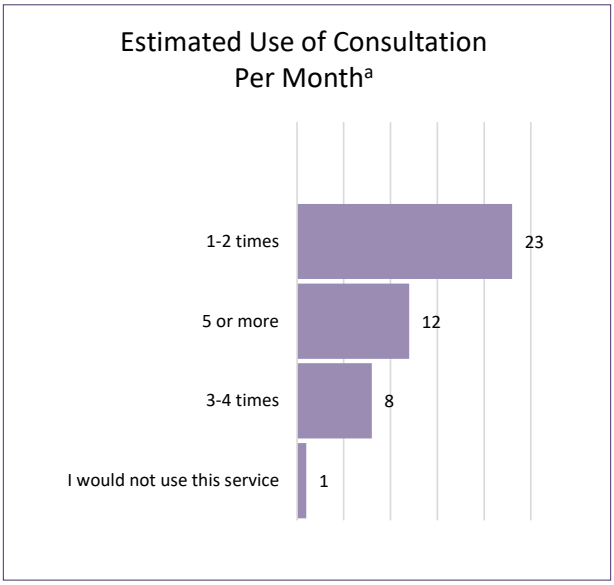
These changes require time and resources to implement. A combined approach of CoCM and an Access Program would contribute significantly to facilitating systemic change to care access in NH and support immediate needs. CoCM, as a protocol-driven model, provides the structure to support long-term practice change and improved patient outcomes, while an Access Program can provide immediate support and improve the provider experience.[16,49] As shown in Figures 2 and 3, both models are popular among pediatric PCPs in the state.[1]

Figure 2. NH Pediatric PCPs Perceived Benefit of CoCM



[a]Data from the Current State Assessment.[1] Full question states "Do you think the Collaborative Care Model (CoCM) could be beneficial to your practice?"; n=35

Figure 3. NH Pediatric PCPs Self-Estimated Use of Consultation



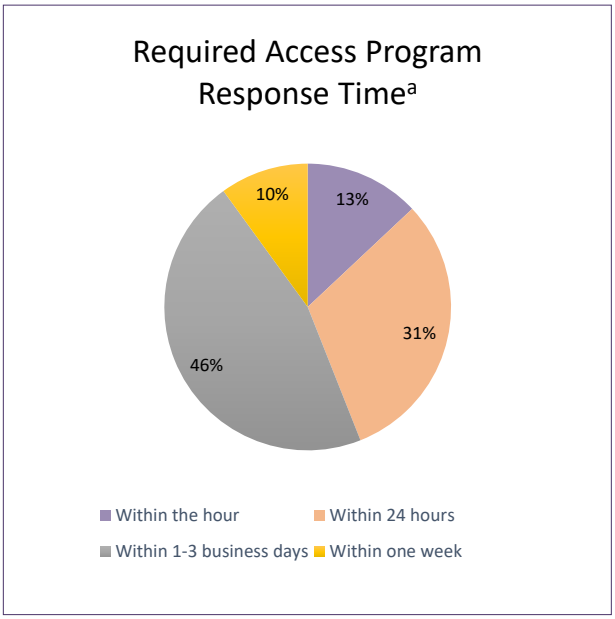
[a]Data from the Current State Assessment.[1] Full question states "How quickly would you require a response from an external provider to provider consultant for it to be helpful to you?"; n=44.

Access Program

Modality & Structure

The pediatric PCPs surveyed prefer live phone call as an Access Program modality, with 2/3 preferring phone consults over e-consults.[1] The majority did note that responses did not need to be immediate (<24h) to be helpful (see Figure 4). NH could minimize costs by using a messaging system or administrative staff member to receive calls and maintaining a response window of 24-48 hours for on-call CAPs.

Figure 4. Required Access Program Response Time



[a]Data from the Current State Assessment.[1] Full question states "How quickly would you require a response from an external provider to provider consultant for it to be helpful to you?"; n=44.

State Models with Comparable Population and Associated Demand

Delaware Child Psychiatry Access Program[a]

- Volume: 16-24 consults per month
- Workflow: Care Coordinator answers calls and provides care coordination/ outreaches CAP
- Staffing:
  - Care Coordinator (1FTE): answers calls, coordinates CAP referrals and record-sharing, marketing and recruitment, manages referral database
  - Program Manager: operational and financial oversight
  - CAP: per diem; contracted to respond w/i 24h

Rhode Island Psychiatry Resource Network[50]

- Volume[b]: 18 consults per month
- Workflow: Administrative staff triage calls and refer to care coordinator or CAP; documented in EHR; note sent to requesting PCP
- Staffing[50]:
  - Care Coordinator (0.5FTE): scheduling, chart preparation, data collection

Sources:
[a]J.A. Hughes, Delaware Child Psychiatry Access Program, oral communication, March 13, 2023
[b]S. Hagin, PhD, Rhode Island Hospital, email communication, August 28, 2023

Financing

As discussed in the funding strategies section, there are billing codes to support an Access Program; however, they are not currently covered by NH Medicaid. Billing these codes would result in a patient copay, which may impact provider utilization, patient access, and equity. It is also not financially feasible as a standalone financing strategy, as shown in Tables 3 and 4.

In order to operate an Access Program as cost neutral through billing, commercial volume would need to compensate for the lack of Medicaid reimbursement (see Table 3). As shown, this would require an untenable 770.78 consults per week.

Table 3. Achieving Access Program Cost Neutrality Through Billing

Payer	Average Rate Per Consult[a]	Required Annual Service Volume[b]	Annual Revenue[c]
Medicaid	$0	22,098.33	$0
Commercial	$39.77	14,128.44	$561,888.00
	Totals	36,226.77 (770.78/wk[d])	$561,888.00
			Annual Cost[e]
		Staffing Expenses	$505,708.00
		Other Operating Expenses	$56,180.00
		Total Expenses	$561,888.00
		Net Total	**$0**

[a]Average rate for CPT codes 99446-99449. See 'Average Rate', Appendix 2
[b]Based on service volume needed to achieve cost neutrality using average rates (see Appendix 2) with consideration for 2021 payer mix (see Appendix 3)[2]
[c]Projected revenue needs based on program costs (see Appendix 1)
[d]Based on 47 work weeks per year
[e]See Appendix 1

Table 4 uses estimated Medicaid rates, based on what NH Medicaid tends to pay relative to Medicare, to illustrate how required service volume would change if NH Medicaid expanded coverage.[51] As shown, this results in an estimated 371.16 consults per week which is unmanageable without increasing staffing and associated costs.

Table 4. Billing Using Estimated Medicaid Rates, If Covered

Payer	Average Rate Per Consult[a]	Required Annual Service Volume[b]	Annual Revenue[c]
Medicaid	$28.72	11,934.25	$342,751.68
Commercial	$39.77	5,510.09	$219,136.32
	Totals	17,444.34 (371.16/wk[d])	$561,888.00
			Annual Cost[e]
		Staffing Expenses	$505,708.00
		Other Operating Expenses	$56,180.00
		Total Expenses	$561,888.00
		Net Total	**$0**

[a]Average rate for CPT codes 99446-99449. See 'Average Rate', Appendix 2
[b]Based on service volume needed to achieve cost neutrality using average rates (see Appendix 2) with consideration for 2021 payer mix (see Appendix 3)[2]
[c]Projected revenue needs based on program costs (see Appendix 1)
[d]Based on 47 work weeks per year
[e]See Appendix 1

Instead, NH might consider establishing an assessment fee on NH health insurance carriers and self-insured plans to cover the operating costs of the Access Program, as Washington has done.[52] By applying a calculated rate on the reported number of children and adolescents covered by the carrier or plan, the cost of care- and children's access to care- could be distributed equitably (see Table 5).

Table 5. Distribution of Access Program Costs Through Assessment Fee

Payer	% Covered Lives[a]	Total Assessed Amount[b]
Medicaid	61%	$342,751.68
Commercial	39%	$219,136.32
	Total Annual Revenue	$561,888.00
		Annual Cost[c]
	Staffing Expenses	$505,708.00
	Other Operating Expenses	$56,180.00
	Total Annual Expenses	$561,888.00
	Net Total	**$0**

[a]Based on 2021 members who meet selection requirements of at least 9 months of enrollment, NH resident, and less than 18 years of age[2]
[b]Represents total projected costs distributed across percentage of covered lives[2]
[c]See Appendix 1

There are several policy options NH could consider to implement this fee. One potential option is to modify statute to carve out a portion of the Insurance Premium tax (P. Sletten, MPA, NH Fiscal Policy Institute, oral conceptual conversation, August 13, 2023). This carve-out could then be used to create a non-lapsing fund dedicated to the Access Program. A second option could be to modify the cap of the High-Risk Pool and allocate additional funds raised to the Access Program (P. Sletten, MPA, NH Fiscal Policy Institute, oral conceptual conversation, August 13, 2023).

Collaborative Care Model

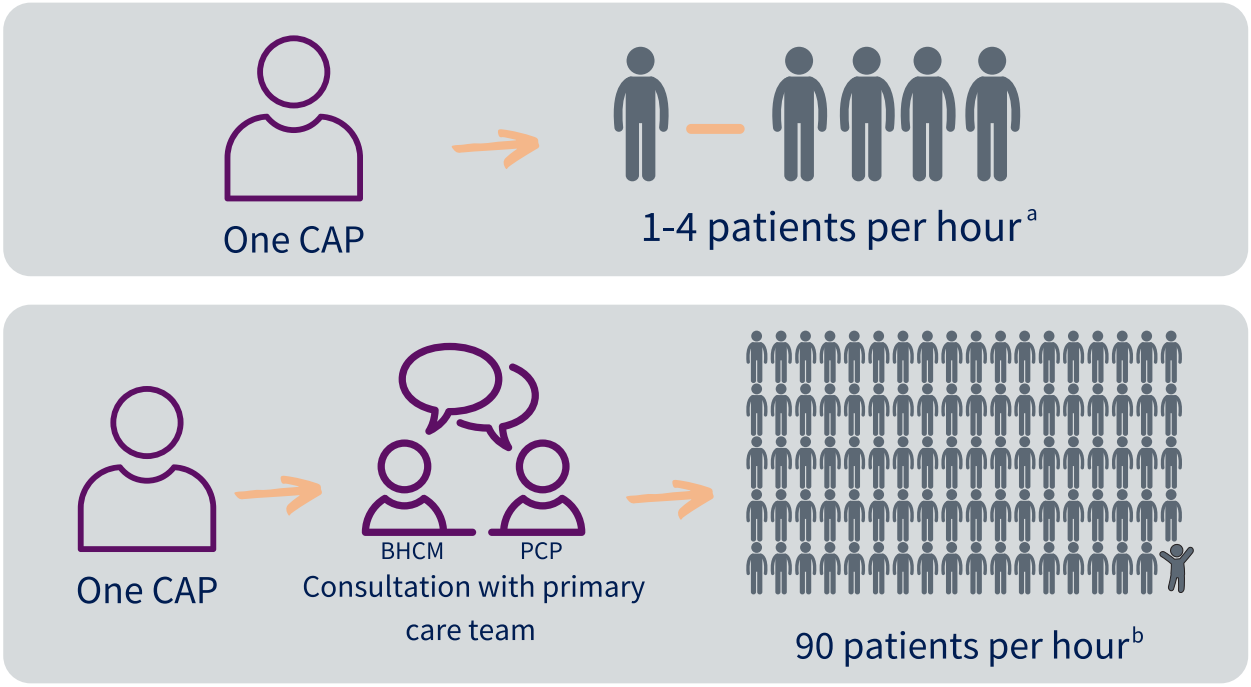
Most of the barriers associated with CoCM are related to implementation and do not persist beyond that stage. As seen in other states, health systems are more likely to buy into CoCM program development if they have access to technical and financial assistance.[13]

Exemplary State Funding Strategies	
TX	• Leveraged philanthropic grant funding and American Rescue Plan Act funds to support implementation and technical assistance.[13]
WA	• Developed per member per month (PMPM) case rate for patients on active CoCM caseload with pay-for-performance payment opportunities.[13]
Exemplary State Implementation Strategies	
NC	• Formed Medicaid-led Consortium which successfully advocated for alignment of billing requirements and coverage across payers and increased managed care organization rates to 120% of Medicare; • Provide no-cost practice coaching, peer learning, and educational programs; • Maintains directory of psychiatry consultants interested in providing CoCM; • Provides no-cost access to state-specific web-based registry tool.[13]
NY	• Requires certification by state Medicaid office prior to initiating billing in effort to reduce denials and ensure to ensure fidelity to model[41]; • Provides access to free, tailored technical assistance and implementation support and discounted training; • Provides access to state-specific web-based registry tool – no-cost in first year and discounted thereafter.[13]
WA	• Provides access to registry tool for participating health systems[13]; • Requires attestation that practice meets all CoCM requirements prior to billing to ensure fidelity to model.[41]
MT	• Provide phase-based implementation support to cohorts of practices based on progress toward implementation (e.g., planning, early implementation, sustainability); practices must meet specific goals within designated time frame to progress to next phase (V. Little, PsyD, oral communication, March 29, 2023).

Impact on Access

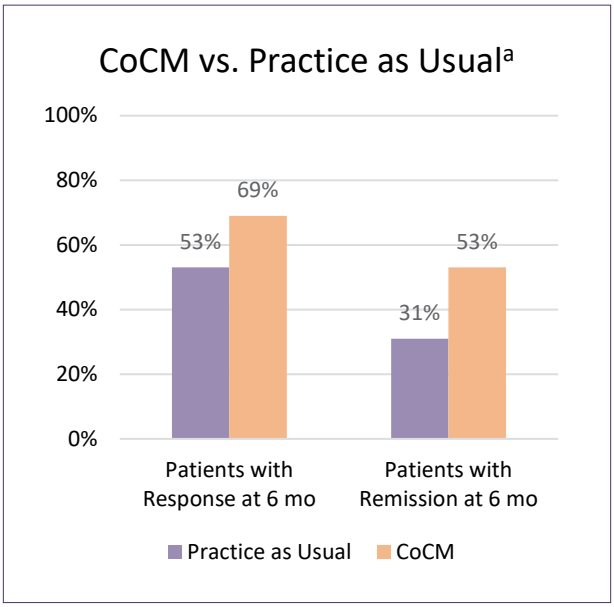
Though NH will likely continue to experience workforce issues and resource shortages, CoCM represents a realistic and practical strategy for improving care access for youth statewide. It does not rely on a workforce that does not yet exist but instead uses existing staff to their maximum potential. By leaning on the protocol-driven structure of CoCM, NH could maximize the impact of bachelor's level staff and the limited reserve of CAPs. Figure 5 shows how the addition of one BHCM (1FTE) can enhance the number of children supported by a CAP (0.04FTE). In addition to serving more kids, CoCM provides better treatment than practice as usual, as shown in Figure 6.[49]

Figure 5. Estimated Maximization of CAP Resource



[a]Based on 15-60 minute visits
[b]Represents the number of patients being managed on a BHCM caseload, reviewed with CAP during weekly caseload review (V. Little, PsyD, oral communication, March 29, 2023). Use of registry helps maximize use of this time to ensure all patients are reviewed and high-priority patients are discussed.[53]

Figure 6. Comparison of Outcomes of CoCM With Practice as Usual



[a]Adapted from Shippee et al.[49]; response to treatment for depression defined as 50% or greater reduction in PHQ9 score and remission for depression defined as a PHQ9 score <5.

Financing

Analysis shows that CoCM reimbursement exceeds projected costs when calculated with the payer mix of all NH youth (see Table 7). CoCM may be less financially feasible for practices that serve a higher rate of youth insured by NH Medicaid. Table 8 shows how alignment with Medicare rates could improve reimbursement potential.

Figure 7. Estimated Net CoCM Financial Impact of One Team[a] Based on NH Rates

Payer	Average Monthly Case Rate Per Patient[b]	# Case Rates Billed Per Year[c]	Annual Revenue
Medicaid	$56.27	684	$38,345.70
Commercial	$163.67	432	$71,312.68
	Totals	1116	$109,658.38
			Annual Cost[d]
		Staffing Expenses	$81,030.00
		Other Operating Expenses	$9,003.00
		Total Expenses	$90,033.00
		Net Total	**$19,625.38**

[a]Refers to BHCM (1FTE), CAP (0.04FTE), PCP (cost/revenue not included)
[b]Based on calculated estimated monthly billing rate per payer (See Appendix 5)
[c]Based on point in time caseload of 90 with 90% billable at end of each month and 2021 payer mix applied (V. Little, PsyD, oral communication, March 29, 2023)[2]
[d]See Appendix 1

Figure 8. Potential Net CoCM Financial Impact of One Team[a] Based on Medicare Rates

Payer	Average Monthly Case Rate Per Patient[b]	# Case Rates Billed Per Year[c]	Annual Revenue
Medicare	$134.38	1116	$149,968.08
		Total Revenue	$149,968.08
			Annual Costs[d]
		Staffing Expenses	$81,030.00
		Other Operating Expenses	$9,003.00
		Total Expenses	$90,033.00
		Net Total	**$59,935.08**

[a]Refers to BHCM (1FTE), CAP (0.04FTE), PCP (cost/revenue not included)
[b]Based on calculated estimated monthly billing rate per payer (See Appendix 5)
[c]Based on point in time caseload of 90 with 90% billable at end of each month and 2021 payer mix applied (V. Little, PsyD, oral communication, March 29, 2023)[2]
[d]See Appendix 1

Summary of Recommendations for NH

Strategy 1: Pilot a low-cost, high-impact Access Program design and gather volume data to support policy change.
Provide telephonic consults with 24-48 hr CAP response window; contract with a CAP provider group to allow the program to scale as demand increases and support the program's ability to document consultations and bill, as desired; include students and residents to develop NH workforce and reduce program costs; contract with an evaluator for data collection and programmatic evaluation. *Funding source: HRSA PMHCA grant funding 2023-2026*

Strategy 2: Incentivize and support uptake of CoCM by increasing opportunities for implementation support.		
Pilot impact of provision of no-cost registry tool and technical assistance on willingness/experience with implementation *Funding Source: HRSA PMHCA grant FFY 2024-2026*	Provide access to registry tool for first year to incentivize implementation *Funding Source: Identify philanthropic and federal grant opportunities*	Provide technical assistance using phased cohort model: preparation, early implementation, sustainability *Funding Source: Identify philanthropic and federal grant opportunities*

Strategy 3: Explore increased reimbursement potential for CoCM	
Explore increase of Medicaid rates to align with Medicare (see Tables 7 and 8) *Funding Source: Leverage Affordable Care Act Home Health provision and FMAP[23]; consider costs offset*	Consider pay-for-performance metrics associated with percent of children assessed for and enrolled in CoCM *Funding Source: Leverage Affordable Care Act Home Health provision and FMAP[23]; consider costs offset*

Strategy 4: Explore a quarterly assessment fee on health insurance carriers and self-insured plans to fund an Access Program.
Consider applying a calculated rate on the reported number of children and adolescents covered by the carrier or plan, as has been done in other states, to cover the costs of the Access Program. *Funding source: Health insurance carriers and self-insured plans*

Conclusion

New Hampshire is experiencing a gap between a high level of need for youth behavioral health treatment and a lack of such services, due to both a shortage of providers and other systemic factors that limit patient access. Broad implementation of pediatric CoCM and a Child Psychiatric Access Program is a realistic strategy to fill that gap without adding significant strain to an already overtaxed workforce. The two models complement each other, filling different niches in supporting NH's care system in a time when it is greatly needed. CoCM promotes systemic change that would increase PCP capacity to respond to behavioral health issues on a larger scale. It is sustainable through billing but takes significantly more time and resources to implement than an Access Program. Conversely, an Access Program takes significantly less investment to implement and can serve as a support to providers during the implementation of CoCM and as an additional resource beyond that. It also serves as a safety net for those who are, for one reason or another, not eligible for a CoCM program. Though an Access Program is not feasible through billing in NH, alternative funding sources are proposed in this report.

The discrepancy between demand for youth behavioral health treatment and capacity is unlikely to be resolved in the short term, but these models offer a way to close the gap by maximizing the current workforce. Implementation is much more feasible today than it was even a few years ago, with substantial technical assistance available as well as a variety of existing state programs to model after. State partners can play a role in expanding access to care through activities like engaging and educating policy leaders, promoting integration across care settings, and connecting with NH Citizens Health Initiative or the variety of other resources within this report. The need for youth behavioral health treatment in NH is severe, but it can be improved by expanding and reinforcing the capacity of primary care.

Abbreviations

Access Program- Child Psychiatry Access Program

AIMS Center- Advancing Integrated Mental Health Solutions Center

APA- American Psychological Association

BHCM- Behavioral Health Care Manager

CAPs- Child and Adolescent Psychiatrists

CMS- Centers for Medicare & Medicaid Services

CoCM- Collaborative Care Model

CPT- Current Procedural Terminology Codes

ECHO- Extension for Community Healthcare Outcomes

EHR- Electronic Health Record

FTE- Full-Time Equivalent

HRSA- Health Resources and Services Administration

IHPP- Institute for Health Policy and Practice

NHMCAP- New Hampshire Mental Healthcare Access in Pediatrics

NH PIP- New Hampshire Pediatric Improvement Project

PCP- Primary Care Provider

PMHCA- Pediatric Mental Health Care Access

PMPM- Cost per member per month

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Appendix 1: Data Used for Cost Projections

Access Program Operating Expense per CAP FTE	Salary[a]	Fringe (37%)	Totals
CAP (1.0 FTE)	$233,920	$86,550	$320,470
Administrative Assistant (1.0 FTE)	$43,110	$15,951	$59,061
Program Manager (1.0 FTE)	$92,100	$34,077	$126,177
Data Collection & Evaluation	$0	$0	$56,180[b]
		Total	**$561,888**

[a]Based on 2022 NH salary estimates[38]
[b]Represents approximately 10% of total program costs[52]

CoCM Operating Expense per BHCM Team	Salary[a]	Fringe (37%)	Totals
CAP (0.04 FTE)	$9,356	$3,462	$12,818
Care Coordinator (1.0 FTE)	$49,790	$18,422	$68,212
Data Collection & Evaluation	$0	$0	$9,003
		Total	**$90,033**

[a]Based on 2022 NH salary estimates[38]
[b]Represents approximately 10% of total program costs[52]

Appendix 2: Billing Codes and Rates

Interprofessional Collaboration (Access Program)						
Type	**Billing Provider**	**CPT code**	**Description**	**Medicare Rate[a]**	**Actual[b] and Estimated[c] NH Medicaid Rate**	**Average[d] and Estimated[e] Commercial Rate**
		99446	5-10 min consult	$19.50	Actual: Not covered	Actual: Unknown
					Est: $11.70	Est: $16.66
		99447	11-20 min consult	$38.21	Actual: Not covered	Actual: Unknown
					Est: $22.93	Est: $32.40
		99448	21-30 min consult	$57.20	Actual: Not covered	Actual: $49.00
					Est: $34.32	
		99449	> 30 min consult	$76.55	Actual: Not covered	Actual: $61.00
					Est: $45.93	
Without Discussion	Consulting Provider	99451	> 5 min consult	$37.20	Actual: Not covered	Actual: $80.00
					Est: $22.62	
Time spent preparing for referral and/or communicating with consultant	Treating Provider	99452	16-30 min preparing referral and/or communicating with consultant	$38.57	Actual: Not covered	Actual: Unknown
					Est: $23.14	Est: $82.25
			Average Rate[f] 99446-99449	**$47.87**	**$28.72**	**$39.77**

[a]Based on 2022 Medicare average rate[49]
[b]Based on 2023 NH Medicaid fee schedule[53]
[c]Estimated rate based on amount NH Medicaid tends to pay relative to Medicare[49]
[d]Average allowable amount across NH commercial payers in years 2020 and 2021[2(p202)]. Unknown denotes there were no commercial claims for these codes in 2019, 2020, or 2021 that met the requirements of: under 18 years old, NH resident, and continuous eligibility of at least 9 months.
[e]Estimated rate based on amount Medicare and commercial payers pay relative to available rates[2]
[f]Calculated using actual amount when available and estimated amount when not available for CPT codes 99446-99449

Collaborative Care Model (CoCM)				
CPT code	**Description**	**Medicare Rate[a]**	**NH Medicaid Rate[b] (Percent of Medicare)**	**NH Commercial Rate[c] (Percent of Medicare)**
G2214	30 min/mo for initial or subsequent mos CoCM	$57.19	$65.77 (115%)	$75.00 (131%)
99492	Initial psych care mgmt., 70 min/mo, CoCM	$147.12	$59.94 (41%)	$182.00 (124%)
99493	Subsequent psych care mgmt., 60 min/mo CoCM	$139.18	$53.97 (39%)	$182.00 (131%)
99494	Initial/subseq psych care mgmt., add'l 30 min CoCM	$56.53	$28.89 (51%)	$27.00 (48%)
99484	Care mgmt. services, 20 min/mo-General BHI	$41.99	$21.50 (51%)	$46.00 (110%)

[a]Based on 2023 Medicare non-facilities payment[54]
[b]Based on 2023 NH Medicaid fee schedule[53]
[c]Based on average allowable amount across NH commercial payers in 2021[2]

Appendix 3: Payer Mix

Percent of All Covered[a] NH Children by Insurer Type, 2021

Insurer Type	Eligible Enrollees, 2021	Percent of Covered NH Children, 2021
All Commercial	59,683	39%
All NH Medicaid	91,707	41%

Tables adapted from Swanson, et al[2]
[a]All children insured commercially or by NH Medicaid

Appendix 4: Washington State Bill Authorizing Assessment Fee

WAC 182-110-0100 General.[55]

(1) The Washington state health care authority (authority), the University of Washington department of psychiatry and behavioral sciences, and Seattle children's hospital administer the partnership access lines described in RCW 71.24.061, relating to mental health services for children and the treatment of depression in pregnant women and new mothers.

(2) The authority and the University of Washington department of psychiatry and behavioral sciences administer the psychiatric consultation line described in RCW 71.24.062 to give certain providers on demand access to psychiatric and substance use disorder clinical consultation for adult patients.

(3) The authority or its designee:

(a) Determines the administrative costs for each program identified in subsections (1) and (2) of this section;

(b) Calculates the proportion of clients that are covered by programs administered under chapter 74.09 RCW; and

(c) Collects a proportionate share of program costs that are not for covered lives from the assessed entities under contract with the authority as Medicaid managed care organizations.

[Statutory Authority: RCW 41.05.021, 41.05.160, 71.24.061, and 71.24.062. WSR 21-07-013, § 182-110-0100, filed 3/4/21, effective 4/4/21.]

Appendix 5: Assumptions Used in CoCM Financial Model

All assumptions are based on calculations made using the AIMS Center Financial Modeling Workbook, unless otherwise stated.[43]

Caseload and Case Volume Capacity	
Single Point in Time Caseload Capacity	90[a]
Average Weeks Between First and Last Patient Contacts	28[a]
Average Count of Patient Care Services Provided	21
Projected Annual Caseload Capacity	166
Projected Annualized Monthly Case Rate Potential	1,241
Estimated Average Monthly Billing Rate	
Projected Number of Patients Served per Calendar Month	117
Percentage of Patients Billable via CoCM Codes per Calendar Month	90%[a]
Total Number of Medicaid Patients Billable via CoCM (61%)[2]	57
Total Number of Commercial Patients Billable via CoCM (39%)[2]	36

[a]V. Little, PsyD, oral communication, March 29, 2023

Monthly Service Mix	
Code	**Percent of Eligible Patients Per Month**
Not seen/threshold not met	10%
30 min ANY month (G2214)	10%
70 Initial Month Minutes (99492)	20%
100 Initial Month Minutes (99492) + (99494)	3%
130 Initial Month Minutes (99492) + (99494*2)	2%
60 Subsequent Month Minutes (99493)	45%
90 Subsequent Month Minutes (99493) + (99494)	5%
120 Subsequent Month Minutes (99493) + (99494*2)	5%