

PSYCHOTHERAPY CARVEOUT IN COMPREHENSIVE COMMUNITY SERVICES (CCS) PROGRAM

CURRENT CHALLENGES & POLICY RECOMMENDATION



Wisconsin Primary Health Care Association

SUMMARY

WPHCA and Community Health Centers recommend that DMS enable **Community Health Centers to be reimbursed by Medicaid for providing psychotherapy services to patients, regardless of enrollment status in the Comprehensive Community Services (CCS) program** as a pragmatic step to minimizing barriers of care for patients and enabling more meaningful partnership between County CCS programs and Community Health Centers.

BACKGROUND

COMMUNITY HEALTH CENTERS & BEHAVIORAL HEALTH SERVICES

Community Health Centers deliver high-quality primary medical, oral health, and behavioral health care, including substance use disorder (SUD) treatment and recovery services. Community Health Centers provide this comprehensive array of primary care services to patients with complex needs, including patients living in underserved areas, special populations (e.g., patients experiencing homelessness), and serve patients regardless of their insurance status or ability to pay. Community Health Centers' integrated, patient-centered, culturally appropriate, and team-based approach to care supports the coordination of patient care across the health system. There are currently 19 HRSA-designated Community Health Centers in Wisconsin with 208 service delivery sites. (2021 Wisconsin Community Health Center Data).

In response to the urgent unmet need for behavioral health services across the state, Community Health Centers are committed to creating greater access to care by integrating and expanding behavioral health services within primary care settings. In 2021, Wisconsin Community Health Centers provided over 186,000 behavioral health visits, including visits for mental health and SUD recovery and treatment. In an effort to expand access to patients in both rural and urban areas, 48% of these visits were virtual.

Community Health Centers provide a robust array of behavioral health services including brief behavioral health interventions, outpatient psychotherapy and counseling, group therapy school-based behavioral healthcare services, comprehensive medication assisted recovery programs, and more to both children and adults. Community Health Centers have evolved their services in response to their community's needs. For example, some Health Centers in Wisconsin have invested in developing intensive outpatient SUD and BH services, while others have adopted integrated models of primary medical and behavioral health care that focus on providing brief action-oriented behavioral health interventions. One Community Health Center, Family Health Center of Marshfield, is participating in a hub-and-spoke demonstration site.

CCS AND COMMUNITY HEALTH CENTERS

Similar to the Community Health Center model, Comprehensive Community Services (CCS) is designed to support a team of coordinated providers in delivering care to individuals with complex needs. Both CCS and Community Health Center models aim to provide the right service to the right person at the right time in a way that manages risks for the patient, prioritizes time for care teams to listen and deeply understand the needs of a patient, and focus on developing and facilitating a comprehensive plan of care for patients that leverages a wide array of community resources to meet patient needs. Although CCS has a narrower population focus than Health Centers, the alignment in service models and significant overlap in patients served creates a natural opportunity for alignment between Health Centers and CCS.

Community Health Centers in Wisconsin are currently working with County CCS programs at varying service levels including co-located services, contracted service models (e.g., a Community Health Center is contracted with CCS to provide medication assisted treatment), and referrals for care. Complexity regarding the interplay between CCS and Health Center reimbursement models has made it challenging to develop sustainable pathways for more integrated and coordinated services via contractual relationships.

Today, Community Health Centers are unable to be reimbursed for psychotherapy services for patients who are also enrolled in the CCS program. This brief describes Wisconsin Medicaid's "Psychotherapy Carveout" policy, highlights the impact of this policy on Medicaid members and Community Health Centers, and offers a recommendation to address the issue to improve services for patients.

CHALLENGES

"THE PSYCHOTHERAPY CARVEOUT"

ForwardHealth Memo 2014-42 outlines that Medicaid members enrolled in a CCS program must receive outpatient psychotherapy services, through the CCS program and these services will not be reimbursed separately under any other Medicaid or BadgerCare Plus benefit per DHS 107.13(7). In other words, if a Medicaid member enrolls in a CCS program, they no longer have coverage for outpatient psychotherapy services from providers outside of the CCS program (such as Community Health Centers). Under current interpretation, Community Health Centers do not have a sustainable reimbursement pathway to providing psychotherapy services, unless contracted as a part of the CCS program.

Outpatient psychotherapy services, as well as adult mental health day treatment, are the two service types that Medicaid requires to be exclusively provided by the CCS program. Other services provided in CCS program, such as Medication Assisted Treatment (MAT) and substance use disorder (SUD) counseling, are not carved out as an

as Medication Assisted Treatment (MAT) and substance use disorder (SUD) counseling, are not carved out as an exclusive CCS service under Medicaid coverage.

In practice, the psychotherapy carveout causes confusion and disruptions in patient care, creates barriers for Community Health Center providers in treating new or existing patients, and limits the opportunities for CCS teams to compliment the care that has developed around the patient prior to CCS enrollment.

BARRIERS FOR PATIENTS

- **Limiting Patient Choices & Access to Providers:** If a patient is enrolled in CCS, they are not guaranteed coverage for outpatient psychotherapy services if provided by a non-CCS contracted provider. With the threat of potentially needing to pay out-of-pocket, patients are unlikely to pursue or continue receiving services from a provider who is not covered by BadgerCare. Although CCS may provide the right level of care and open the doors for patients to get their needs met, it can also have the unintended consequences of limiting a patient's options and resources for behavioral health care support. This can be confusing and frustrating for patients, especially those who have established a relationship with an existing non-CCS provider.
- **Continuity of Care:** A trusting relationship between a behavioral health provider and patient is an integral part of delivering care. Several studies have shown that strong provider-patient relationships can promote recovery, reduce relapse, and enhance treatment adherence.¹ Continuity of care with an established provider and/or team can be a critical support for a patient and creates an opportunity that the CCS program can leverage in the development of a patient-centered care plan. Unfortunately, when patients enroll in CCS they may need to end their relationship with their existing behavioral health provider or team during a period of increased severity of their condition and needs. Discontinuity of meaningful care relationships are detrimental to patient care and recovery, unnecessarily restrict care within a primary care context at Health Centers and limit the effectiveness of the CCS program to stabilize an individuals' mental health and substance use concerns by meeting their unique needs.
- **Diminishes Access to Whole-Person Integrated Primary Care:** Many Community Health Centers provide integrated primary medical care and behavioral health services. Integrated models, like the Primary Care Behavioral Health Consultant Model (PCBH) and Collaborative Care Model (CoCM), extend behavioral health care providers into the primary care team to manage patient's behavioral health concerns and biopsychosocial influenced health conditions, such as diabetes. Integrated care models focus on prioritizing and resolving behavioral health-related issues as a routine part of primary care with the goal of early identification, quick resolution, long-term prevention, and wellness for as many patients as possible. In some cases, integrated behavioral health care models also serve as a front door for patients to access a higher-level of care, provide a bridge between care transitions, and offer timely access to behavioral health care to meet their most pressing needs alongside other supports a patient is receiving. Integrated behavioral health care models within primary care provide a uniquely different service than the more intensive, long-term outpatient psychotherapy services provided through CCS. However, behavioral health encounters within a primary care setting are coded as psychotherapy visits (typically using the 90832 code), and these types of integrated behavioral health care interactions are not covered by Medicaid when a patient is enrolled in CCS.

CHALLENGES FOR COMMUNITY HEALTH CENTER PROVIDERS

- **Disruptions in Implementing a Coordinated Team-Based Approach:** Community Health Centers are committed to supporting patients to identify and access the right level of care to meet their needs. Nevertheless, a patient's enrollment in CCS often results in a patient losing access to their established behavioral health provider or team at the Community Health Center, instead needing to switch to a CCS provider. This results in an unnecessary fragmentation of a provider team who are wrapping services around the patient. For example, a patient may continue their medical care with the Community Health Center but discontinue their outpatient mental health services. It's also possible that the patient's intensive recovery services, like Medication Assisted Treatment (MAT), may continue at the Community Health Center and psychotherapy would occur at the CCS provider. In both of these situations, a patient has experienced an unnecessary barrier and the team has been fragmented. Community Health Centers are investing in developing a continuum of care that provides multiple services under one roof, through a coordinated team. When a patient needs to cease outpatient psychotherapy services at a Community Health Center and seek those services from a CCS provider instead, this fragments the whole-person health approach that Community Health Centers are implementing.
- **CCS Enrollment Verification:** Community Health Centers do not currently know whether their patients are enrolled in the CCS program unless a patient proactively informs their provider. Health Centers are concerned that patients will be responsible for outpatient psychotherapy charges incurred due to care provided at Community Health Centers, given the current restrictions.
- **Provider Shortages & Wait Lists:** Fragmentation resulting from the psychotherapy carveout contributes to growing wait lists for CCS enrollees and unnecessary administrative burdens. Even the process of seeking a new provider and establishing care can be a significant challenge. Providing timely care is important; delays or concerns related to coverage are not beneficial to patient recovery.

POLICY RECOMMENDATION

Enable Community Health Centers to be reimbursed by Medicaid for providing psychotherapy services to patients, regardless of enrollment status in the CCS program. This step would support the integrated teamwork already in place at Community Health Centers and prevent the fragmentation of care when the patient chooses to keep their existing psychotherapy provider. Lifting this restriction is one critical step towards harmonizing practices between two highly needed systems of care; Community Health Centers and County CCS. **WPHCA urges DMS to reissue Forward Health Memo 2014-42 and explicitly remove the psychotherapy carveout rule for Community Health Centers.**

WPHCA and Community Health Centers view this policy change as a pragmatic step to minimizing barriers of care for patients and enabling more meaningful partnership between County CCS programs and Community Health Centers.

**FOR MORE INFORMATION, PLEASE CONTACT MOLLY JONES
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ADDENDUM: PATIENT STORY

All identifiers have been changed.

Robert came to a Community Health Center after 10 years without primary care. He was 55 years old, 30 of which were spent in corrections beginning at the age of 16 for attacking his girlfriend with a knife when under the influence of LSD. He had been in 3 different foster homes and struggled with PTSD. He was neglected and abused as a child and witnessed his father committing murder. As an adult, he struggled with confinement and was still learning to handle freedom - acting out with petty violations of his probation, as he realized, like a 16-year-old in an adult body. He lacked life-skills to integrate into community. He also struggled with hearing voices and suicidal thoughts, especially after his release from prison when he found his brother and sister and mother had all died. He was alone.

His last set of foster parents who had cared for him as a youth and managed to stay in touch – they were his life-line. He wanted, desperately, to show them that he could succeed. He also wanted to experience their faith but was too angry with God for taking his family away.

Through a Community Health Center’s behavioral health service, Robert was stabilized on Seroquel, stopped drinking, and no longer felt suicidal. He also took care of his fiancé who was disabled with a bad arm, helping her every morning by combing her hair to help her get ready for work. Outpatient psychotherapy was the first experience he had of feeling understood and began taking concrete steps to improving his life. He was able to account for his behavior and the adverse childhood experiences that led to incarceration, and a long series of missteps with probation. On paper, he looked like a “loser” and was handled as a lost cause by the courts.

Charges for petty theft were hanging over him. He was mortified with the threat of a return to prison, where he would go back to “living like an animal.” Doomed by his impulsivity, he was actively triggered by the thought of returning to prison and struggled to communicate his situation to the courts. Robert needed a legal advocate, as well as coordinated crisis stabilization supports, life skills training, and integration of his psychiatric and medical services. Robert’s psychotherapist at the Community Health Center discussed the Comprehensive Community Services Program which could offer service facilitation, and a rehabilitation team. He asked if this team could include his old foster parents, and teared up when he learned this was all possible. “It’s like a dream, this is what I’ve always wanted... I can finally show them.”

The only problem was the prospect of separating Robert from his psychotherapist due to the carveout restrictions of the CCS program. His psychotherapist was the one person he learned to trust with his grief and could help him to make sense of his problems. He also saw the potential support of a team and the promise of not having his legal legacy proceed him for the rest of his life. He was forced to make the difficult choice to embrace the team and start over with a new therapist.