Stigma, Reimbursement Remain Barriers to Better Care for Mental Health

Payment challenges, gaps in regulation, hurt patients too

by Shannon Firth, Washington Correspondent, MedPage Today
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WASHINGTON -- Poor reimbursement, workforce shortages, and lax government oversight of mental health parity laws limit access and integration of behavioral health, according to a new report from the Bipartisan Policy Center (BPC).

But of all the barriers to accessing quality and affordable mental health services, stigma may be the most powerful, said Patrick Kennedy, founder of the Kennedy Forum, a mental health and substance abuse advocacy organization.

"If this were any other disease, we'd be running towards the problem, not away from it," he said during a panel discussion on integrating mental and behavioral health into clinical care, hosted Thursday by the BPC.

Authors of the new report said their ideas were to be taken as "policy options" or a "starting point for discussion" rather than as a specific set of recommendations. Kennedy noted that similar reports have been ignored and are now just "sitting on shelves."

"The big narrative here is the lack of political will," said Kennedy, a former Democratic congressman from Rhode Island. "It's the urgency that's missing."

Kennedy said he views mental health parity as a civil rights issue, explaining that the medical system discriminates against patients with mental health and substance use problems. Just as the Civil Rights Act of 1964 didn't end racism, he said, advocates can't force an end to stigma, but they can fight for better laws and better policies.

"It may be another generation before we really make a dent in the stigma issue," he said.

In the meantime, he urged action on expanding mental health parity laws to include the Centers for Medicare and Medicaid Services.

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 was passed to prevent insurers who offer mental health and substance use disorder benefits from "imposing less favorable benefit limitations" for those services than they would for medical or surgical services. But the law hasn't been well enforced, say advocates and stakeholders. The law also currently excludes Medicare and Medicaid.

Medicare, Medicaid Obstacles to Care

Medicaid often has carveouts that separate payment for behavioral health services from medical benefits. One policy option noted in the BPC report would require "full integration" of all services in Medicaid managed care contracts and have such carveouts be phased-out by a certain date.

But "carving in" isn't enough, said Stephen Cha, MD, chief medical officer for UnitedHealthcare Community & State and a former director in the State Innovation Group at the Center for Medicare & Medicaid Innovation (CMMI). Care delivery needs to change, he said.

Kevin Davidson, of MemorialCare Health System in Orange County, California, explained that in his health system, primary care physicians are responsible for a care team that includes a licensed social worker and consulting psychiatrist. The physician screens individual patients and when needed, does a "warm hand-off" to a social worker during that same clinical visit.

The team's consulting psychiatrist typically works with the care team to design a care plan and treatment. The majority of cases involve more moderate mental illness, usually anxiety and depression, and those care plans can be delivered by the primary care team with the advice of the consulting psychiatrist.

Same-day billing also presents an obstacle for providing care to some patients with behavioral health issues. Medicare does not allow reimbursing for more than one evaluation and management (E/M) visit for providers in the same specialty for the same patient on the same day, the report noted. While some states have adopted new policies to allow same-day billing, many have not, panelists explained.

This is a significant barrier to care delivery, they noted, because the chances that someone who's really struggling with mental illness or addiction is going to wait another day, then make another visit, are slim, said Marian Earls, MD, deputy chief medical officer for Community Care of North Carolina.

Others on the panel agreed that making patients come back a second day isn't "person-centered."

Beyond eliminating carveouts and same-day billing, other policy ideas discussed in the report include:

- Eliminating Medicaid's Institutions for Mental Disease exclusion, which prevents Medicaid from paying for a patient with a behavioral health condition to stay in an institution with more than 16 beds
- Expanding mental health parity laws to Medicaid and Medicare
- Expanding and reauthorizing the Certified Community Behavioral Health Clinic demonstration program in Medicaid, which currently operates in eight states
- Extending waivers for face-to-face requirements in Medicare home-health services

Workforce, Access to Care

The BPC report also examined workforce barriers, including a shortage of mental health providers, which has obvious consequences for access to mental health services and integration of care. The U.S. Bureau of Health Professions project that by 2020 about 12,624 child and adolescent psychiatrists will be needed, but only about 8,312 will be in supply.

And according to data from the Substance Abuse and Mental Services Administration (SAMHSA) cited in the report, while over 20% of the nation's population lives in rural areas, three in four rural counties do not have an advanced behavioral health provider.

To help address these challenges, the authors described a number of policy options such as investing in more training for allied mental health professionals, promoting "pipeline programs" at community colleges, and subsidizing training programs at the federal and state level.

In addition, primary care physicians should be encouraged to "weave mental health competencies into their day-to-day practice and develop relationships in their communities with mental health professionals" Earls told *MedPage Today*.

Even if a physician can't integrate a mental health provider into their practice, by developing those relationships, they can learn how to "co-manage" patients, she said.

In most states there's a movement toward value-based payment, especially in Medicaid, and while transforming care at a "onesie and twosie" practice is more challenging than it might be at a multi-center practice, it's important to stay active and engaged in the state chapter of your local medical society, said Earls, and to push for the kinds of support that would help your practice, added Cha.

The BPC report also touched on other policy options such as developing and sharing evidence-based best practices related to telehealth service; promoting behavioral health integration at the undergraduate and graduate level in nursing schools and medical schools; and suggesting the Secretary of Health and Human Services issue guidance to "incentivize or require" that states comply with licensure compacts, which allow clinicians to treat patients across state lines.

Accountability for Private Insurers

Data collection plays a role in enforcing mental health parity, and when there are problems, those need to be highlighted publicly, said panel moderator Chris Jennings, president of the health policy consulting firm Jennings Policy Strategy.

Jennings said that he sees some efforts at the state level, but not as much from the Department of Health and Human Services or the Department of Labor.

"My view is that the law is in place and should be being enforced ... to the extent that more and more people see that it's not [enforced], I think you'll see actions to intervene," he said.

Asked what clinicians can do to advance parity, Jennings urged them to report problems with enforcement.

"Don't just throw up your hands, help us document it," he said, adding that he was pleased to see the American Medical Association's recent report on parity.

At the same time, Jennings said he's noticing that private payers are acknowledging that in the long-term they can't manage their overall health spend without managing their mental health spend.

"What I'm encouraged about is that the provider community and the purchaser community now are seeing the value of integrated care and want to see it ... instituted in a rational, sustainable way," he told *MedPage Today* after the panel.

Insurers are realizing that they want to keep the same enrollees in their plans longer, so that when they do invest in their care, they get a return on that investment, Jennings added.

Kennedy was a bit more critical of insurers and questioned why America's Health Insurance Plans (AHIP) "just hangs back" rather than taking the lead on designing payment models that reward better outcomes for patients with mental and behavioral health issues.

He said there's both the "push and the pull" to move payers to an environment where mental health is no longer seen as not real.

If a "shame factor" will help, he's ready to use that lever too, Kennedy said.