



Advising the Congress on Medicare issues

Behavioral health care and the Medicare program

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Behavioral health disorders

- Include mental health and substance use disorders
- Estimates of prevalence:
 - NAM: 14–20% of all elderly population
 - Depressive disorders and dementia-related disorders most prevalent
 - 30% of beneficiaries self-report a behavioral health disorder
 - Beneficiaries under 65 are much more likely than elderly beneficiaries to have behavioral health disorders
 - 4 times more likely to have schizophrenia
 - 2 times more likely to have major depression or other mood disorders

People with behavioral health disorders have higher mortality rates

- Studies have found that people with behavioral health disorders may die 8 to 30 years earlier than others
- Most frequent causes of death are the same as those of other beneficiaries; e.g., heart disease or cancer

Behavioral health disorders are a risk factor for chronic physical conditions

- Lifestyle—people with mental health disorders are:
 - 2 times more likely to smoke
 - More likely to be sedentary and to have poor diets
 - Frequently have co-occurring substance use disorders
- Treatments for behavioral health disorders can worsen physical health (e.g., antipsychotics)
- People with behavioral health disorders may have more difficulty adhering to treatment for physical conditions
 - *Medicare per capita spending for people with behavioral health disorders is ~2 times higher than average*

The aging process increases vulnerability

- Chronic illness, disability, pain, and grief can cause or exacerbate depression and anxiety
- Drugs commonly prescribed for elderly patients can cause or exacerbate behavioral health issues
- Age-related changes in the metabolism of drugs and alcohol can cause or exacerbate substance use disorders and increase risk of side effects and overdose

Care for people with behavioral health disorders: Systemic problems

- Service delivery that may be shaped more by financing than by best care practices
 - E.g., prohibition on Medicaid reimbursement for services provided to enrollees aged 21 to 64 in freestanding psychiatric facilities (the “IMD exclusion”)
- Shortage of state- and county-owned psychiatric hospitals, which historically have cared for patients who are the most difficult to treat
 - Lack of capacity to serve the most seriously mentally ill patients burdens both the health care system and the criminal justice system

Care for people with behavioral health disorders: Systemic problems, cont.

- Shortages of behavioral health professionals
- Wide variation in the workforce licensed to treat behavioral health disorders, with differing educational and training requirements
- Low rate of clinician adherence to evidence-based medicine
- Poor integration between physical and behavioral health care, which undermines treatment for both

Care for people with behavioral health disorders: Systemic problems, cont.

- Lack of coordination of care, especially after discharge from a psychiatric hospital stay
 - Can place patients at risk for relapse, homelessness, incarceration, and other adverse outcomes
 - Lack of progress in developing meaningful quality measures
 - Patient unwillingness or inability to obtain care
- Medicare's ability to effect significant change in the delivery of behavioral health care may be limited

Improving care for beneficiaries with behavioral health disorders

- Improving payment & outcomes for beneficiaries who need inpatient psychiatric care
- Integrating primary care and behavioral health services

Improving payment & outcomes for inpatient psychiatric care

- Inpatient psychiatric facility (IPF) PPS implemented in 2005
- Overall review of system needed to assess impacts:
 - Changes in use of IPF services
 - Changes in use of post-discharge services, including ED use and readmissions
- Development of policies to encourage better follow-up care after IPF discharge

Integrating primary care and behavioral health

- Many individuals receive no behavioral health care
- Primary care providers (PCP) have begun delivering behavioral health care
- Studies suggest PCPs need more support treating behavioral health
- One solution: better integration of behavioral health clinicians and PCPs

Why integration?

- Builds on an established relationship between provider and beneficiary
- Utilizes an existing provider
- Holistic health management
- Improves diagnosis and treatment in primary care settings

Models of integrated care

- Previous studies indicate positive outcomes
- Collaborative care model (CoCM)
 - Requires three providers: PCP, behavioral health manager, psychiatric consultant
 - Uses standardized tools (PHQ-9) to diagnose and track progress
- Variations of integration
 - Providers involved/decision-making
 - Co-located vs. embedded

Integrated care models and Medicare payment policy

Policy issue

CMS's 2017 proposal

How does Medicare pay for the service?

- New fee schedule codes
- Payment made to clinician for CoCM team services

What are the requirements for the payment?

- Code for the specific CoCM
- Clinician meet requirements to bill the code

Are there provider or beneficiary requirements?

- Any clinician specialty can bill
- Not limited to clinicians with existing relationship with beneficiary
- Covered for all beneficiaries

Program integrity

- Multiple services can be billed for a single beneficiary

Integrated care models and Medicare payment policy, cont.

- Concerns with CMS's proposal to pay for CoCM through fee schedule codes
 - Codifies specific care delivery model into the payment system
 - Leakage: multiple providers can receive payment for the same services for the same beneficiary
 - The efficacy of the CoCM may depend on structured training and strict adherence to the model
 - Service covered for any beneficiary and provider, no matter their existing treatment relationship
- Even if all of these issues are addressed, larger question of ensuring that the service is of high value and relevant to the beneficiary

Behavioral health professionals billing Medicare, 2014

Provider	License/certification	Medicare covers	Most common services	Number of providers	Total beneficiaries treated
<i>Psychiatrist</i>	Medical doctor	All medically-necessary physician services	E&M, psychiatric diagnostic evaluation	22,610	3,034,742
<i>Licensed clinical social worker</i>	Masters in social work, two years supervised work, state licensing as a clinical social worker	Social work services (diagnosis and treatment of a mental illness)	Psychotherapy	16,498	526,039
<i>Clinical psychologist</i>	Doctorate of psychology, state licensing at the independent practice level	Clinical psychology services (diagnostic and therapeutic)	Psychiatric diagnostic evaluation, psychotherapy	14,650	878,920

Medicare policies to improve ambulatory behavioral health

- Models that integrate behavioral health with primary care may be one way to improve access
- Would still require decisions on how to pay for these services in FFS Medicare to ensure high-value spending
- Could also consider policies regarding Medicare's behavioral health providers
- Many reasons for undersupply of behavioral health services; Medicare payment rates unlikely to be the most significant factor

Discussion

- Consideration of Medicare's policy levers in this area
- Next steps
 - Improving the payment system for inpatient psychiatric facilities
 - Improving access to ambulatory behavioral health services