The Psychiatric Shortage:

Causes and Solutions

Editors

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National Council Medical Director Institute

- Medical directors from mental health and substance use treatment organizations from across the country.
- Advises National Council members, staff and Board of Directors on issues that impact National Council members' clinical practices.
- Champions National Council policy and initiatives that affect clinical practice, clinicians employed, by member organizations, national organizations representing clinicians and governmental agencies.

Membership

- Chief Medical Officers of behavioral health organizations
  - 22 Provider Representatives
  - Four Affiliate Representatives
  - Board Liaison
- Diverse Backgrounds
  - Psychiatrists and Primary Care
  - Child/adolescent, addiction, academic, emergency, geriatric
  - CMHCs, FQHC, Addiction Treatment, Hospital systems, MCOs, Foundation, Consulting

Expert Panel

- Practitioners
- Administrators
- Policymakers
- Patients/Peers
- Researchers
- Innovators
- Educators
- Advocates
- Payers

Modular Tool You Can Customize

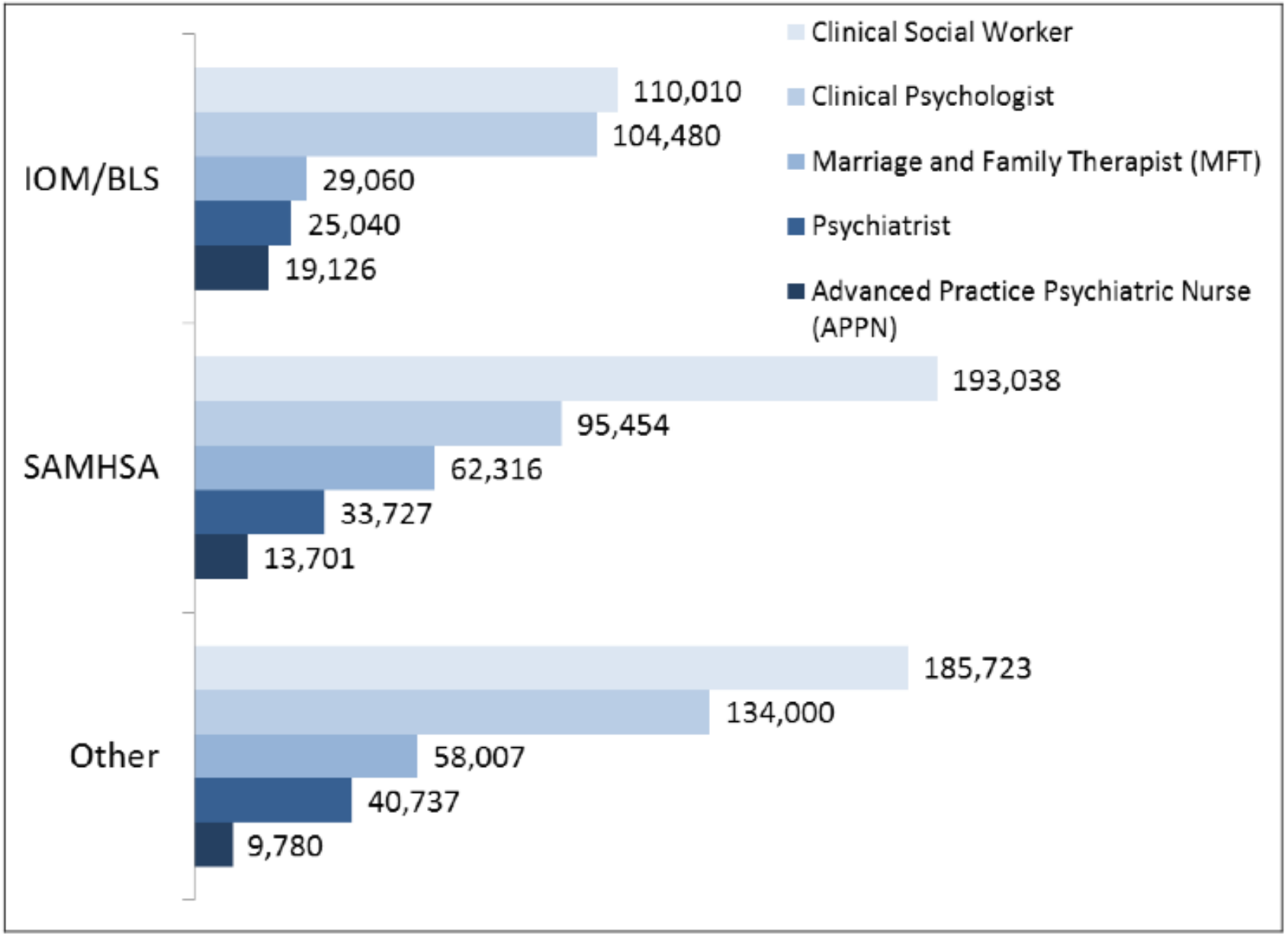
- Executive Summary
- Environmental Scan – Causes and Impacts
- Potential Solutions
- Recommendations – specific and actionable
  - Federal and State Government
  - Provider Organizations
  - Psychiatrists and Allied Psychiatric Professions
  - Payers
  - Training Programs

CURRENT SHORTAGE

- Best data: Study by University of North Carolina commissioned by Health Resources and Services Administration (HRSA)
- Demonstrated shortages for all MH professionals, especially “prescribers”
  - 77% of U.S. Counties have “a severe shortage of prescribers, with over half their need unmet”
  - 96% of US counties have “some unmet need”

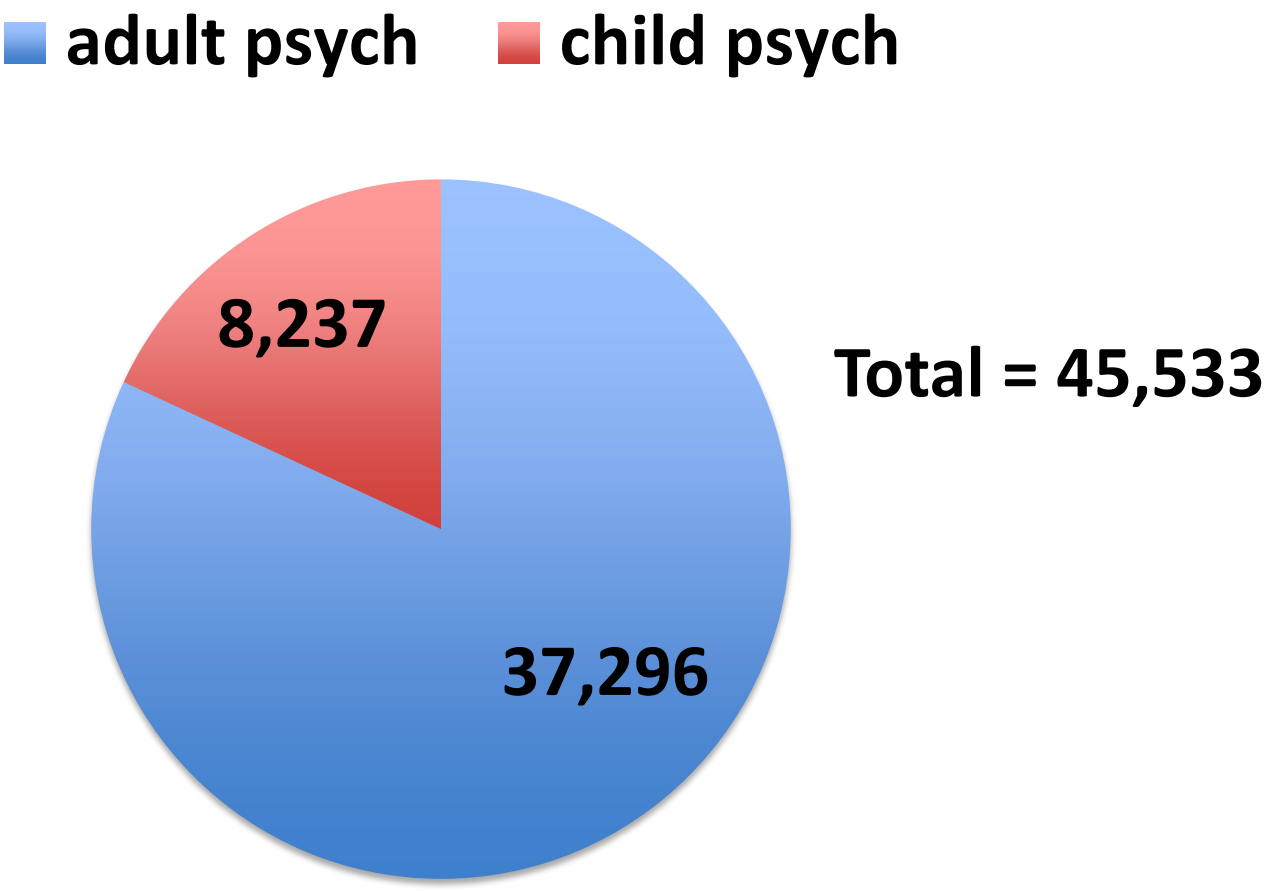
Konrad et al, Psych Services, 60: 1307-14, 2009

Figure 1. Workforce Size Estimates, by Mental Health Provider Type



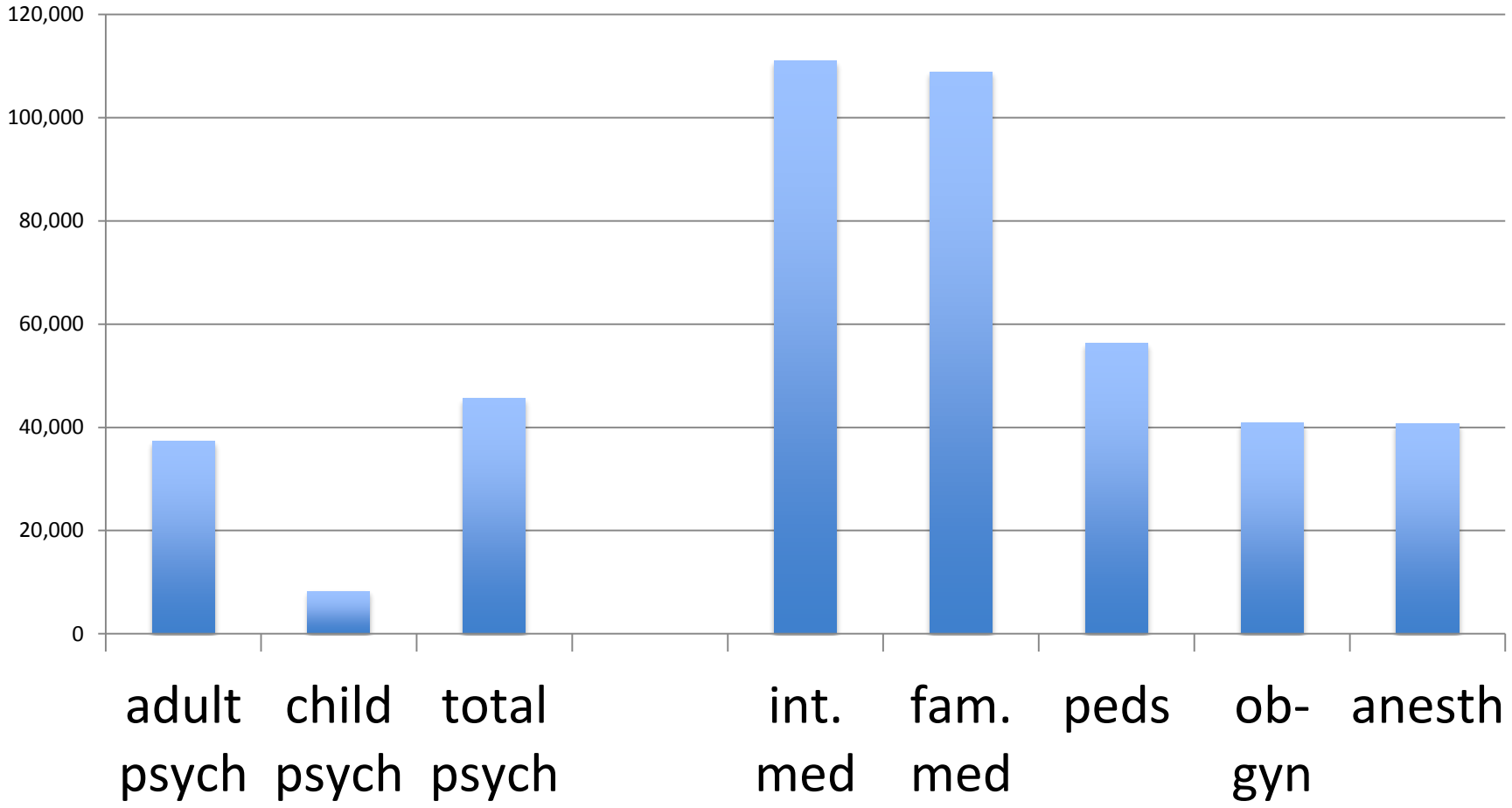
Source: Heisler and Bagalman, Congressional Research Service, April 2015

Total # Active Psychiatrists in US



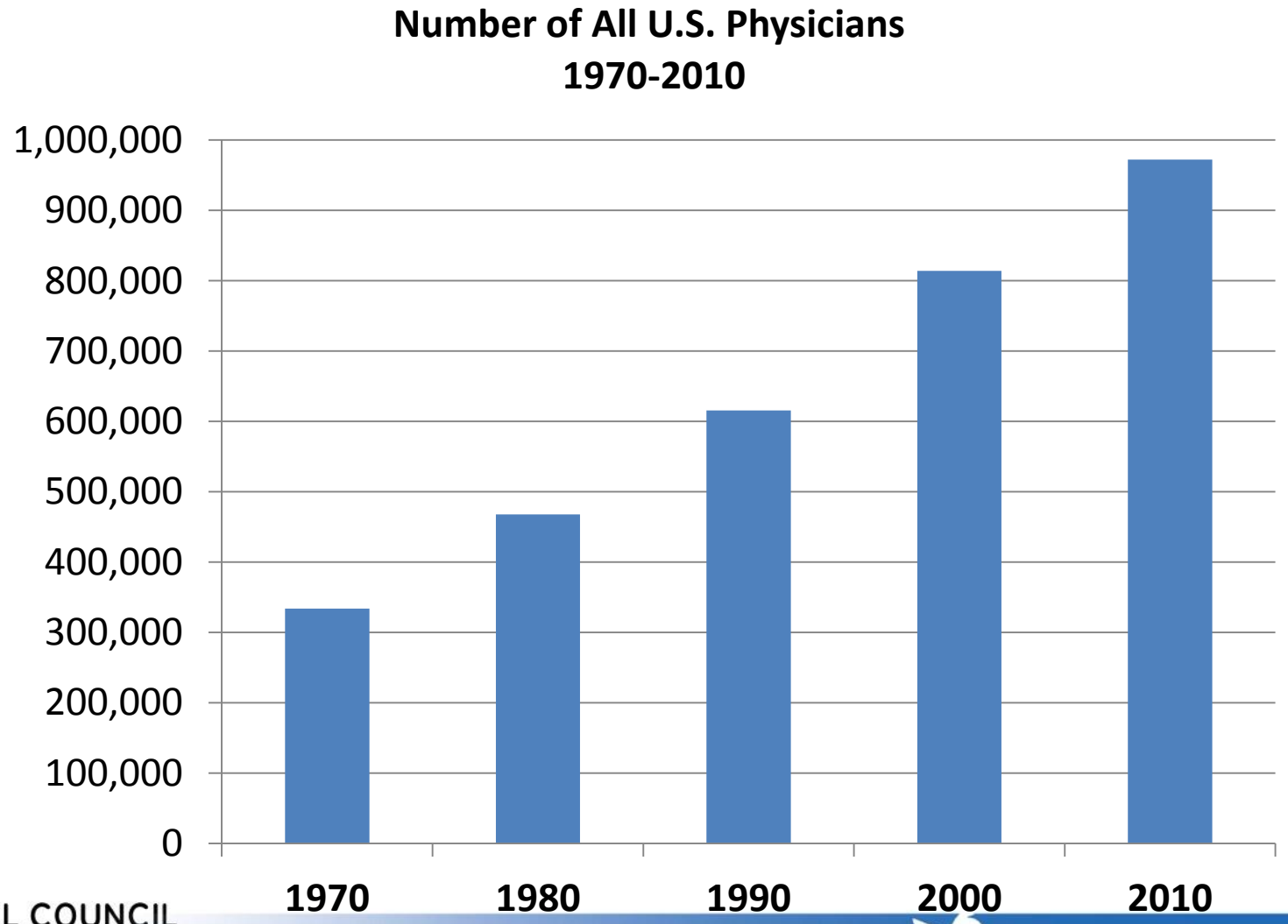
Source: AAMC Center for Workforce Studies, Physician Specialty Databook, 2014

Perspective:
All Active Physicians = 830,000

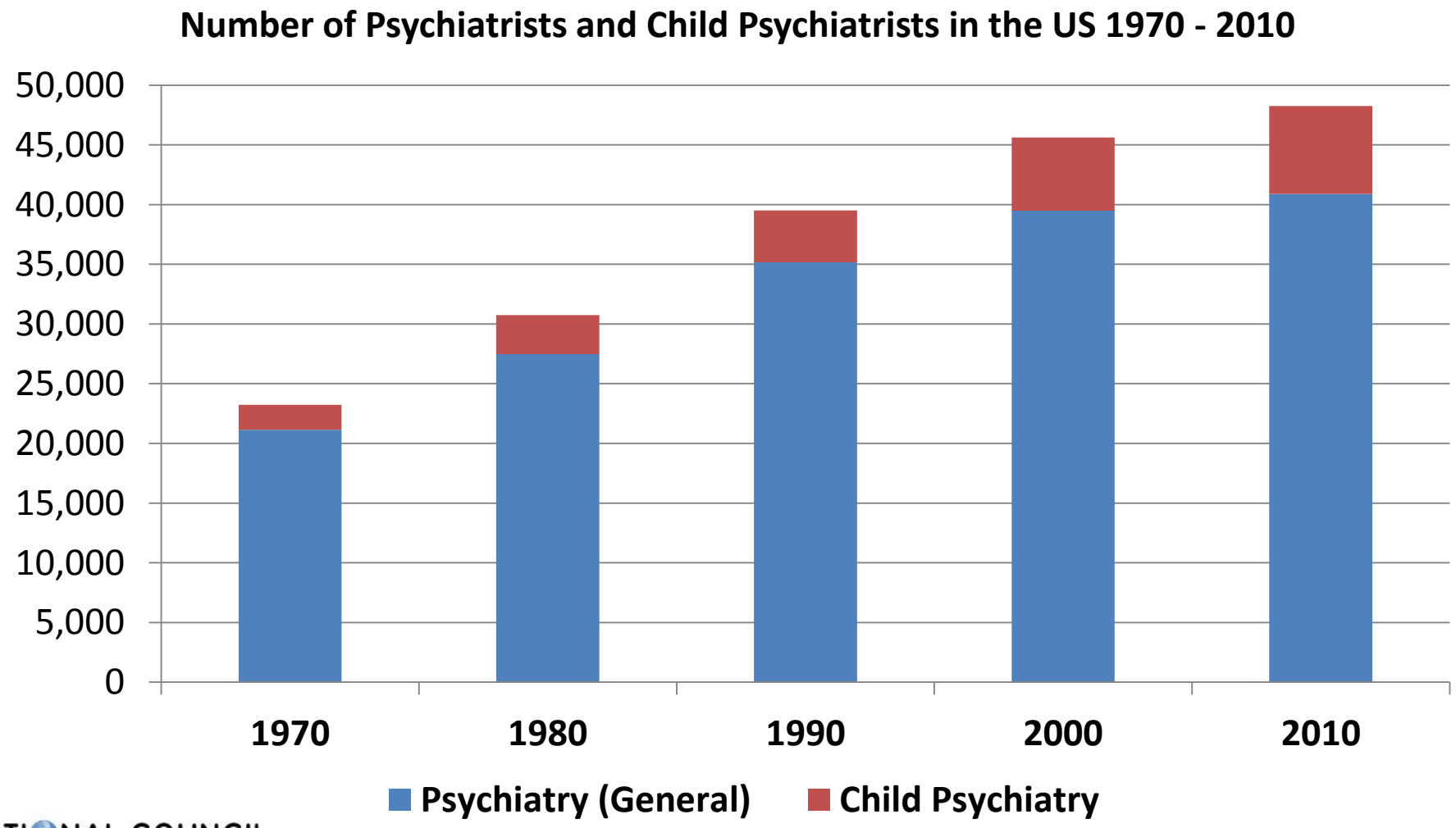


Source: AAMC Center for Workforce Studies, Physician Specialty Databook, 2014

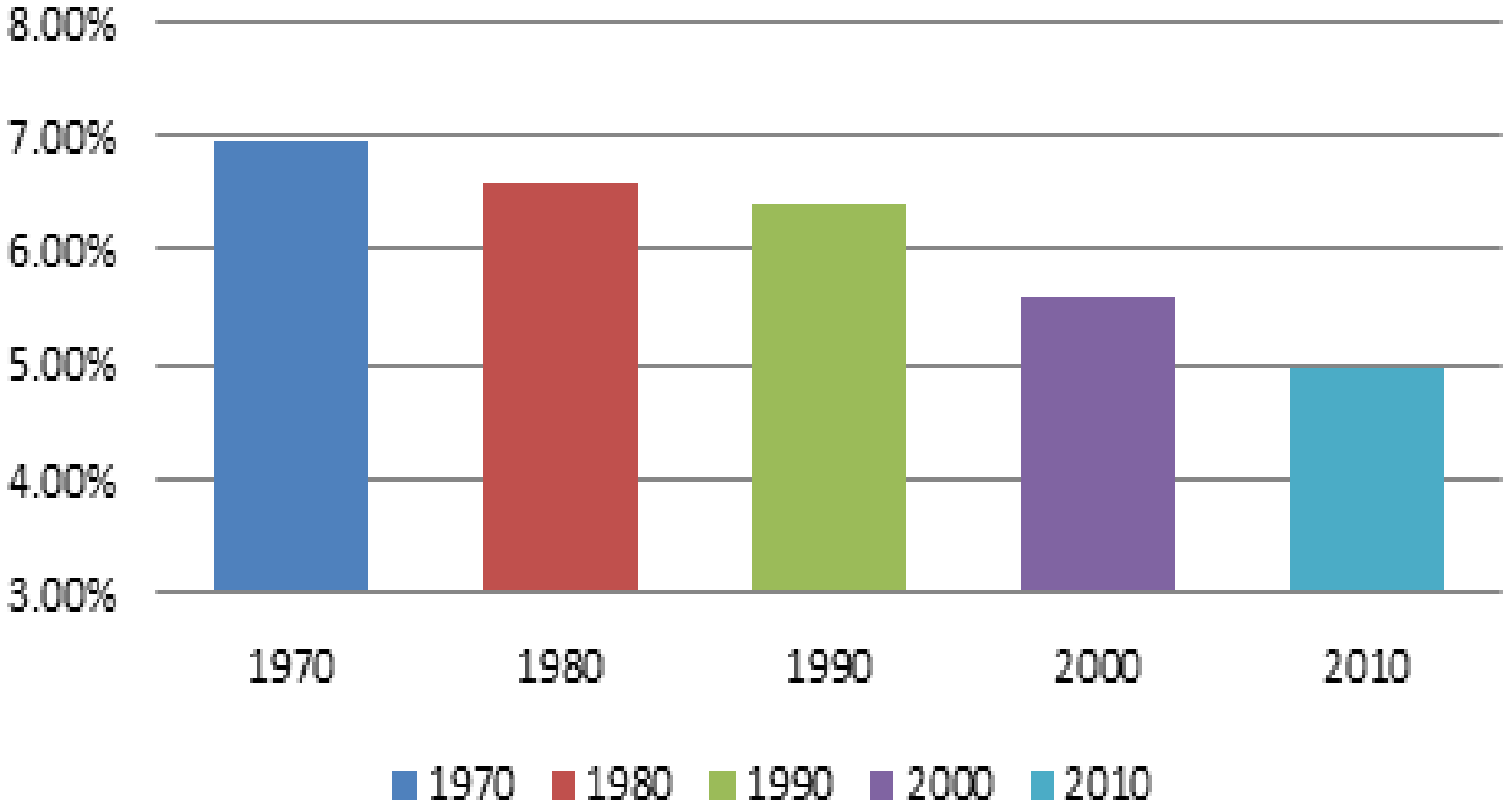
Total Number of Doctors in US – Steady Increase



Total Number of Psychiatrists (including FMG's) - Slight Increase



% of Psychiatrists of All U.S. Physicians 1970 - 2010



PHYSICIANS PER 100,000 RESIDENTS WITHIN HOSPITAL REFERRAL REGIONS

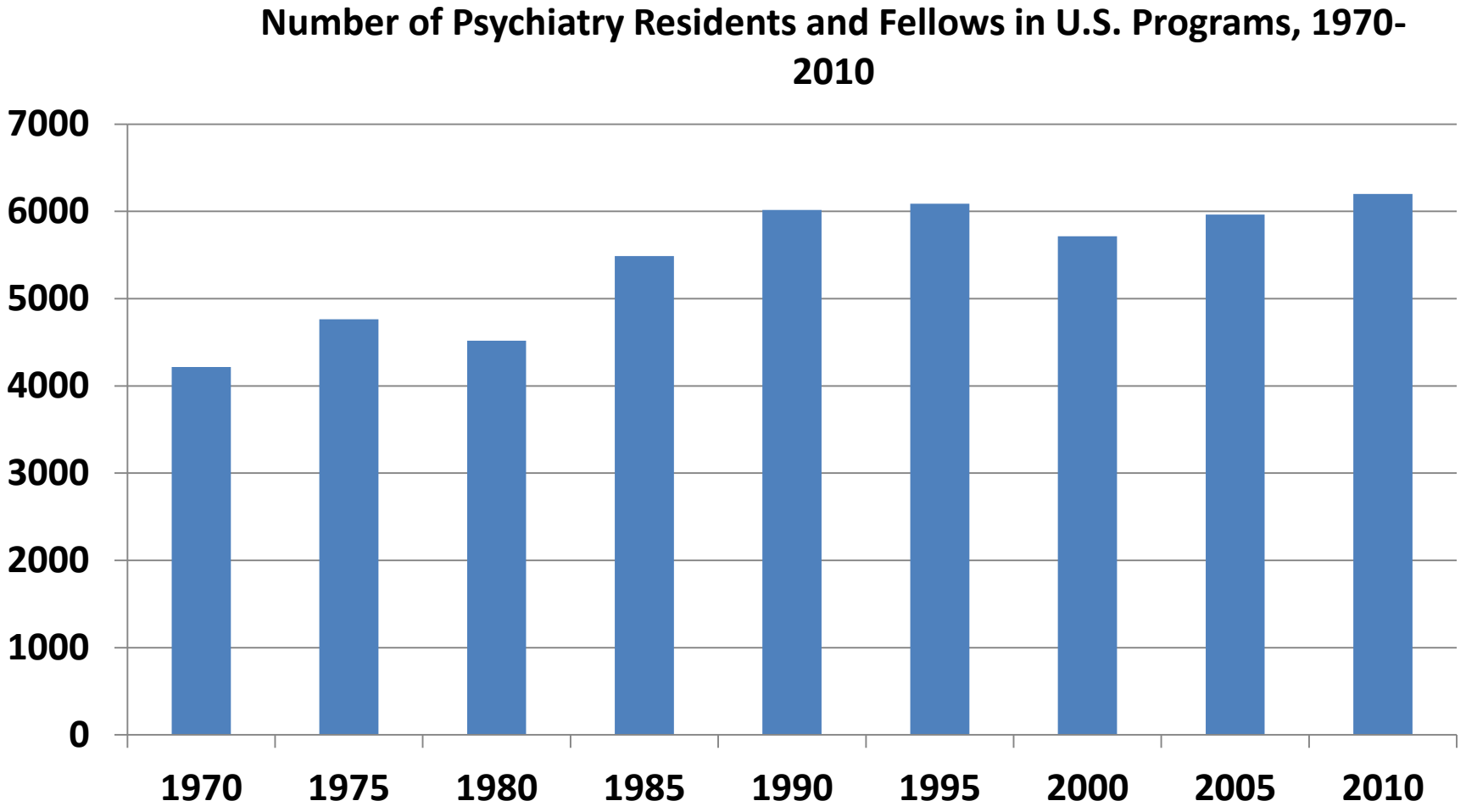
2003 and 2013

EXHIBIT 1

		Total	Mean per 100,000 residents	Median per 100,000 residents	Interquartile rage	Interquartile ratio	Gini Coefficient
Psychiatrists	2003	37,968	10.5	8.2	5.5-12.9	2.37	0.354
	2013	37,889	9.6	7.4	4.9-11.9	2.42	0.358
	Change	-0.2%	-9.0	-10.2	_[a]	2.3	1.3
Neurologists	2003	12,720	3.64	3.11	2.30-4.36	1.89	0.293
	2013	17,268	4.39	3.61	2.38-5.51	2.31	0.339
	Change	35.7%	20.4	15.8	_[a]	22.4	15.7
Adult Primary Care Physicians	2003	192,801	63.3	59.9	52-71	1.36	0.142
	2013	211,121	64.4	60.7	53-73	1.38	0.149
	Change	9.5%	1.7	1.3	_[a]	1.2	4.6
All Physicians	2003	755,270	227.7	206.1	168-255	1.52	0.196
	2013	862,444	236.9	208	167-272	1.62	0.214
	Change	14.2%	4.0	0.1	_[a]	6.7	9.6

Source: Authors' analysis of data for 2003 and 2013 from the Area Health Resources Files (see note 20 in text).
Note: Primary care is general practice, family medicine, and general internal medicine. The interquartile range and ratio and the Gini coefficient are explained in the text. [a] Not applicable.

Number of Psychiatry Residents In US Programs Has Been Flat Over Past 30 Years



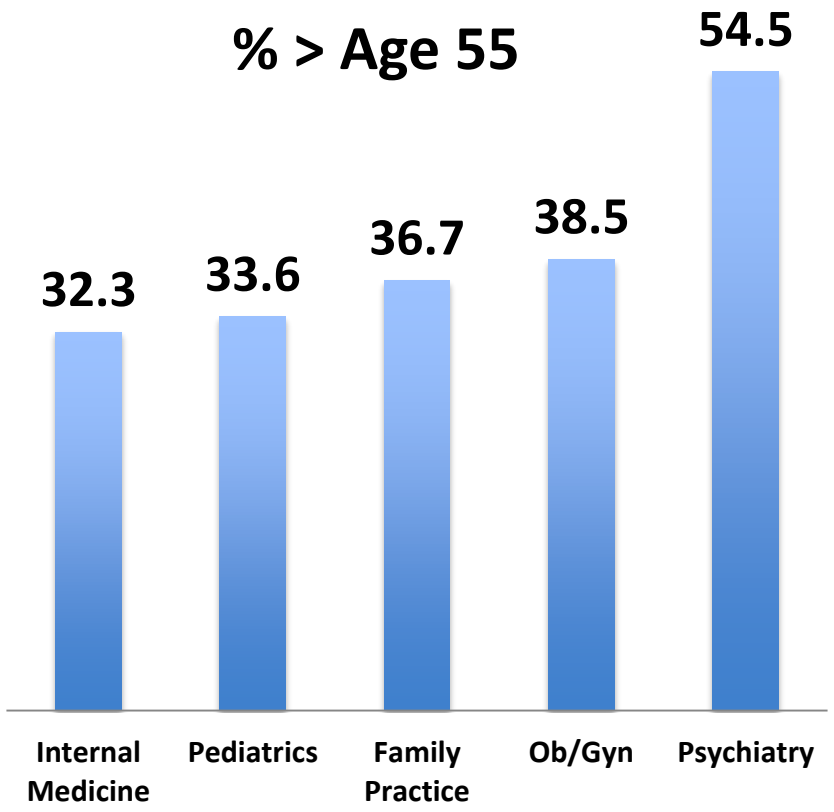
Psychiatric Times Series on Psychiatrist Shortage (Summer 2010)

- "Psychiatry Job Openings Surge into the Future": Physician recruitment company, Merritt Hawkins reported a 121% increase in requests for psychiatrists between 2007/2007 and 2009/2010

- "45,000 More Psychiatrists, Anyone?": HRSA commissioned studies considered "very conservative" because of exclusion of many patients with disorders that require some type of treatment (ADHD, Conduct Disorder, Dysthymia)

Aging Out!
% of MD's by Specialty > age 55

- Off all sub-specialties (35), Psychiatry is second oldest (Second only to Preventive Medicine)
- 55% of current psychiatrist are > age 55



Current supply and need of psychiatrists

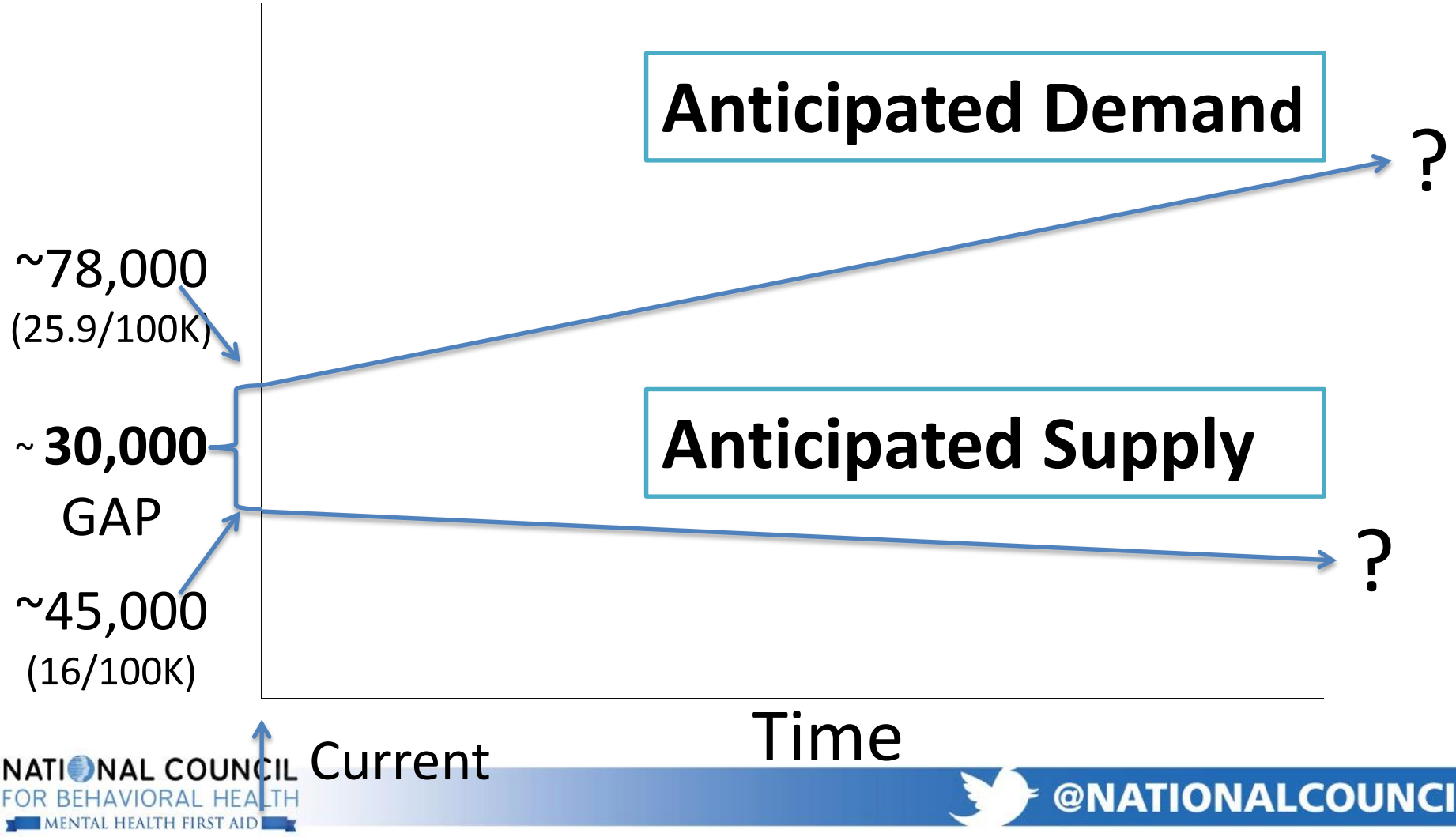
- Estimated need of 25.9 psychiatrists/100,000 population
  - With current population of 300,000,000, this is 78,000.
- Current supply is ~ 48,000 (~ 16/100,000)
- Current gap = at least 30,000
- Much greater supply vs. need gap for child and adolescent psychiatry (~ 7,500 total)

Sources: Konrad et al, Psych Services, 60: 1307-14, 2009

Increased Demand: Possible Factors

- Increase in number of patients utilizing services
  - Growing and aging population
  - Mental health parity, Affordable health care act
  - Some progress in anti-stigma efforts
- Psychiatric problems related to:
  - Economic downturn
  - Psychological toll of two wars
- Direct marketing to the public for psychoactive meds
  - *"…Ask your doctor if the addition of Abilify to your antidepressant is right for you?"*
- Black box warnings (e.g., kids, elderly)

Meanwhile, demand for psychiatric services is likely to continue to increase



Extended Outpatient Wait Times

- Common in all settings
- High risk in publicly-funded community behavioral health centers (Medicaid-covered)
  - Centers have high percentage of chronic mental health disorders
- Can lead to medication non-adherence with more ED visits and hospitalizations

Consequences

- For referring primary care physicians
  - **2 out of 3** reported difficulty accessing psychiatric services
- For Emergency Departments
  - 42% increase in individuals using EDs to obtain psychiatric services over the last 3 years.
  - Patients stuck waiting for evaluations and referrals
  - Frustrated ER staff, impacts care of other patients
- For inpatient psychiatric services
  - Closure of psychiatric inpatient units
  - Unable to recruit and retain psychiatrists

Consequences

- Inadequate diagnosis, prescribing and overuse of antipsychotics among vulnerable populations
- Lack of timely access to collateral clinical information and less time to talk with patient's family or other caregivers
- Prescriptions refilled without monitoring for side-effects
- Rationing services to most severe illnesses, limiting access for patients milder conditions

Consumer Experience

- Low patient satisfaction in community mental health centers due to:
  - Quality of patient-clinician interaction
  - Time limit (often 15 minutes)

"Compressed time with patients may lead to cold environments and an over-focus on deficits or weaknesses that may disempower or frustrate individuals" – Depression and Bipolar Support Alliance (DBSA)

Addiction and Mental Health VS Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates

Milliman Research Report – November, 2017

- 42 Million lives covered by 350 payers
- Three Years 2013-2014
- Payers include
  - Large employers, health plans, government plans
  - active employees, early retired, COBRA continues, dependents
  - No Medicaid or Medicare
- Two Analysis'
  - Out-of-network vs In-network Utilization
  - Reimbursement Rates

Why Out-of-Network Matters

- Higher Separate Deductible
- Higher Co-Pays
- Many patients don’t even asking for an appointment unless the provider is listed as on panel (in-network) on the Insurers website

Out-of-network vs In-network Utilization

Analysis Design

- Three types of Benefit compared
  - Inpatient including Skilled Nursing and Residential Tx
  - Outpatient Facility
    - Medical: PT, OT, Speech, Cardiac Rehab
    - BH: Intensive Out-Patient, Partial Hospital
  - Office Visits

- Three types of Provider compared
  - PC: Family Practice, Internal Medicine, Pediatrics
  - BH: Psychiatrist, Psychologist, Supportive Therapist
  - Other Specialties: Dermatology, Ortho Surg, OBGYN

Out-of-Network Utilization

Inpatient Facility

Year	Med/Surg	Behavioral Health	Higher Portion for BH
2013	3.4%	9.6%	2.8X
2014	4.0%	11.3%	2.8X
2015	4.0%	16.7%	4.2X

Out-of-Network Utilization

Out-Patient Facility

Year	Med/Surg	Behavioral Health	Higher Portion for BH
2013	5.3%	15.6%	3.0X
2014	5.6%	22.5%	4.0X
2015	5.5%	31.6%	5.5X

Out-of-Network Utilization

Office Visits

Year	Primary Care	Specialist	Behavioral Health	Portion VS PC	Portion VS Spec
2013	3.8%	5.1%	18.9%	5.0X	3.7X
2014	4.0%	5.1%	16.2%	4.8X	3.7X
2015	3.7%	5.2%	18.7%	5.1X	3.6X

In-Network Payment Vs Medicare

Analysis Design

- Benchmarked against Medicare Rates
- Only includes Physician Rates
- Two levels of Care compared:
  - Low Complexity Evaluation and Management (99213)
  - Moderate Complexity Evaluation and Management (99214)
  - Both Combined
- Three types of Physician Providers compared
  - PC: Family Practice, Internal Medicine, Pediatrics
  - BH: Psychiatrist,
  - Other Specialties: Dermatology, Ortho Surg, OBGYN

Low Complexity Office Visit Rates

Compared to Medicare

Year	Primary Care	Specialist	Behavioral Health	PC % Higher	Spec % Higher
2013	112.6%	106.0%	95.1%	18.3%	11.4%
2014	115.1%	108.1%	97.2%	18.4%	11.2%
2015	115.4%	109.2%	95.7%	20.6%	14.1%

Moderate Complexity Office Visit Rates

Compared to Medicare

Year	Primary Care	Specialist	Behavioral Health	PC % Higher	Spec % Higher
2013	110.9%	107.8%	92.2%	20.4%	16.9%
2014	113.3%	110.0%	94.5%	19.9%	16.4%
2015	115.4%	112.2%	95.2%	20.0%	17.8%

All Office Visit Rates

Compared to Medicare

Year	Primary Care	Specialist	Behavioral Health	PC % Higher	Spec % Higher
2013	112.1%	110.1%	92.8%	20.7%	18.5%
2014	114.6%	111.9%	94.0%	22.0%	19.1%
2015	115.2%	111.3%	95.1%	21.2%	17.1%

The Big Picture

Overall

- Patients are forced to go out-of-network 3-5 Xs more often for BH care than for PC or other Specialists
- PC physician rates are 15% above Medicare
- Psychiatrist rates are 5% below Medicare
- Primary Care Rates are 21% higher than Psychiatry Rates

Differential Reimbursement of Psychiatric Services – Mark et.al

Psychiatric Services 69:3, 2017

- 30 Million lives covered by Commercial payers
- For 2014
- 3.8 Million persons had claims with a primary diagnosis for MH or SUD (ICD-9 codes 290-316)
- BH Providers included: Psychiatrists, Psychologists, Social Workers, Psychiatric Nurse Practitioners
- Non-Psychiatrist Physicians included: Family Practice Doctors, Internists, and Pediatricians

Differential Reimbursement of Psychiatric Services

Analysis Design

- Identified the 5 most commonly billed code for each Provider type
- Identified the median reimbursement (insurance + patient out-of-pocket) for each service
- Compared in-network to out-of-network reimbursement and utilization
- Compared median out-of-pocket costs for the same service by different providers

Median Medication Visit Reimbursements

Code	Provider	In-Network	Out-of Network	% Increase Out-of-Network
99213	Psychiatrist	$66	$100	67%
	Psych NP	$42	$84	100%
	Non-Psych MD	$76	$78	3%
99214	Psychiatrist	$91	$122	34%
	Psych NP	$75	$105	40%
	Non-Psych MD	$114	$115	1%

Median Medication Visit Out-of-Pocket Cost

Code	Provider	In-Network	Out-of Network	% Increase Out-of-Network	% Visits Out-of-Network
99213	Psychiatrist	$20	$38	90%	16%
	Psych NP	$20	$44	120%	5%
	Non-Psych MD	$20	$29	45%	6%
99214	Psychiatrist	$20	$47	135%	13%
	Psych NP	$20	$60	200%	6%
	Non-Psych MD	$24	$30	25%	5%

Median Therapy Visit Reimbursements

Code	Provider	In-Network	Out-of-Network	% Increase Out-of-Network	% Visits Out-of-Network
90834	Psychiatrist	$92	$131	42%	34%
	Psychologist	$88	$150	82%	26%
	Social Worker	$67	$125	87%	21%
90836	Psychiatrist	$74	$134	60%	35%

Median Therapy Visit Out-of-Pocket Cost

Code	Provider	In-Network	Out-of-Network	% Increase Out-of-Network	% Visits Out-of-Network
90834	Psychiatrist	$20	$45	125%	34%
	Psychologist	$20	$50	150%	26%
	Social Worker	$20	$42	110%	21%
90836	Psychiatrist	$0	%37	N/A	35%

The Big Picture

Overall

- Non-Psychiatrists are paid 15%-25% more in-network than non-psychiatrists for the same service
- Psychiatrists are paid 6%-28% more out-of-network than non-psychiatrists for the same service
- BH prescribers get paid 34% to 100% higher rates out-of-network than in-network
- The portion of Psychiatrists paid out-of-network is 3X greater than for non-psychiatrists
- Therapists get paid 34% to 100% higher rates out-of-network than in-network
- 21%-35% of Therapy visits are out of network compared to 5-6% of PCP visits for BH
- Patients pay 110%-150% higher out of pocket when out of network for BH

Low Rates Impair Access to Care

- Lower Rates attract fewer BH providers to participate in-network and are an obstacle to accessing care
- BH providers are paid much higher out-of-network incentivizing them to not join the network
- Fewer BH providers in-network force more patients to go out-of-network
- Higher out-of-network deductibles and co-pays are an obstacle to accessing care

Mental Health Parity

Wellstone-Domenici Act

- The Act prohibits more restrictive ways of administering MH benefits than Medical benefits – Medical and BH must be treated equally.so if…
  - Lower MH rates than Medical rates that…
  - Result in more out-of-network care at higher cost to patients…
  - Is the same as charging higher deductibles and co-pays for BH which is prohibited.
- Therefore - The combination of lower rates and higher out-of-network utilization should be treated as a parity violation

Access to Behavior Health Services

Unacceptable at Current Payment Rates

It is not creditable to assert Network Adequecy when Out-of-Network Utilization compared to Medical care BH is:

- 420% higher for Inpatient Care
- 550% higher for Facility Out-Patient Care
- 280% higher for Office visits
- Out-of-network for 21%-35% of all therapy visits

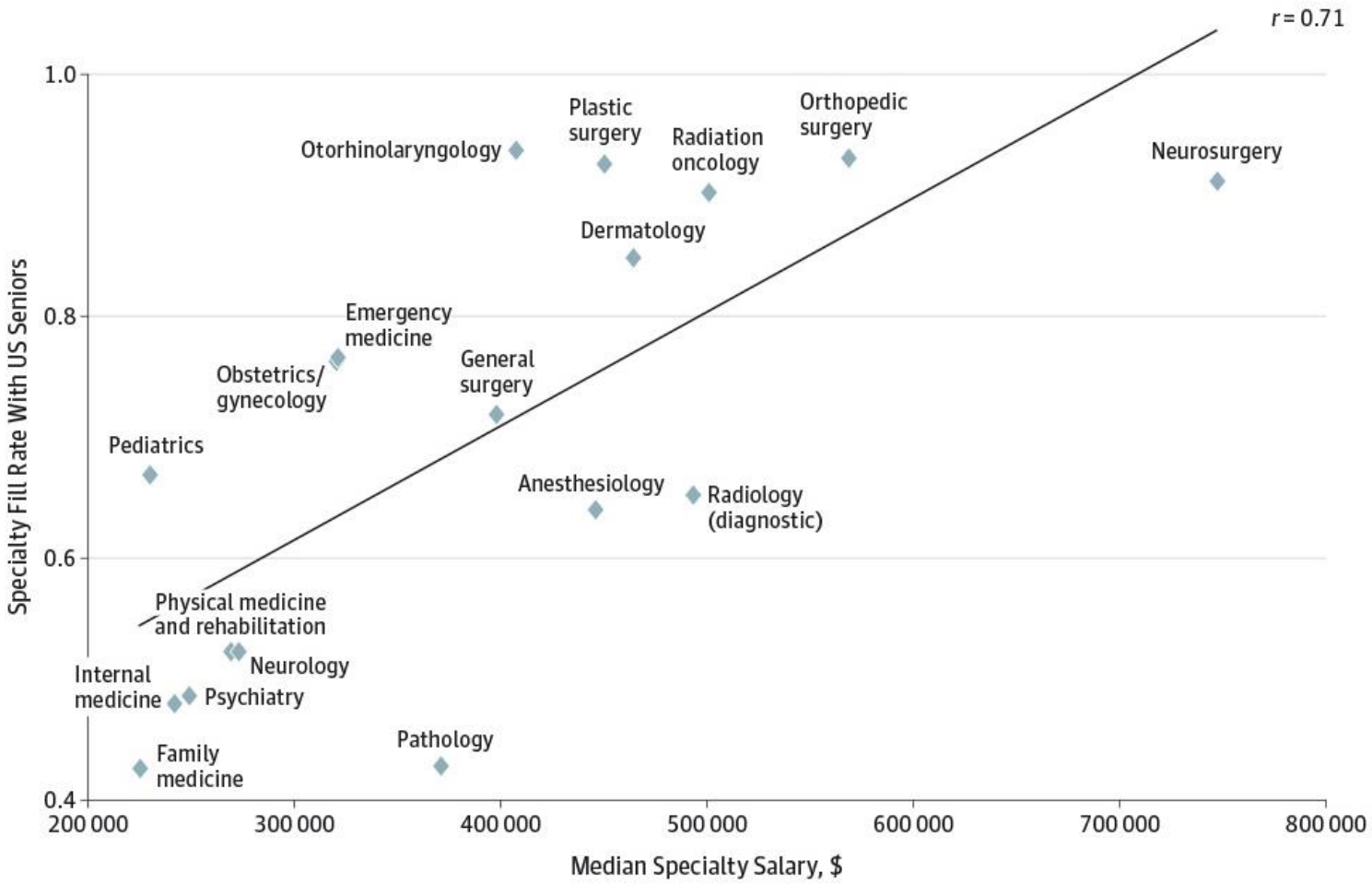
Contributing Causes

Workforce Shortage Contributing Factors

- Psychiatrists burnout
- Rates and methods of reimbursement
- Documentation requirements
- Regulatory restrictions

Median Salary vs. Positions Filled

Figure. Association Between the Median Salary of a Specialty and Its Competitiveness, as Measured by the Percentage of Positions Filled by Graduates of US Medical Schools



Burnout by the Numbers

- Physicians experiencing burnout **increased 8%** from 2011 to 2014
  - **8% decrease** in work satisfaction due to insufficient family and personal time

- U.S. Department of Veterans Affairs psychiatrists report alarmingly high burnout rate
  - **86%** report high exhaustion
  - **90%** report high cynicism

Shanafelt, T., et al. (December 2015) Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014. Mayo Clinic Proceedings.

Psychiatrist Burnout Causes

- Regulatory restrictions on sharing information
- Limited time with patients
- Increased documentation requirements
- Minimal support resources to organize medical records, conduct routine assessments, etc.
- Schedules do not allow collegial sharing, supervision and consultation

Populations Served by Existing Workforce

Cash-only private practice is common.

Outpatient Reimbursement

- More than **75%** of the National Council's state association members lost $$ on psychiatry
  - 3 year losses increased from $481,000 in 2013 to more than $550,000
- Must earn surplus of **15%** or more to balance budget

Inpatient Reimbursement

- Rates not sufficient to underwrite their cost of psychiatrists in general hospitals
- Reimbursement rates lower than cost of care lead to psychiatric inpatient unit closures
- Reluctance to admit potentially violent clients due to risk of property damage, funding security staff
- Salaries for psychiatrists are lowest among specialties

Regulatory Barriers

- Confidentiality Rules
  - Individual state requirements for mental health PHI that are more restrictive than HIPAA
  - 42 CFR part two
- Prohibitions Of Same-Day Service
- Restrictions on Foreign Medical Graduates
- Medicare GME payments

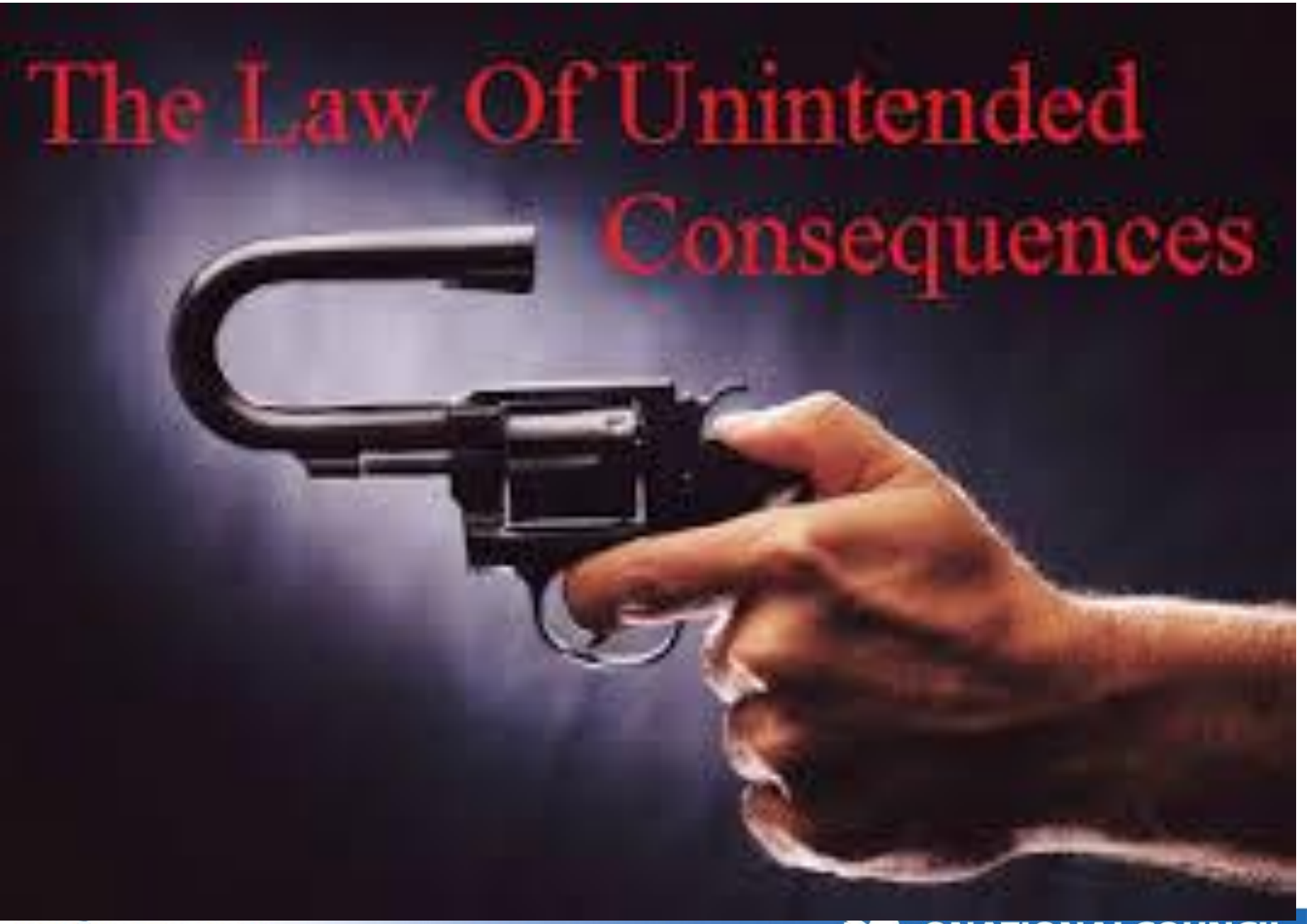
Confidentiality rules specific to Behavioral Health are a barrier to access to Psychiatric Services

- Separate and more restrictive confidentiality rules for psychiatric services make it less likely that:
  - psychiatric expert opinion will be shared with treatment providers outside of where the psychiatrist is employed.
  - Psychiatrists will be added to health care settings not already employing them due to additional administrative burden and cost

- Therefore often healthcare providers outside the clinic where the psychiatrist works do not have access to the benefit of that psychiatric service provided in the clinic

Mental health confidentiality rules more restrictive than HIPAA are a barrier

- In General HIPAA allows MH treatment information to be shared among treatment providers in exactly the same manner as general medical information
  - The exception is psychotherapy process notes, but
  - Very few psychiatrists keep psychotherapy process notes
- Many states have adopted additional confidentiality restrictions specific to mental health treatment that are more restrictive than the federal HIPAA regulations


The Law Of Unintended
Consequences

"GME curriculums lack sufficient emphasis on care coordination, team-based care, costs of care, health information technology, cultural competence and quality improvement — competencies that are essential to contemporary medical practice."

– Institute of Medicine, 2014

Consequences

- Inadequate workforce has limited ability to deliver safe and effective care
- Low level of patient satisfaction
- Limited opportunities for innovation
- Less supervision and collaboration
- Limited opportunities to practice up to level of licensure
- Residency training does not provide adequate population health skills
- Psychiatry is a “loss leader,” despite emerging acceptance of its value

Impact on Services

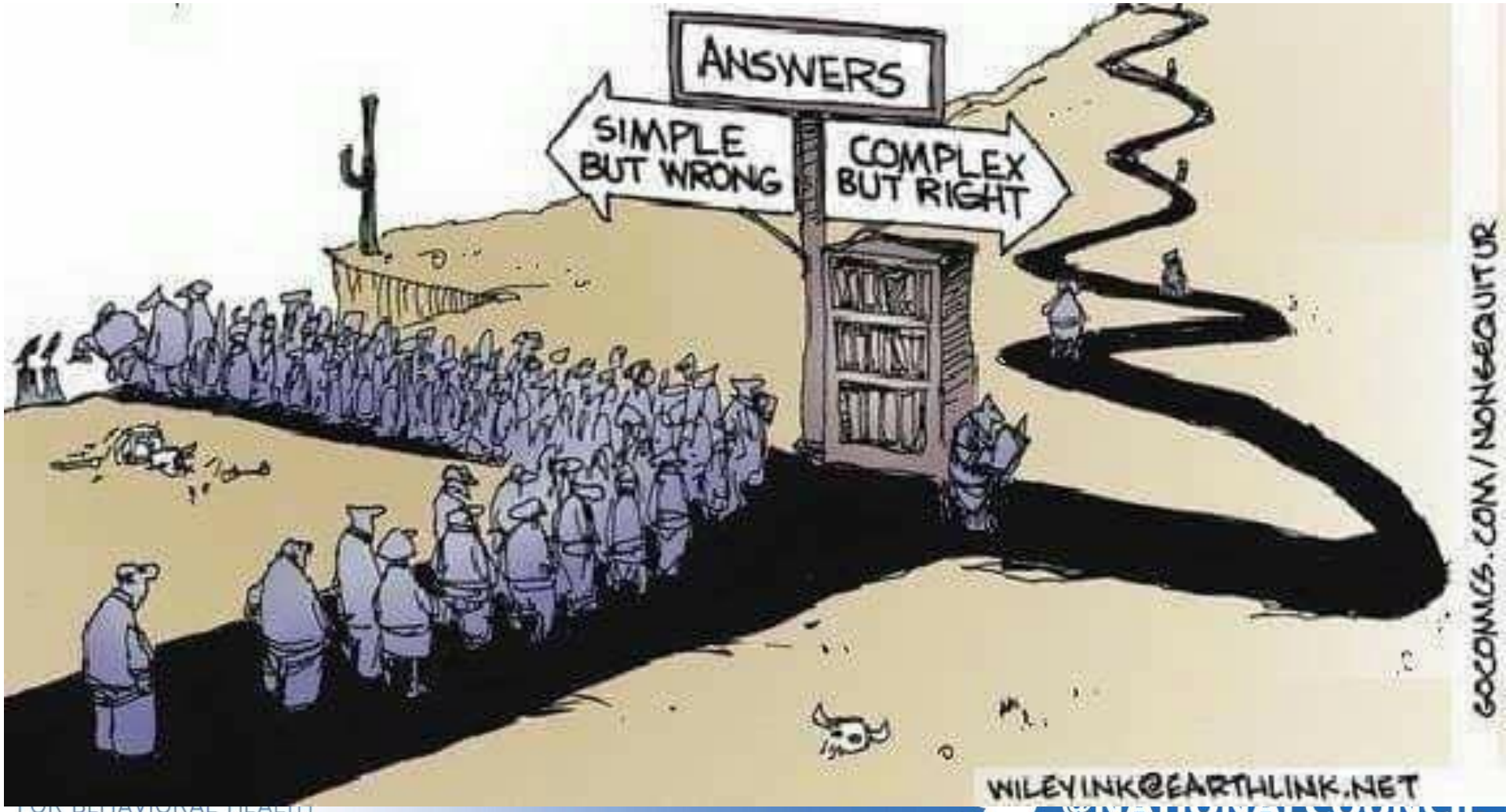
- For referring primary care physicians:
  - 2 out of 3 reported difficulty accessing psychiatric services
- Closure of psychiatric inpatient units
- Unable to recruit and retain inpatient psychiatrists

Conclusions

- The shortage of psychiatrists will increase
- Traditional model of psychiatric care delivery is unsustainable
- Psychiatrists are not sufficiently groomed or practicing up to level of licensure
- Increasing number of psychiatrists will not be sufficient enough to improve access and quality of care

Solutions and Recommendations

"The solutions cannot rely on a single change in the field such as recruiting more psychiatrists or raising payment and reimbursement rates. Rather, the solutions depend on a combination of interrelated that require support from a range of stakeholders."


ANSWERS
SIMPLE BUT WRONG
COMPLEX BUT RIGHT
WILEYINK@EARTHLINK.NET

Stakeholder Groups

"If all stakeholders take even just one action that is immediately feasible for them, meaningful improvements in access to psychiatric services will occur."

- Government
- Payers
- Health care treatment organizations
- Advocacy organizations
- Psychiatrists
- Nurse practitioners, PAs and clinical pharmacists with specialty psychiatric certifications
- Psychiatric training programs

Overview of Recommendations

- Expand the psychiatric workforce
- Increase efficiency of delivery of services
  - Reforming and revising constraining regulations
- Implement innovative models of care to impact total cost of care for high-cost/high-risk populations
- Improve training for psychiatric residents
- Adopt effective payment structures

Update Psychiatry Residency Training

- Design new skills, including:
  - Team leadership
  - Health care data analysis
  - Population health
  - Impact of chronic medical conditions on mental illness
- Increase availability of training beyond inpatient/outpatient mental health programs
- Practice in settings that include expanded role for families supporting care

Restrictions on foreign medical graduates Decreases Access to Psychiatric Services

- In 2014
  - 30% of all US psychiatrists were FMGs vs 24% of all physicians
  - 44% of all US psychiatric residents and fellows were FMG's vs 34% of all residents and fellows

- Psychiatry is more dependent of FMGs than most other specialties

Visa's and Waivers for FMG's

- H1-B Visa - Does not require return to home country to continue working in USA. Requires more paperwork from training program. Capped nationally it 65,000 slots.
- J-1 Visa - Requires return to home country for two years prior to continue working in USA.
- Conrad 30 Waiver - Each state receives 30 slots annually they can be used to waive the return to home country requirement for FMG's with J-1 Visa

Recommendation for Change of Federal Statute

- Revise Conrad 30 program so that states can waive the return to home country requirement for J1 visa physicians who are board certified or board eligible in psychiatry without the psychiatrist J-1 Visa waivers counting towards their states of 30 total slots

Fund Psychiatry Residency Training

- Increase funding for training in shortage areas such as rural hospitals, correctional settings, etc.
- Expand HRSA funding for GME programs in underserved areas
- Expand federal funding for GME resident positions through Medicare and Medicaid

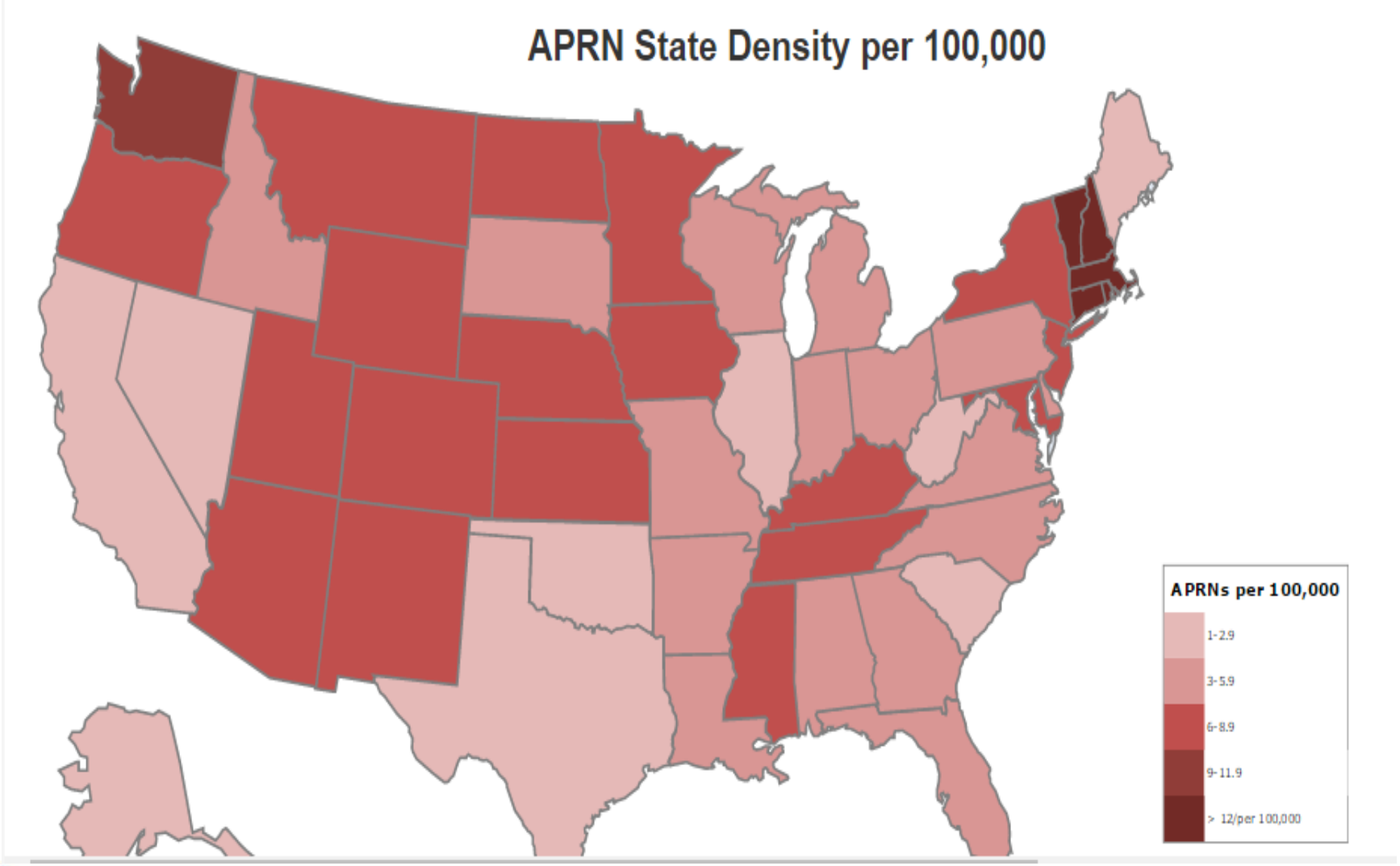
Expand Workforce of Other Providers

- Develop Physician Assistants psychiatric subspecialty
- Expand Clinical Pharmacists board certified in Psychiatry
- Expand APRNs
  - Valuable for patients with co-occurring medical conditions
    - Currently 13,815
    - Projected to reach 17,900 by 2025

Advanced Practice Registered Nurses (APRNs)

- Psychiatric Mental Health (PMH) APRNs hold an RN and a PMH graduate nursing degree (since 2014 all APRNs now graduate from PMH NP programs)
- Nationally certified as either PMH Clinical Nurse Specialists (CNS) or Nurse Practitioner (NP)
- There are 13, 815 certified PMH APRNs
- 4,928 PMH CNSs and 8,887 PMH NP
- 63% of all PMH CNSs work in direct care roles and prescribe *

PMH APRN distribution



PMH NP Educational Training is Consistent across Programs: Directed by National Competencies

- PMH NP programs follow National Organization of Nurse Practitioner Faculties (NONPF) competencies
- 118 PMH NP graduate programs- both Masters and Doctor of Nursing Practice (DNP) level
- PMH NP graduate programs educate students in conducting comprehensive psychiatric assessments, diagnosis, treatment planning, delivery of a wide range of evidence-based therapy interventions, patient education, prescribing and treatment evaluation.

Telepsychiatry

- Increased access for:
  - Rural areas
  - Areas with cultural/linguistic barriers
  - Settings requiring immediate access to psychiatrist, such as an emergency room
- Can provide more efficient consultation to other behavioral health providers
- Eliminates travel time, increasing productivity

Adequate Staff Support

- Support staff includes nurses, medical assistants, non-licensed personnel with specialty training
- Duties:
  - Handling phone calls
  - Collecting screening info and vital signs
  - Assuring all required forms are available
  - Arranging referrals, return visits
  - Tracking lab/pharmacy information
  - Making photocopies

Integrated Care

- Makes functional integration easier
- Decreases discrimination
- Increases access to primary care consultations
- Creates common medical record
- Increases patient follow-through with referrals
- Preferred by most patients
- Increases primary care practitioners' knowledge of psychiatric treatment and vice versa

Collaborative Care Model

- Good evidence for the success of the collaborative care model (CoCM) resulted in new CPT code
- Stepped care approach includes case manager to measure outcomes
- Allows each psychiatrist to impact 5 times as many patients

42 CFR part two Is a Barrier to Access to Psychiatric Services

- Approximately 50% of people treated by psychiatrists currently have or had had a substance use disorder
- 42 CFR part two is more restrictive than HIPAA or federal statute requires
- If a psychiatrist integrates SUD treatment information from a covered entity into their treatment record than the psychiatrist record is much harder to share with general medical providers

Recommendations for SAMHSA

- Eliminate all parts of 42 CFR part 2 not required by statute that restrict more than HIPAA Consent for a specific purpose
  - Consent to a specific organization
  - Consent must be time limited
  - Consent is limited to minimum necessary for the specific purpose
  - Prohibition on Re-disclosure
- Incorporate HIPAA definitions and details into new 42 CFR Part 2 by reference to HIPAA wherever possible

Recommendations for Payers and Providers

- Do not overemphasize prohibitions and penalties on sharing information in your organizational policies and training on HIPAA and 42 CFR part two
- Confidentiality training should primarily emphasize the extent to and ways in which treatment information can be shared.
- Do not make reduction of a future hypothetical legal liability a higher priority than immediate clinical and operational liabilities

Prohibitions on payment for same-day services are a barrier to access to psychiatric services

- There is no federal statute or regulation prohibiting payment for psychiatric service on the same day as payment for any other health care service

- Regarding Federally Qualified Health Centers:
  - Nine states to not pay for MH services at a FQHC
  - 14 states do not pay for MH services on the same day as PC services at a FQHC

- Prohibition on same day service
  - Dis-incentivizes general medical providers from co-locating and integrating psychiatric services
  - Increases treatment no-shows for both psychiatric services and general medical services

FQHC Recommendations

- All states should:
  - pay for MH services at a FQHC
  - pay for MH services on the same day as PC services at a FQHC

- HRSA should require states to:
  - pay for MH services at a FQHC
  - pay for MH services on the same day as PC services at a FQHC

Finance and Reimbursement

- Medicaid is major payer of behavioral health, so providers can't make up for payment rates
  - Disincentive to provide psychiatric services

- New payment ideas:
  - Cost-based rate
    - Used by prospective payment systems (PPS) and certified community behavioral health clinics (CCBHCs)
  - Bundled payments

Recommendations for National and Treatment Organizations

- Attract and retain psychiatrists in public settings:
  - Provide Adequate nursing and administrative supports
  - Do not limit psychiatrists solely to diagnosis and medication visits
  - Reduce documentation requirements
  - Have a Medical Director
  - Attention to provider burnout, retention and appreciation

Recommendations for Payers

- Work with providers, experts and researchers to match reimbursement with practices and provide incentives for improved outcomes, reduced total cost of care
- Standardize outcome measures and partnership among payers, policymakers, providers and consumers
- Payers should have in-house medical director

Recommendations for Payers

- Incentivize open access or walk-in clinics
- Pay higher amounts for first appointments to incentivize providers to target harder-to-reach populations
- Include telepsychiatry as covered service
- Improve access to psychiatric care in EDs
- Cover payment for CoCM at no less than Medicare rate
- Reimburse for psychiatric services using evolving technologies for increased access

Recommendations for Payers

- Ensure that administrative and documentation policies are not overly burdensome
- Design payments with population-based health in mind with actual cost of direct psychiatric services in bundled payment calculation
- Ensure compliance with MHPAEA and new Medicaid rule

Access Parity via Rate Parity

- Rates paid by Insurers yield lower access to available psychiatrists than other physician types
  - 45% of Psychiatrists don't take insurance
  - A larger portion of psychiatrists on panel don't take new patients
  - Rate inequity is a Non-Quantitative Parity restriction
- Recommend – CMS and State and Federal Insurance regulators should benchmark psychiatry rates and access using secret shopper surveys

State Approaches to Parity & Provider Pay

Model legislation

Addresses rates as part of states' parity enforcement obligation

- Requires enforcement by state agency of federal and state parity laws, including **conduct examinations demonstrating compliance with rate parity** (among others)

https://paritytrack.org/wp-content/uploads/2018/01/2018-State-Model-Parity-Legislation.pdf

State legislative action: WA

HB 860, signed into law Aug. 2017

Required Dept. of Consumer and Business Services to:

- Examine historical data to determine if insurers were paying in-network behavioral health providers rates that were “equivalent” to those in place for in-network medical providers.
- Examine if insurers pay “equivalent” reimbursement rates for time-based procedural codes for in-network behavioral health and medical providers.
- Examine whether the methodology insurers use to set rates for in-network behavioral health providers was equivalent to that used for in-network medical providers.
- Submit a report documenting the results of these activities by 9/1/19.

Authorized a maximum of $600,000 to fund these activities.

State legislative action: RI

S 200, died March 2013

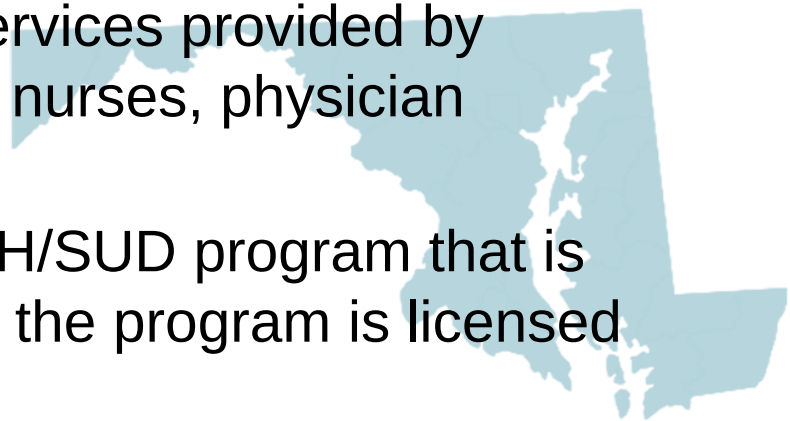
- Tried to change the section of the state insurance law about parity so that insurance plans would have to use the same criteria for determining reimbursement rates for behavioral health providers as they use for other medical providers.

State legislative action: MD

HB 1217/SB 899, signed into law May 2016

Requires the Dept. of Health & Mental Hygiene to issue regulations on compliance aligned with the Federal Parity Law. Among the required areas that must be addressed are:

- Reimbursement rates
- Billing for licensed MH/SUD services provided by physicians, advanced practice nurses, physician assistants
- Billing for licensed specialty MH/SUD program that is not the primary location where the program is licensed



Advantages & disadvantages of legislative action

- Law applicable to all plans in state; can provide appropriations to support activities
- Lawmakers typically do not legislate specific reimbursement methodologies…
  - …meaning that legislative action in bills to date is limited to requiring additional oversight or market conduct reviews.
- Difficulty of establishing a standard for "comparable to" in regard to NQTLs.

State regulatory action: MD

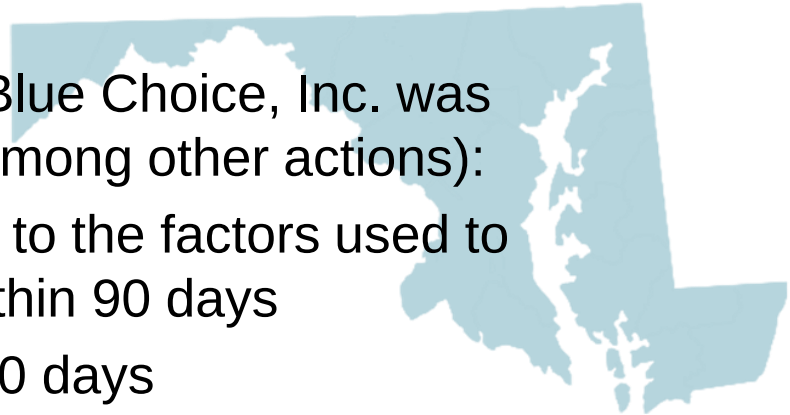
October 2015

The Maryland Insurance Administration (MIA) conducted a market conduct examination of CareFirst Blue Choice, Inc. following responses to a survey about compliance with the Federal Parity Law. Among the violations found:

- Geofactors are applied to the base reimbursement rate for providers of medical/surgical benefits but not MH/SUD benefits

To come into compliance, CareFire Blue Choice, Inc. was required to complete the following (among other actions):

- Documentation showing changes to the factors used to calculate reimbursement rates within 90 days
- Pay a penalty of $30,000 within 30 days



Advantages and disadvantages of regulatory action

- Market conduct exams provide highly specific, actionable solutions to coverage that is in violation of parity…
  - …but apply only to the plan under review.
- State regulations modeled on federal guidance don't add new clarity…
  - …though regulations can extend the reach of parity by applying this guidance to add'l plans.

"These new regulations will fundamentally change the way we get around them."

Litigation landscape

In very early stages

- Subject of most litigation to date has been:
  - Coverage exclusions
  - Utilization management (e.g. prior authorization, concurrent review, visit caps, etc.)
  - Medical necessity
- Common conditions for which litigation has been filed:
  - Eating disorders
  - Autism

Provider pay litigation

AMERICAN PSYCHIATRIC ASSOCIATION V. ANTHEM (2016)

- The psychiatrists and the associations allege that the health insurers discriminate against patients with mental health and substance use disorders **by systemically reimbursing providers of services to treat these disorders at a less favorable rate than for other healthcare services.** They argue that this less favorable reimbursement policy prevents many psychiatrists from accepting health insurance. The policy limits patients' access to necessary services and frequently forces them to change providers. Plaintiffs allege that this practice discriminates against patients with mental health and substance use disorders in violation of the MHPAEA and ERISA.
- **Appeal/disposition**: The court agrees that the Plaintiffs lack standing and affirms the district court's order to dismiss the case.

Advantages and disadvantages of litigation

- Successful cases establish case law that is applicable to other plans.
- Often a very long time horizon…
  - …meaning litigation typically cannot provide immediate relief to providers wondering how to keep their doors open tomorrow or next month.
- Requires significant state commitment of time and money…
  - …and the “right” plaintiffs to bring the case.

What are the limitations of parity in addressing low provider pay?

Limits of parity?

- Legislation and litigation have long time horizon
- Litigation and some regulatory reviews require complaints to be filed before action can be taken
- Granularity of analysis means regulatory review body findings often applicable to only one plan
  - **Proactive (i.e. prior to plans being approved for sale) market conduct exams likely have the most potential impact**

Alternative Activities to Raise Provider Pay

Rate Reform Initiative

- **Massachusetts:** multi-year rate reform initiative founded on the principle that rates have not kept pace with costs.
- MORE TO COME

Managed Care Contracts with State

- To promote adequate payment, Medicaid contracts with MCOs should:
  - Establish a payment floor no less than current Medicaid fee-for-service rates; and
  - Require MCOs to apply any state-mandated rate changes immediately upon taking effect and make retrospective adjustments to any previously paid claims subject to the rate increase.
- Contracts can also include provisions related to prompt payment of claims, payment recoupments, provider credentialing, and more.

Sample contract language

New York State Network Monitoring Requirements – Section 3.6(l)

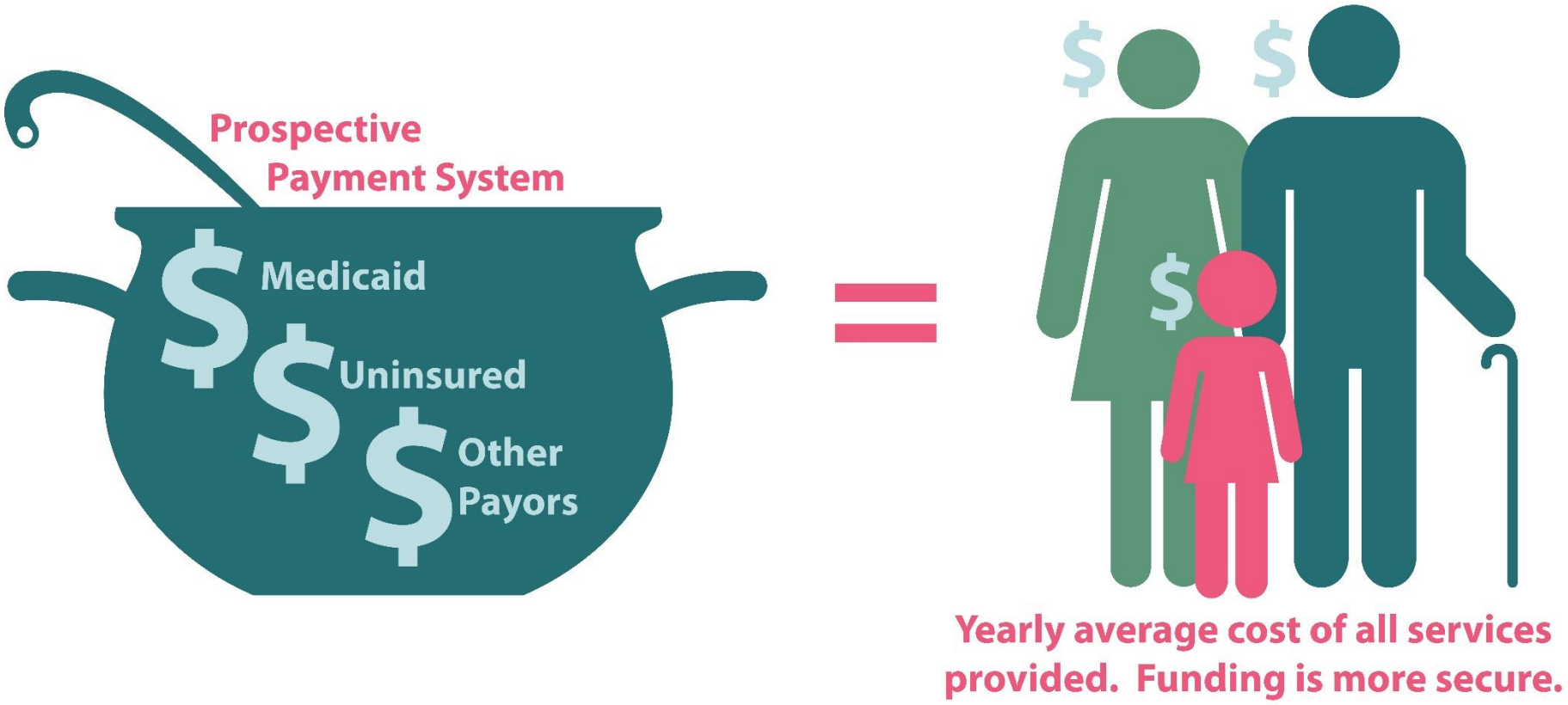
"MCO's will be required to reimburse OMH-licensed and OASAS-certified behavioral health providers including ambulatory service providers, CPEP and EOB programs, and Residential Addiction Services at the Medicaid FFS rates for at least 24 months after the effective date of the transition."

Medicaid Access Regulation

- https://www.medicaid.gov/federal-policy-guidance/downloads/smd17004.pdf

CCBHC Payment

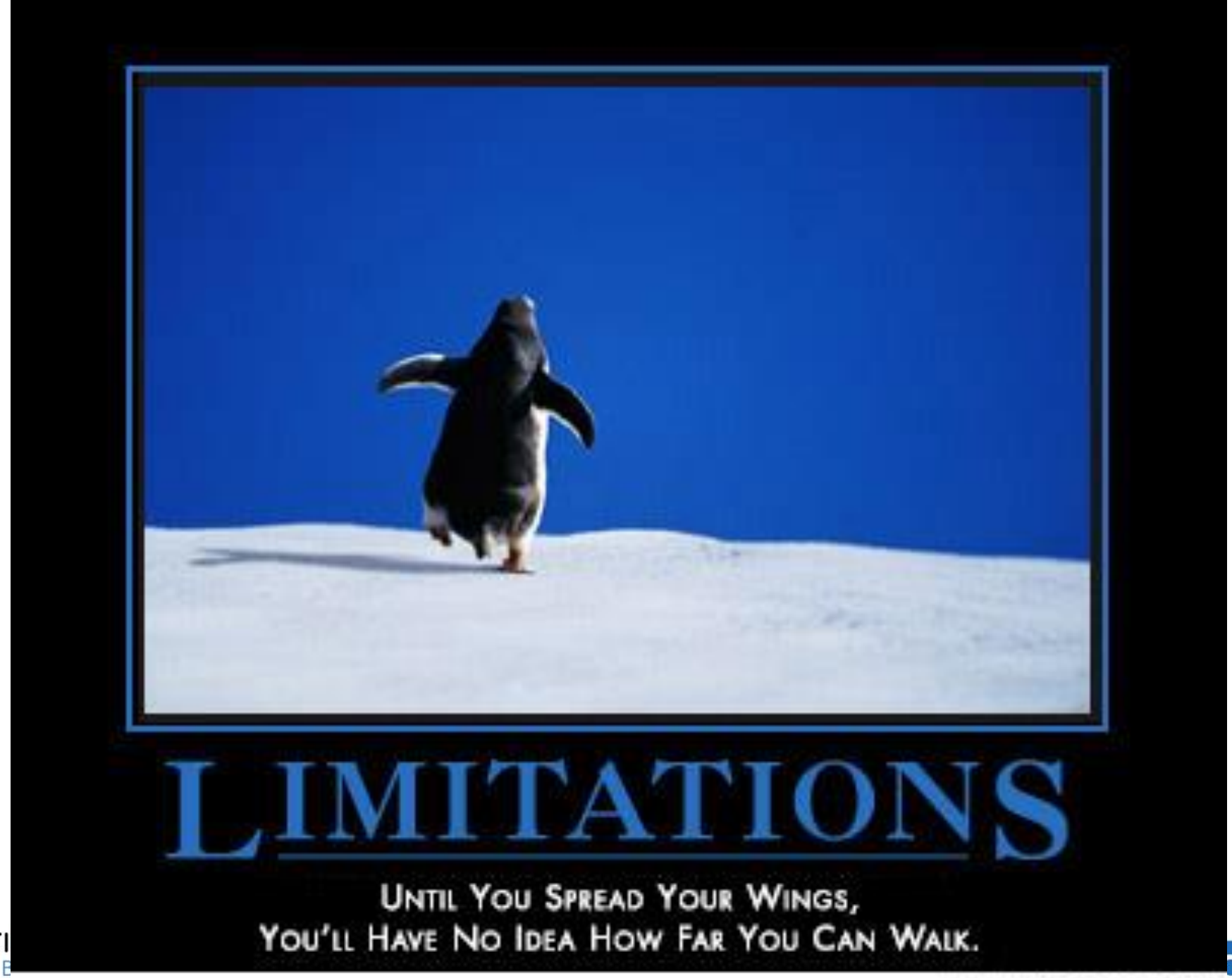
Establishment of a Prospective Payment System



PPS-1 Guidelines

- CCBHC's receive **a fixed daily reimbursement per visit**
  - Based on the FQHC PPS approach used nationally
- Payment is the same regardless of intensity of services

$$\frac{\text{Total allowable costs of providing services}}{\text{Total number of daily visits per year}} = \text{Daily per-visit rate}$$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Questions ?

- The paper can be accessed here: https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf

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