Medicare Managed Mental Health Care: A Looming Crisis

Committee on Aging of the Group for the Advancement of Psychiatry

Mental Health coverage under the Medicare+Choice models presents serious concerns unless significant reform efforts are undertaken. In this column we alert geriatricians and general psychiatrists to the current limits on coverage and seek to stimulate advocacy efforts for appropriate reimbursement and parity.

Medicare coverage has been an example of lack of parity for mental health care. In addition to lower reimbursement for comparable work in the field of psychiatry relative to other specialties and a higher cost-sharing burden, lifetime limits were set on care within freestanding psychiatric facilities (190 days per lifetime), which was the dominant mode of psychiatric care when Medicare was founded in 1965. Although renewable psychiatric benefits for care in psychiatric units were allowed within general hospitals, capitation was applied through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and now through a Prospective Payment System (1). The Medicare+Choice provision of the Balanced Budget Act of 1997, also known as Medicare Part C or managed Medicare, allowed Medicare beneficiaries to leave traditional Medicare for private health care options (2). This column will show how privatization of Medicare has actually worsened psychiatric coverage under Medicare.

Mental health services under Medicare+Choice

Traditional Medicare covers three categories of individuals: people aged 65 years or older who are eligible for Social Security, younger patients who have received Social Security Disability Insurance for at least two years, and patients with end-stage renal disease. Medicare consists of basic coverage by Part A (hospital insurance) and supplemental Part B for professional fees. Part B is available for an extra monthly premium. As of 1992, all recipients who are eligible for Medicaid have their supplemental medical insurance (Part B) premium paid by the state. Outpatient psychiatric fees for psychotherapy are reimbursed at 50 percent (62.5 percent of 80 percent of the approved amount). Although outpatient medication management and evaluation and management services are supposed to be reimbursed at 80 percent, there are many examples of regional carriers reimbursing these charges at the level of 50 percent. Lifetime limits for care in freestanding psychiatric hospitals continue, but there have never been lifetime limits on inpatient care provided in general hospitals where benefits also renew if a patient has not been institutionalized for 60 days (3,4).

In 1990, only 3 percent of the Medicare dollar was spent on mental health care, with a disproportionate share being spent on care for persons with disabilities under the age of 65. The younger group with disabilities constituted only 9.5 percent of the overall Medicare population but accounted for 39 percent of psychiatric hospital discharges (5).

With Medicare+Choice, significant financial incentives are given to encourage the shift to private plans by offering lower to no additional premiums. At least 15 percent of Medicare recipients have chosen managed care plans because of promises of a lower copayment amount and often medication benefits, and this proportion is expected to soon exceed 30 percent of Medicare recipients. The Medicare Reform Act of 2003 (6) provides incentives for health plans to expand their Medicare offerings and will accelerate this movement.

All Medicare+Choice contracts are also called Medicare risk contracts, because a set amount per covered life is provided to the carrier, and the organization can lose money if it overspends this allotment. On the other hand, there is an opportunity for large profits if spending is curtailed. Profits can be achieved only by administrative streamlining, denial of care, or reduction of fees paid to providers. The monthly enrollee allotment has been as low as $367 per month (in 1998) but has increased annually by complicated area-specific rate adjustments and annual 2 percent increases. Organizations must meet certain size qualifications to ensure economies of scale and solvency. Although managed care organizations are contracted to supply the same minimal coverage as traditional Medicare, in practice they create their own internal regulatory guidelines for service eligibility (7). For example, one organization has been observed to have inpatient qualifying guidelines that are identical to involuntary hospital-

The members of the committee are Kenneth Sakauye, M.D., Karen Blank, M.D., Carl I. Cohen, M.D., Gene D. Cohen, M.D., Gary Kennedy, M.D., Benjamin Liptzin, M.D., Jason Schillerstrom, M.D., and Susan Schultz, M.D. Send correspondence to Dr. Sakauye (chair) at LSU Health Sciences School of Medicine, 1542 Tulane Avenue, Suite 322, New Orleans, Louisiana 70112 (e-mail, ksakau@lsuhsc.edu). Marion Zucker Goldstein, M.D., and Olivera J. Bogunovic, M.D., are editors of this column.

Regulatory methods to slow or reduce payments

Medicare-specific strategies
- High copayments, cost-sharing (Medicare covers only outpatient psychiatric services at 50 percent of approved rates)
- Capitation of overall Medicare spending via the Balanced Budget Act (pits one group against another for a share of available resources)

Medicare managed care strategies
- Fail-first policies (psychiatric approval requires an initial failure with primary care)
- Raising the bar (acuity criteria are unreasonably high, and often care is denied before the patient is close to remission)
- Rationing through inconvenience (requirement for excessive documentation and use of gatekeepers)
- Harassment, daily "doc-to-doc" reviews (insurance reviewers ignore documentation and insist on speaking to the treating psychiatrist daily)
- "No care zones" (inadequate participation in insurance panels; often a shortage of specialists)
- Carve-out contracts for mental health (more restrictive than Medicare)

Used by both Medicare and Medicare managed care
- Encouragement of reviewers to deny coverage
- Substitution of a less expensive option, even if it is less effective
- Placement of blame on the provider (denial explained as resulting from the provider's failure to follow the rules)

ization criteria (homicidal, suicidal, or gravely disabled) with no support for care transitions after behavioral stabilization has been achieved.

Medicare managed care has a variety of models that differ in the amount of cost savings offered. The confusing array of Medicare+Choice options includes health maintenance organizations, preferred provider organizations, provider sponsored organizations, religious fraternal benefit plans, private fee-for-service plans, and point-of-service plans (2). PACE (Programs of All-Inclusive Care for the Elderly) and medical savings plans add to the complexity. In practical terms, programs differ in their flexibility in using out-of-network physicians or facilities and the range of services available within their system of care. The more individual choice, the higher the out-of-pocket cost to the individual (8). Ironically, managed care has been transmogrified into the bureaucratic system that was rejected in the 1990s because of concerns about rationing of care by a third party and restriction in choice of provider.

Another confusing aspect of privatization of Medicare in psychiatry is the difficulty of knowing who is really in charge of providing the program benefits. Many programs carve out mental health benefits and set up their own risk contracts with mental health management subcontractors. This approach reduces the organization's risk of overspending but adds another layer of administrative costs. "Carve ins" use internal staff and facilities. In either case, access and benefits are heavily controlled. In practice, the review process has served as a barrier to specialty care and to adequate follow-up (9).

In an ideal setting, managed care has potential benefits. Managed care can create and enforce evidence-based treatment algorithms, provide the infrastructure for continuing education, ensure continuity of care, and provide screening and outreach programs. Unfortunately, most managed care carve-out organizations manage only immediate costs.

Insurance strategies to limit reimbursement

Privatization of Medicare has hurt mental health care. Medicare was revolutionary when it was established in 1965, providing mental health benefits at a time when very few insurers were funding such care. However, Medicare had built-in restrictions that limited outpatient benefits to $500 a year for services but only $250 a year for each patient, because it covered only 50 percent instead of 80 percent of approved rates. In 1984, Medicare implemented the first change in mental health coverage in 20 years by eliminating the $250-a-year cap and then covering medication management at parity with other types of office visits but did not change the 50 percent coverage limit for psychotherapy. An overall budgetary limit on Medicare was set by Congress in the Balanced Budget Act of 1995. However, placing a cap on Medicare spending only pits one professional group against another for its fair share of the allocation.

Often practice settings are targeted for review by Medicare. In the 1980s there was concern about a lack of psychiatric services in nursing homes. However, in the 1990s attention shifted to reduce the expansion of psychiatric services in these settings. Nursing homes were targeted for audits by the Office of the Inspector General (OIG) of the Department of Health and Human Services. The initial OIG report stated that 40 percent of the psychiatric services provided in nursing homes should not have been paid for because of lack of documentation of medical necessity (10). This finding was interpreted by many that care should not have been provided. The suggestion of unnecessary care was inconsistent with known high rates of depression, psychosis, adjustment disorders, or behavioral disturbances associated with dementia in nursing homes (11). Nevertheless, many Medicare carriers began reviewing 100 percent of nursing home cases, increased documentation requirements, and increased denials that discouraged provision of services in nursing homes (12).

Other cost-saving strategies by managed care differ from those under Medicare. Some policies require that a patient must first fail to respond to primary care treatment. Plans that provide pharmacy benefits require that older and less expensive medications be used, even if the evidence shows better response with fewer adverse effects from newer medications. Other plans arbitrarily set capitation limits, lower provider

rates below fair market rates, set a high cost-sharing burden for the patient, or set eligibility criteria that do not conform to evidence-based standards of practice (see box).

What should care providers do?

There is no uniformity of procedures or review criteria by insurance carriers. The clinician must know the regulations of each Medicare+Choice carrier or co-insurer, become an authorized provider if the fees are acceptable, and follow each carrier's procedures. Special attention should be given to optimizing coding, especially for dementia care (13).

If payment is denied, the patient cannot be abandoned or discharged until he or she is stable. However, every denial must be appealed. Appeals may go all the way to a judicial hearing. The process must be exhausted, because such action also costs the managed care carrier money and may force a change in regulations if the carrier spends too much money on appeals.

Beyond these cost issues, we have an obligation to our patients to serve as advocates. Now is the time to get involved in organized medicine and act as a group to lobby for mental health reform. The immediate task is to write your Congressional representative to support bills on mental health parity and reform. Legislators do look at letters from constituents. People who think Congress will take care of this for them will find cold comfort in old age unless the current situation changes.

The longer-term task is part of a larger problem of health care reform. The Institute of Medicine's *Insuring America's Health: Principles and Recommendations* stated that universal health care is essential (14). This often-maligned term does not necessarily mean socialized medicine. Many models of private universal health plans and alternatives to managed care are reviewed in the American Psychiatric Association Resource Document on Alternatives to Managed Care (15).

Our primary goal should be to advocate for what insurance should cover rather than the particular model of funding. Principles for minimal psychiatric coverage are captured in position papers from the National Council on Disability (16), the President's New Freedom Commission on Mental Health (17), and the APA Vision (18). The essential features are universal health care (everyone must be covered), continuous health care coverage, affordability of insurance, economic sustainability for society, and provision of high-quality, timely, and equitable care that promotes patients' well-being. These criteria imply full access to psychiatric and rehabilitative care and provisions for chronic care when recovery is not possible. Shaping a new system should become our new priority while we continue to fight against the regulatory changes that restrict geriatric psychiatric care. ♦

References

1. Medicare Program: Prospective Payment System for Inpatient Psychiatric Facilities: Final Rule. Federal Register 69(219): 66922, Nov 15, 2004
2. Reed RL, Hepburn KW: Managed care for older people: a primer for the geriatrician. Journal of the American Geriatrics Society 47:241–249, 1999
3. Centers for Medicare and Medicaid Services: Medicare and Your Mental Health Benefits. Bethesda, Md, National Institute of Mental Health, Office of Communications and Public Liaison, 1999
4. Coviello A, Glaun K: Medicare Mental Health Coverage. Issue Brief 4(3). Washington, DC, Center for Medicare Education, 2003
5. Lave JR, Goldman HH: Medicare financing for mental health care. Health Affairs 9(1):19–30, 1999
6. Medicare Program: Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub L 108–173
7. Rosenbaum S, Kamoie B, Mauery DR, et al: Medical Necessity in Private Health Plans: Implications for Behavioral Health Care. DHHS pub no (SMA) 03-3790. Rockville, Md, Center for Mental Health Services, 2003
8. Horgan CM, Merrick EL, Garnick DW, et al: The Provision of Mental Health Services in Managed Care Organizations. DHHS pub no (SMA) 03-3797. Rockville, Md, Center for Mental Health Services, 2003
9. Colenda C, Banazak D, Mickus M: Mental health services in managed care: quality questions remain. Geriatrics 53:49–63, 1998
10. Office of the Inspector General: Mental Health Services in Nursing Facilities. Pub no OEI-02-91-00860. Washington, DC, Department of Health and Human Services, May 1996
11. US Department of Health and Human Services: Mental Health: A Report of the Surgeon General. Rockville, Md, Center for Mental Health Services, 1999
12. Castle NG: Deficiency citations for mental health care in nursing homes. Administration and Policy in Mental Health 29:157–171, 2001
13. Fillit H, Geldmacher DS, Welter RT, et al: Optimizing coding and reimbursement to improve management of Alzheimer's disease and related dementias. Journal of the American Geriatrics Society 50:1871–1888, 2002
14. Institute of Medicine Committee on the Consequences of Uninsurance: Insuring America's Health: Principles and Recommendations. Washington, DC, National Academies Press, 2004
15. American Psychiatric Association Committee on Managed Care: Alternatives to Managed Care Resource Document. Arlington, Va, American Psychiatric Association, 2003
16. The Well Being of Our Nation: An Inter-Generational Vision of Effective Mental Health Services and Supports. Washington, DC, National Council on Disability, 2002. Available at www.ncd.gov
17. Achieving the Promise: Transforming America's Mental Health Care in America. Washington, DC, President's New Freedom Commission on Mental Health, 2003
18. American Psychiatric Association Task Force for a Vision for the Mental Health System: A Vision for the Mental Health System. Arlington, Va, American Psychiatric Association, 2003