TRENDWATCH

Increasing Access to Behavioral Health Care Advances Value for Patients, Providers and Communities
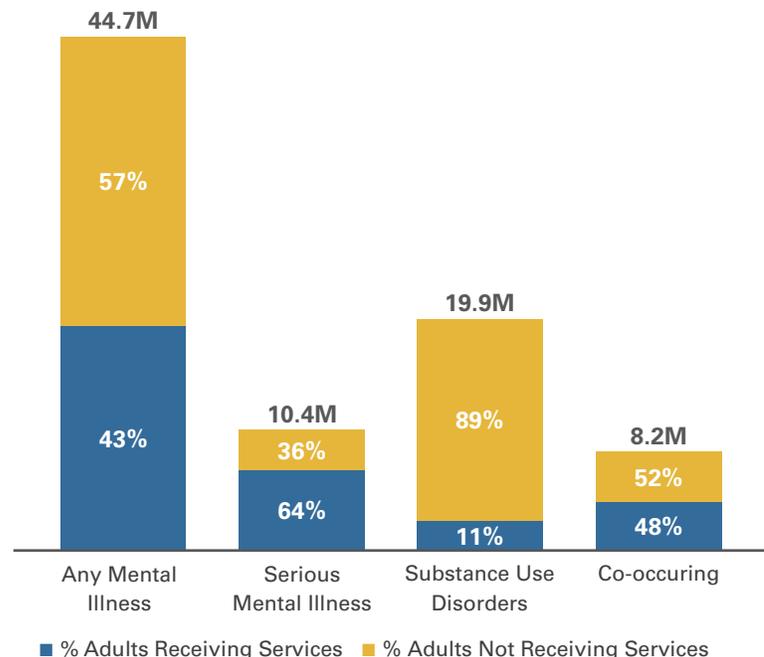
Key Messages:

- Behavioral health is essential to individual and population health.

- Timely access to affordable services remains a challenge for many Americans.

- Increasing access to behavioral health services can improve outcomes and lower costs.

- Hospitals and health systems are implementing innovative strategies to increase access to behavioral health care in their communities.

- However, policymakers need to address barriers, such as inadequate reimbursement and workforce shortages, and fully implement the mental health parity law to support replication of successful health system strategies.

Behavioral health disorders affect nearly one in five Americans and have community-wide impacts.[1] Despite the prevalence of these disorders, behavioral health care needs often go unmet. In 2016, only 43 percent of the 44.7 million adults with any mental health disorder received treatment, and less than 11 percent of adults with a substance use disorder received treatment (see Chart 1).[2]

Hospitals' roles in their communities as providers of emergency, inpatient and outpatient care, as well as their relationships with community-based organizations, have made them central to addressing community-wide behavioral health care needs. Many are designing and implementing innovative strategies that support efforts to improve care, promote population health and lower costs of health care.

This *TrendWatch* shares ways that hospitals and health systems are identifying and addressing behavioral health care needs in their communities, the strategies they are using to increase access and the barriers to broader progress. The report explores how unmet behavioral health care needs among adults have increased demands on hospitals and health systems across the continuum of care. The *TrendWatch*

Despite the need for behavioral health services, access is still limited.

Chart 1: Behavioral Health Disorders in U.S. Adults and Access to Services, 2016 (in millions)

- ■ % Adults Receiving Services ■ % Adults Not Receiving Services

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey and Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52).

also shares the findings from four case studies, showcasing Cambridge Health Alliance (Somerville, Mass.), Lee Health (Fort Myers, Fla.), Mission Health (Asheville, N.C.) and PeaceHealth (Friday Harbor, Wash.) and how they are increasing access to care and advancing value for patients, providers and communities.

Hospitals and Health Systems Address Behavioral Health Care Needs Across the Care Continuum

With one in every five American adults living with a behavioral health disorder, there is widespread need for behavioral health services.[4] Additionally, many people with behavioral health disorders have co-occurring physical conditions that further complicate care, negatively impact outcomes and increase overall costs. The prevalence of behavioral health issues and their interactions with – and impact on – physical health have created an increasing demand on hospitals and health systems across the continuum of care.[5]

Patients present with behavioral health care needs in almost every setting across the continuum, including emergency departments (EDs), acute inpatient units (such as oncology, cardiology and orthopedics), specialized psychiatric and substance use disorder, geriatric, eating disorder and medical/psychiatric disorder units, and physician offices and outpatient clinics. Additionally, one out of four patients admitted to a general hospital also has a behavioral health diagnosis.[6]

Hospitals and health systems are also often the "safety nets" for behavioral health care – especially when community-based services are in short supply.[7] At times, this can lead to patients with chronic behavioral health

disorders seeking care in hospitals that have been designed for short-stay medical care.[8] To address these issues, hospitals and health systems are examining ways to increase access to care in more appropriate settings through forging community partnerships, integrating physical and behavioral health care in primary care settings, and re-examining the role of EDs.

Community Partnerships: Hospitals and health systems are developing new and strengthening current community-based partnerships to prevent and address behavioral health issues outside of the four walls of a hospital or physician's office. For instance, hospitals and health systems are partnering with law enforcement, community mental health clinics (CMHCs), community behavioral health clinics (CBHCs), federally qualified health centers (FQHCs), academic medical centers, churches, community advocacy groups and other social service agencies to connect people with behavioral health disorders with care and resources.

Primary Care: Primary care settings are a "gateway" to care for many individuals with behavioral health care needs.[9] Many hospitals and health systems are coordinating or integrating behavioral health assessments and services into primary care, as well as supporting behavioral health training and education for primary care providers. Health systems are using patient-centered medical homes (PCMHs), case managers, behavioral health professionals and other clinicians in primary care settings to provide assessments, consultations and treatment.

EDs: EDs are a major stop-gap in the behavioral health delivery system,

providing an always-accessible site of care for individuals with behavioral health care needs. However, these facilities often are not well suited to provide comprehensive and ongoing behavioral health care. Specifically, EDs may be limited by the lack of psychiatrists, high demand and busyness.

Approximately one in eight ED visits involves behavioral health conditions.[10] The rate of behavioral health-related ED visits increased 44.1 percent between 2006 and 2014, with the number of visits related to suicidal ideation growing the most.[11] In communities where access to behavioral health care is limited, EDs are often where patients await the availability of an appropriate inpatient psychiatric bed, sometimes for many hours or even days.[12] As a result, hospitals and health systems are focusing on how to reduce these "boarding" stays and connecting these patients with appropriate, timely care.

Patient and Community Impacts

Behavioral health disorders have significant impacts on individual and community health, utilization of services and costs. People with behavioral health disorders are more likely to have other chronic medical conditions such as asthma, diabetes, heart disease, high blood pressure and stroke than those without a mental illness.[14] In addition, those with physical health conditions (e.g., asthma or diabetes) also report higher rates of substance use disorders and "serious psychological distress."[15] As a result, those with behavioral health disorders – and co-occurring physical health conditions – are likely to use more services, such as hospital and ED care, which increases costs.[16]

While this *TrendWatch* primarily focuses on behavioral health care needs among adults generally, there are unique population-specific needs. For instance, all of the interviewed health systems highlighted outreach and treatment for children and adolescents as a focus of current and future efforts to improve access to behavioral health services. Other populations with unique needs include geriatric, veteran and LGBTQ groups as well as rural populations.

- Approximately 30 percent of adults with a medical condition also have a behavioral health disorder.
- Close to 70 percent of behavioral health patients have a medical co-morbidity.[13]

Impact of Co-Morbidities: Care for people with behavioral health disorders is often complicated by the presence of comorbid and chronic conditions. For instance, 15 percent to 30 percent of people with diabetes also have depression, often resulting in worse outcomes such as increased risk of other conditions (e.g., coronary artery disease and microvascular complications).[17,18] Among Medicare, Medicaid and dually eligible populations, more than 50 percent of adults treated for a behavioral health disorder had four or more comorbid physical conditions.[19] Many mental health diagnoses also are associated with a reduction in life expectancy by 7 to 24 years compared to individuals without such disorders – greater than the estimated 8 to 10 years of reduced life expectancy from heavy smoking.[20]

Costs are also 75 percent higher for people diagnosed with both behavioral health and other common chronic conditions than for those without a co-occurring mental health diagnosis.[21] In Medicaid, the cost of care is two to three times higher for beneficiaries with co-occurring behavioral health and chronic conditions.[22] Patients with behavioral health disorders also have significantly greater spending for general medical conditions than patients without a behavioral health disorder.[23]

Disparities: Studies have demonstrated disparities in behavioral health care access for various populations, including racial and ethnic minority groups, the LGBTQ community, military service members and veterans, and rural residents. These disparities continue to result in poorer health outcomes and increased costs across the health care system.[24]

Disparities in behavioral health care access are well-documented for racial and ethnic minorities. For example, one study found that 48 percent of white adults with mental illness received services in 2015; however, only 31 percent of African-American and Hispanic adults with mental illness and only 22 percent of Asian-American adults with mental illness received services that year.[25] Additionally, American Indians and Alaska Natives have low rates of

Increased number of co-occurring physical and behavioral health conditions drives health spending.

Chart 2: Impact of Co-occurring Behavioral Health and Physical Health Disorders on Health Spending

Average Annual Spending, 2010-2013 (in billions)

	BH Disorder Only	One Co-occurring Condition	Two Co-occurring Conditions	Three Co-occurring Conditions	Four or More Co-occurring Conditions
Depression	$5.49B	$13.79B	$18.85B	$34.31B	$354.02B
All BH Disorders	$12.13B	$27.44B	$39.56B	$52.61B	$540.62B

Source: Thorpe, K. Jain, S., & Joski, P. (2017). Prevalence and Spending Associated with Patients Who Have A Behavioral Health Disorder and Other Conditions. *Health Affairs,* 36(1), 124-132, doi: 10.1377/hlthaff.2016.0875.

use of mental health services and elevated suicide rates.[26] There are also racial and ethnic disparities in the treatment of substance use disorders. Although studies have found similar rates of access to substance use treatment among populations, there are differences in the course of care and completion of treatment.[27,28] For example, one study found that African-American and Hispanic individuals were less likely to complete substance use disorder treatment.

This disparity was largely attributable to socioeconomic factors, underscoring the complex nature of behavioral health disorders and access to care.[29] Numerous factors contribute to racial and ethnic disparities in behavioral health care access and treatment. These can include difficulty finding and paying for care because of lack of insurance or underinsurance, lack of culturally competent providers, and inadequate availability and support of safety net providers.[30] However, other factors have to do with long-standing and cultural differences toward behavioral health conditions including issues with stigma about mental illness or distrust of the health care system.[31]

Other examples of populations facing disparities in behavioral health access include:

- **Military Service Members and Veterans:** The suicide rate for veterans and military service members is higher than that for the general population; 20 percent of all suicides are by veterans.[32] Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that approximately 50 percent of returning service members who need treatment for

behavioral health conditions seek it, but only slightly more than half who receive treatment receive adequate care.[33]

- **LGBTQ Individuals:** While LGBTQ individuals have higher rates of behavioral health service use than their heterosexual counterparts, they are more likely to attempt or commit suicide, particularly during adolescence.[34,35,36] LGBTQ individuals may also face stigma or discrimination in accessing care.

- **Rural Populations:** While the prevalence of behavioral health conditions is generally similar in rural and urban populations, rural populations are less likely to receive any or an insufficient level of treatment due to lack of access and less anonymity for those seeking care in small communities.[37]

Spending for behavioral health treatments is expected to increase.

Chart 3: Estimated spending for behavioral health treatments.
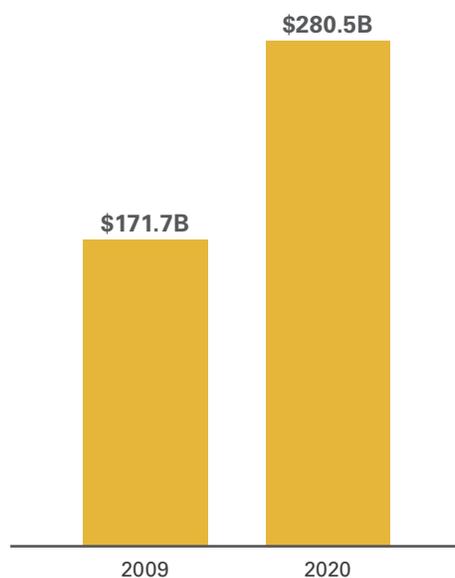
$280.5B

$171.7B

2009   2020

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020. HHS Publication No. SMA-14-4883. *https://store.samhsa.gov/shin/content/SMA14-4883/SMA14-4883.pdf*

Economic Impacts

In 2013, expenditures for treatment of mental health disorders reached $201 billion, surpassing spending for heart conditions by $54 billion and cancer by $79 billion.[38] According to recent estimates, spending for behavioral health treatments is expected to total $280.5 billion in 2020, an increase from $171.7 billion in 2009.[39] These projected expenditures reflect the need for institutional services and the high rate of growth in spending on behavioral health disorders.[40]

Behavioral health disorders also have broad indirect economic impacts on households and communities including reduced productivity, poorer educational outcomes and legal issues. Serious mental illness (mental health conditions that cause serious functional impairment such as major depression, schizophrenia and bipolar disorder) costs the United States $193.2 billion in lost earnings per year.[41,42] More than one-third of students ages 14 to 21 who have a mental health condition and are served by special education drop out – the highest dropout rate of any disability group.[43] Inadequate access to mental health services also contributes to the overcrowding of jails and state prisons.[44] Approximately 16 percent of those in prison have a mental illness or substance use disorder, and repeated incarceration is common for those who lack access to behavioral health services.[45,46,47]

Increasing Access to Advance Value

Increased access to behavioral health services is associated with improved health outcomes and quality as well as lower overall health costs. Research demonstrates that models that incorporate behavioral health

An analysis of more than 20 million people with commercial insurance, Medicare and Medicaid found that medical and behavioral health integration could save $26-$48 billion annually.

into other medical settings through collaborative or integrated care models are associated with positive impacts on behavioral and physical health outcomes as well as reductions in use of acute services.

Improving Quality and Outcomes:

- A 2012 analysis of nearly 80 research trials found that patients with depression and anxiety had significantly better outcomes under a collaborative care model than those receiving standard primary care. There was also evidence of benefit in secondary outcomes including medication use, mental health, quality of life and patient satisfaction.[48]

- A study of collaborative care interventions for patients with opioid or alcohol use disorders demonstrated significant increases in the likelihood of receiving treatment and abstaining from alcohol and drugs. At six months, 39.0 percent of the intervention group received treatment compared with 16.8 percent in the usual care group. Additionally, 32.8 percent of the intervention group reported that they had abstained from opioids or alcohol in the previous month compared with 22.3 percent of those in the usual care group.[49]

- A non-pharmacologic delirium prevention program used in a hospital demonstrated 30 percent lower incidence of delirium and a projected $16.5 million per year reduction in inpatient costs per 30,000 admissions.[50]

Reducing Utilization of Acute Services:

- Yale New Haven Psychiatric Hospital has developed a multidisciplinary inpatient Behavioral Intervention Team (BIT) model, which is associated with a significant reduction of length of stay (LOS) and utilization of constant companions. Findings also demonstrated a return on investment **(ROI) of 1.7:1 even with additional personnel costs**.[51]

- Robert Young Center for Community Mental Health, a hospital-based community mental health center and affiliate of UnityPoint Health-Trinity in Rock Island, Ill., implemented PCMHs in their hospital. The Center was able to **reduce ED visits by 46 percent**, psychiatric admissions by 50 percent, and medical admissions for patients with behavioral health diagnoses by nearly 17 percent.[52]

- Cherokee Health Systems in Knoxville, Tenn., co-located behavioral health professionals in primary care settings to enable real-time consultations. These include behavioral health screenings and tracking high-need patients for treatment adherence. As a result, Cherokee Health Systems **reduced ED visits by 68 percent, hospital care by 37 percent and overall costs by 22 percent**.[53]

- Recent studies also have demonstrated that proactive psychiatric involvement in the hospital setting – ongoing psychiatrist participation with general medical teams rather than as-needed consultation – can reduce LOS and was also was associated with decreased time to consultation.[54]

Reducing Costs/ROI:

- A recent 10-year study of Intermountain Healthcare's integrated team-based care practices demonstrated key improvements in screenings, quality, utilization and cost when behavioral health services were integrated into primary care settings. Based on Intermountain Healthcare's experiences, it is estimated that the United States would **save at least $4 billion a year in health care costs** if the model were used nationally.[57]

- A study on the Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) model, a team-based collaborative treatment model used in primary care settings, found that elderly patients with depression receiving the intervention had approximately **10 percent lower total health care costs** than those receiving usual care.[58]

- An April 2016 World Health Organization-led study estimated a **4:1 ROI** from improved health and ability to work if the United States increased spending on treatment for depression and anxiety disorders by approximately $10 billion per year for 15 years.[59]

- A study examining collaborative care models found that patients with diabetes and depression had 115 fewer days of depression per

year. They also estimated **savings of $2.9 million annually in lower total health costs per 100,000 diabetic patients**.[60]

- Research on collaborative care models for patients suffering from panic disorder found reductions in the number of days of reported anxiety each year and projected savings of **$1.7 million in reduced health costs annually per 100,000 primary care patients**.[61]

Strategies for Improving Behavioral Health Access

Hospitals and health systems are deploying a broad range of efforts to increase access to behavioral health services in the communities they serve (see Chart 4). Case studies with profiled organizations identify a number of key strategies and provide details on these efforts.

Strategy 1. Identification, Prevention and Screening: Identification and screening are foundational elements of improving access to behavioral health services – and can support early intervention efforts for children and adolescents in particular. Estimates

suggest that many mental health conditions develop early, with half of all mental health conditions beginning by age 14, and three-quarters of mental health conditions developing by age 24.[62] Efforts to improve screenings for behavioral health disorders can help promote earlier assistance and treatment.

The Cambridge Health Alliance (CHA) conducts annual screenings during primary care visits to identify high-prevalence conditions such as anxiety, depression and alcohol/substance use disorder. Brief interventions can be provided for low-acuity needs, and referrals are made for those with greater needs to ensure appropriate connections with behavioral health resources. At PeaceHealth, primary care physicians screen for behavioral health care needs and can immediately refer to social workers onsite to conduct further assessment if needed.

Interviewed health systems also mentioned the need to encourage more screening for behavioral health issues in child and adolescent populations. CHA is considering greater implementation of screening

and primary care integration models for younger patients to increase access in pediatrics. Their interest in addressing issues in the youth population is supported by the state's focus on care for this population through the Medicaid program. Under the Medicaid program, states must cover the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which includes screening and treatment for behavioral health issues.

Finally, some health systems are using community-wide assessments to better identify behavioral health care needs at a population level. For example, Mission Health uses community health needs assessments (CHNAs), a strategic-planning process required by the Affordable Care Act (ACA), to identify partners and to design behavioral health programs.

Strategy 2. Coordination and Integration: The health systems profiled in this report also cited the need to integrate behavioral health services into primary care. For instance, CHA's integration efforts equip primary care teams to provide basic care such as brief behavioral

Hospitals and health systems use multiple strategies for increasing behavioral health services access.

Chart 4: Strategies Identified from Health System Case Studies to Increase Access to Behavioral Health Services

| Identification, Prevention and Screening | Coordination and Integration | Community Partnerships | Workforce Development | Infrastructure Development | De-stigmatizing Behavioral Health |

Perspectives on Identification, Screening, and Referral from the ED

Lee Health in Fort Myers, Fla., observed that its ED was often the general point of entry to care for patients with behavioral health conditions – and often co-morbid medical conditions as well. The system now has a consultation team in place that conducts a full evaluation of a patient's needs in the ED. Providers care for all identified medical issues – and patients with behavioral health conditions that can be treated in an outpatient setting are referred to community partners. Lee Health has also developed a partnership with a local inpatient psychiatric facility that helps address acute psychiatric needs.

health interventions. Early outcomes indicate that patients with acute depression in integrated models are receiving more follow-up care and have better depression scores than patients in usual care settings. CHA has observed a significant change in primary care provider knowledge and confidence to support patients with behavioral health disorders. CHA also has added behavioral health care to its PCMHs.

While there is a focus on integrating behavioral health services into settings such as primary care or EDs, there is also a movement to include behavioral health care in physical health care settings beyond primary care.[63] Indeed, CHA and PeaceHealth described the importance of team

members dedicated to patient follow-up, scheduling and coordination. Many hospitals have learned that such integrated and expanded teams improve patient compliance and improve outcomes.

Hospitalization represents an unrecognized opportunity to optimize both mental and physical health outcomes. At Cedars-Sinai Medical Center in Los Angeles, 95 percent of patients admitted to the hospital receive screening and evaluation for depression. Massachusetts General Hospital in Boston has implemented a collaborative care model improving cancer care for patients with serious mental illness. In their efforts to bring the care to the patient, rather than the other way around, Northwell Health embedded two hospitalists in the neighboring inpatient psychiatric hospital; when patients need medical treatment, they can receive it without interrupting their behavioral health treatment. As a result, patients who used to end up in their ED don't anymore, and their 30-day readmission rate has fallen by 50 percent.

Strategy 3. Community Partnerships: Hospitals and health systems are partnering with stakeholders in their communities, including other hospitals and academic medical centers, providers such as CMHCs and FQHCs, community groups and social service organizations. Partnerships help pool community resources to expand access to behavioral health services.

For instance, PeaceHealth is partnering with an academic medical center to use telepsychiatry to

increase access. In Florida, Lee Health opened a triage center supported by grant funding, drawing law enforcement, local charitable organizations and other providers together to provide jail diversion services for those with behavioral health conditions. The center started with 18 beds and has expanded to 58 beds; it offers social work and case management services, as well as medication management and nutritional supports such as a food pantry.

Perspectives on Partnering to Create a Telepsychiatry Program from PeaceHealth

PeaceHealth's Peace Island Medical Center (PHPIMC) is located on San Juan Island in Washington State. Patients on the island previously had limited access to psychiatric services, and going to the mainland required a ferry ride and could take all day. To remedy this, PHPIMC partnered with the University of Washington to offer telepsychiatry services to island residents. Telepsychiatry enables patients to access behavioral health specialists remotely through video conferencing, allowing regular access to health care providers who are trained to work with patients and local clinicians to treat behavioral health care needs. PHPIMC received a Health Resources and Services Administration (HRSA) telehealth grant to establish the program; now patients on the island have reliable access to psychiatrists.

> "Implementing an integration model takes time, but you stick with it and you have to believe it is worth it. It requires planning, but it also requires flexibility."
>
> *– Primary Care Behavioral Health Integration Program Manager at CHA*

Perspectives on Creating Behavioral Health Urgent Care Centers from Mission Health

Mission Health in North Carolina addressed the high demand that behavioral health care needs placed on their EDs by partnering with community groups to build a behavioral health urgent care center that provides services 24 hours a day, 7 days a week. The center includes assessments, intake and psychiatric evaluations, peer support, and pharmacy services. The staff also assess physical health needs. Currently, the center serves 200 people a month – and it has improved access to care for individuals with behavioral health disorders as well as for non-psychiatric patients seeking care in their EDs.

Mission Health worked with community leaders and organizations to open a family justice center, which provides wraparound services for health care and has established a cancer survivorship program to meet patients' psycho-social needs. Mission Health also helped open a child crisis facility that provides residential care for children, including pediatric and psychiatry staff to provide medication.

Strategy 4. Workforce Development: All profiled organizations highlighted the importance of strengthening the workforce to address behavioral health workforce shortages and provider burnout, while increasing access to behavioral health care. CHA has developed a bachelor's degree-level Mental Health Care Partner position

that supports care coordination and patient follow-up. The system also works with community leaders and resources, such as pastors and peer support specialists. Lee Health employs psychiatric liaisons, who often work in primary care and outpatient specialty clinics and use collaborative care models to address the needs of patients with co-morbid behavioral health and physical health conditions.

Mission Health has focused on recruiting new behavioral health providers, as well as addressing burnout for existing providers by implementing a behavioral health response team (BERT) to address behavioral health escalations in acute settings and improve safety for providers.

Strategy 5. Infrastructure Development: Interviewees identified the need to develop infrastructure, including physical space, telemedicine capabilities and health information technology (HIT) to deliver services and monitor behavioral health care needs. Mission Health and Lee Health have developed stand-alone behavioral health centers to improve timely access to care. Primary care integration efforts are also leading to new uses of space that increase patient access to care. For instance, PeaceHealth has private, devoted rooms for screening and discussion of needs, where clinicians can conduct immediate assessments and follow-up with patients. Lee Health has increased timely access to behavioral health specialists through the use of telepsychiatry in community behavioral health clinics.

Profiled organizations also cited the important role of HIT systems in facilitating behavioral health assessments and information exchange. However, while integrating behavioral health data into electronic medical records (EMRs) improves coordination, updates are often complex, expensive and time intensive.

Strategy 6. De-stigmatizing Behavioral Health: Hospitals and health systems have also developed strategies to combat the stigma often attached to behavioral health disorders. CHA and PeaceHealth found that primary care co-location facilitated more immediate care and conveys that behavioral health is a core component of a patient's well-being. Profiled organizations also cited the creation of educational and other resources that are more patient-friendly, as well as engagement in anti-stigma campaigns that can include community engagement discussions or offering more patient-friendly venues for "fireside chats" discussing issues such as loneliness among seniors.

Barriers to and Opportunities for Increasing Access

Traditional and longstanding barriers to behavioral health access – such as lack of coverage and inadequate reimbursement – remain challenges for hospitals, health systems and patients. Legislation, regulations and policy trends provide opportunities to expand services and increase access and reimbursement for behavioral health care. While recent laws are either limited in scope and/or are

"Our partnership with the University of Washington is important, and they are a reliable and helpful partner. They want this to succeed as much as we do."

– *Senior Administrator at PeaceHealth*

inadequately enforced to fully address the need for, and access to, behavioral health care, increased focus on strengthening enforcement of these laws and building on their successes will help address longstanding issues.

Inadequate Coverage: Despite passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, access to equal behavioral health benefits is still a problem for many insured Americans.[64] **While MHPAEA requires health insurers and group health plans *that cover behavioral health services* to provide the same level of benefits for mental health and/or substance use treatment and services that they do for medical/surgical care, it does not require coverage of behavioral health services**.[65] In addition, strict enforcement of these requirements has been lacking, although the Department of Health and Human Services (HHS) released a congressionally-mandated action plan for enforcement of the law in April 2018.[66]

An online survey conducted by the National Alliance on Mental Illness (NAMI) found that **patients seeking mental health care were twice as likely to be denied care based on "medical necessity"** compared with other services – 29 percent compared with 14 percent.[67] Some plans also continue to use other limits on treatments – such as prior authorization – or requirements for provider admission to networks that are stricter for behavioral health care than medical and surgical care.[68]

The ACA also further expanded coverage requirements by ensuring that qualified plans offered in Health Insurance Marketplaces cover behavioral health treatments and services.[69] Still, access to services

may be limited due to high out-of-pocket costs or narrow networks. Further, coverage for behavioral health is not required to be included in short-term insurance or association health plans.

The Medicaid and Medicare programs also have coverage rules and limitations that may impact access to behavioral health services. While Medicaid requires coverage of medically necessary behavioral health services, states have some flexibility in how they define medical necessity, which can create variability in coverage.[70] Further, states may also provide some services as optional benefits (e.g., rehabilitation, therapy, medication management and peer supports). Coverage of these optional services varies widely among states, but many are critical to support improved health and recovery.[71] For example, treatment in institutions of mental disease (IMDs) is an optional service coverage for children and adolescents with behavioral health disorders up to 21 years of age – despite their potential to help with recovery efforts for youth. Medicare also imposes coverage restrictions on some behavioral health services by limiting payments for inpatient care in psychiatric hospitals to 190 days in a beneficiary's lifetime. This restricts access to needed care for beneficiaries – especially those with serious mental illness.

Inadequate Payment: Significant under-funding of state mental health agencies historically responsible for behavioral health care has been a longstanding issue. Traditional, fee-for-service payment systems also have inadequately reimbursed providers across the behavioral health service continuum. Fee-for-service payment structures rarely reimburse for important elements of behavioral

health care such as coordinating care across providers and settings or for non-face-to-face care management (referrals, case management, etc.).

These low reimbursement rates for behavioral health services also impact access.[72] A recent study demonstrated that **behavioral health providers are still reimbursed less than primary care providers by approximately 20 percent**.[73] The reimbursement issues reflect the undervaluing of behavioral health services, which often require more evaluation and time than procedural services.[74] In addition, separate funding streams and benefit structures for psychiatric and substance use disorders create barriers and limit integration, especially in the Medicaid program – the largest payer of behavioral health care – where payment levels and models can vary from state to state.

In Medicaid, the IMD exclusion mentioned above has traditionally prohibited states from receiving federal matching payments for services for adult Medicaid beneficiaries ages 21 to 64 receiving care in inpatient or residential behavioral health facilities with more than 16 beds. While the recently passed Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act has loosened this prohibition, it only gives state Medicaid programs the option to receive federal matching payments for substance use disorder treatment provided in certain IMDs for up to 30 days over a 12-month period – and the provision expires in 2023.[75]

In addition, the lack of adequate funding for community mental health centers – especially following the closure of many state psychiatric hospitals – has left some communities

without sufficient resources to address increased behavioral health care needs.[76] These barriers related to payment contribute to gaps in the continuum of care.

Workforce Shortages: There is a significant shortage of mental health professionals (i.e., federally designated Mental Health Professional Shortage Areas). **An analysis found that in 2017, the United States only fulfilled an estimated 33 percent of its needs for mental health professionals.** [77] Psychiatry shortages are fueled by the gap between newly trained physicians entering psychiatry and growing behavioral health care needs.[78] In addition, since 1998, the number of Medicare-supported residency positions has been frozen at 1996 levels.[79]

A recent analysis by HRSA projects that the behavioral health workforce shortage is expected to continue, with significant shortages by 2025 of psychiatrists, psychologists, family and marriage counselors, and social workers.[80]

Care Coordination and Regulatory Impediments: The lack of physical and behavioral health integration creates barriers to comprehensive care. Care coordination and integration can be particularly difficult for substance use disorder treatment where separate confidentiality standards for medical records – found in title 42 of the Code of Federal Regulations (CFR), Part 2 – impede the responsible sharing of substance use disorder treatment records between providers. As of January 2019, Congress has yet to enact legislation aligning 42 CFR Part 2 with Health Insurance Portability and Accountability Act (HIPAA) legislation. In addition, the rate of HIT adoption has been low among behavioral health providers for a

number of reasons, including upfront cost, maintenance of systems and issues with consent required to share records.[81] Additionally, laws meant to address fraud, waste and abuse such as the Anti-kickback Statute and the law limiting physician self-referral, also known as the Stark Law, require modernization to ensure they do not create barriers to care coordination and value-based care.[82]

Stigma: Even with increased access to behavioral health services, patients may still have difficulty seeking services or discussing their needs. While public understanding of behavioral health disorders and their causes has increased, stigma unfortunately remains prevalent. Certain conditions, such as schizophrenia and substance use disorders, are associated with even higher levels of stigma than other behavioral health conditions.[83]

Opportunities to Address Longstanding Barriers: Recently, Congress enacted legislation designed to improve access to behavioral health services. The 21st Century Cures Act contained provisions to combat opioid addiction, strengthen mental health parity rules, and establish grants to increase the mental health care workforce.[84] However, many of the law's provisions have not been fully implemented, making its impact difficult to assess. Further, the newly passed SUPPORT Act includes provisions to increase prevention, improve access to treatment of opioid use disorder, promote the use of alternatives to opioids, and encourage safe prescribing.

Last, the physician payment changes under the 2015 Medicare Access and CHIP Reauthorization Act underscored the growing emphasis on the transition from volume-based to value-

based payments, including improving quality and controlling the total cost of care across all conditions and settings.[88] While transitioning to new payment models creates opportunities to include or integrate services for behavioral health, new alternative payment models have not focused on behavioral health and integration.

Access Issues Result in National Challenges

Current epidemics in behavioral health are creating increased pressure on hospitals and health systems and increased demand for behavioral health services. In November 2018, CMS indicated additional flexibility for Medicaid programs to provide short-term residential treatment for mental illness which will likely promote access to care;[86] however, further innovations will be necessary to meet the growing need for behavioral health services.

Opioid Epidemic: Drug overdose deaths continue to increase in the United States, with 115 Americans dying each day from an opioid overdose on average.[87] From 1999 to 2016, more than 630,000 people died from a drug overdose.[88] In 2016, the number of overdose deaths involving opioids was five times higher than in 1999 – totaling more than 42,000 people.[89]

Suicide Rate: According to the Centers for Disease Control and Prevention, suicide is now the 10th leading cause of death for Americans. Suicide rates have increased by 30 percent in half of states since 1999, and nearly 45,000 Americans died by suicide in 2016.[90,91] While 45 percent of those who died by suicide saw a physician in the 30 days prior to their death, more than half of cases involved a person who did not have a

known mental health condition.[92,93]

In response, hospitals and health systems across the country have launched suicide-prevention initiatives. A leading example is the Henry Ford Health System in Detroit, which launched the Perfect Depression Care (PDC) initiative to address depression by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.[94] The system reduced the rate of suicide among patients receiving behavioral health care from an average of 96 people per 100,000 in 1999-2000 to 24 per 100,000 from 2001-2010 — a 75 percent reduction.[95]

Policy Recommendations to Support Hospitals and Health Systems in Improving Access

Hospital and Health System Strategies	Policy Recommendations to Support Strategies
Identification, Prevention and Screening	**Reimburse for Screening and Monitoring of Behavioral Health Conditions:** Screening and monitoring of behavioral health care needs is foundational to improving population health. Reimbursement for these activities is necessary to support prevention and early identification of needs.
Coordination and Integration	**Include Behavioral Health in Value-based Payment or Total Cost of Care Models:** As health systems are asked to take on greater risk for caring for populations through value-based payment models, behavioral health services should be included to encourage integration of care across settings. **Eliminate Regulatory Barriers to Care Coordination:** Policymakers must address the barriers to coordinated, effective care posed by the restrictions under 42 CFR Part 2, which limits the ability of providers to share important information regarding care and treatment for substance use disorders. **Reimburse for Transitional Care:** Transitional care that helps patients from inpatient to home and community-based settings is insufficiently reimbursed despite its importance in reducing readmissions and maintaining individuals in community-based settings. **Provide Access to the Full Continuum of Services:** Congress should eliminate the 190-day limit on care in inpatient psychiatric facilities in Medicare and eliminate or permanently limit the scope of the Medicaid IMD exclusion to ensure access to inpatient and residential behavioral health care when clinically appropriate.
Community Partnerships	**Support New Provider Partnerships.** Policymakers should create compensation exceptions to the Stark Law to allow hospitals and physician practices to coordinate and deliver comprehensive care for patients. Current barriers related to the Stark Law are impeding the development of value-based payment models that should drive integration across settings.

Hospital and Health System Strategies	Policy Recommendations to Support Strategies
Workforce Development	**Encourage Greater Availability of Telehealth/Telepsychiatry:** While telehealth is a powerful strategy to extend access to services, it is underused due to existing barriers, including lack of reimbursement. Expanding reimbursement for telehealth services can support more comprehensive, integrated care models and address barriers to access. **Increase Funding for Training and Development:** Policymakers should consider additional funding and/or student loan forgiveness to support training for health professionals at all levels to reduce workforce shortages. **Address Variability of Scope of Practice Laws:** Policymakers should reduce variability of scope of practice laws and support changes that drive integration of care teams.
Infrastructure Development	**Provide Funding for Infrastructure Development:** Policymakers should consider increasing funding and creating more flexible opportunities for hospitals and health systems to invest in physical space, training workforce, and adapting IT systems to better address behavioral health care needs.
De-stigmatizing Behavioral Health	**Engage Communities on Behavioral Health Issues:** Policymakers should work with community organizations, patients, and caregivers to identify and expand programs that reduce stigma and combat barriers to care. Funding could support public service campaigns or other programs to reduce stigma associated with obtaining behavioral health services.

Conclusion

While nearly one in five Americans is affected by a behavioral health disorder, many individuals are unable to access the services they need. Hospitals and health systems play a central role in meeting the health needs of their communities. Many hospitals and health systems are leading innovations in the way behavioral health disorders are identified and treated – and how patients are supported – through changes in their EDs, inpatient and outpatient settings, as well as via community partnerships. These strategies improve the overall value of health care and can lead to improvements in patient outcomes, quality of care, and total costs. To support these efforts, policymakers should work with hospitals and health systems, as well as patients and community-based organizations, to develop policies that address the social, structural, and financial barriers that constrain appropriate access and use of behavioral health services. As Dr. Brock Chisholm, the first Director-General of the World Health Organization, famously stated, "Without mental health there can be no true physical health."[96]

Policy Questions

1. What ways can reimbursement mechanisms for behavioral health services support health system strategies for increasing access?

2. How can policymakers better support hospitals and health systems in addressing the behavioral health care needs of specific populations such as children and adolescents, geriatric, veteran, and racial and ethnic minority communities?

3. How can payment models and care delivery approaches drive behavioral health integration?

4. What types of supports should be made available to hospitals and health systems to help form partnerships that address social determinants of health – and drive value and population health across the system?

5. What are potential policy-related strategies to address stigma?

Other AHA Resources on Behavioral Health

www.aha.org/behavioralhealth

Previous TrendWatches

- TrendWatch, *Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes*, (01/26/2012)

- TrendWatch, *Community Hospitals: Addressing Behavioral Health Care Needs*, (2/20/2007)

Guides/Reports

- Guide/Report, *7 Steps to Expand the Behavioral Health Capabilities of Your Workforce*, (10/4/2016)

- Guide (AHA/HRET), *Triple Aim Strategies to Improve Behavioral Health Care*, (2/29/2016)

- Guide (AHA/HRET), *Integrating Behavioral Health Across the Continuum of Care*, (2/27/2014)

- Guide/Report, *Behavioral Health Challenges in the General Hospital*, (9/13/2007)

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TrendWatch, produced by the American Hospital Association, highlights important trends in the hospital and health care field. Sappho Health supplied research and analytic support for this issue.

TrendWatch — May 2019

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