Turning the Tide on Mental Health

Collaboration needed to meet the needs of working age people

By Denise Giambalvo and Cheryl Irmiter, PhD

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WE ARE LOSING too many people to suicide and opioid deaths with mortality rates increasing 17% for suicide and more than 200% for opioids from 2004 to 2014. In Illinois the state ranks ninth in the nation for adults having a higher prevalence of mental illness and lower rates of access to care, with 10.8% of adults reporting their mental health had not been good for two or more weeks in the past 30 days.

As most of these people are of working age, employers are greatly impacted, and many businesses and organizations are taking matters into their own hands to address mental health in their workforce. Employers realize they can't make progress on their own to meet the growing need for behavioral health services. Achieving systemic change and removing barriers for access to care requires employers (the largest purchasers of health care outside of the federal government), non-profits such as the Midwest Business Group on Health, the Institute of Medicine of Chicago and The Kennedy Forum, health plans and health systems to work together.

Late last year these stakeholders convened to create a mental health collaborative to benchmark access to care in Illinois against other states and address the growing tsunami of mental health issues across the state. The efforts of these stakeholders' center around the following goals:

- Create mental health-informed and prepared communities
- Improve appropriate access to mental health resources
- Reduce harm for those with chronic mental illness
- Improve management of mental illness as a chronic disease

Out-of-Network Challenge

Making systemwide improvements and addressing mental health access is complex and encompasses many factors including the geographic proximity to care and the shortage of care delivery resources. A 2017 Milliman Research study uncovered that patients use a higher proportion of behavioral health out-of-network services than out-of-network medical/surgical services. Between 2013 and 2015, the proportion of inpatient facility services for behavioral health care that were provided out-of-network was 2.8 to 4.2 times higher than the medical/surgical services, and the proportion of outpatient facility services for behavioral health care that were provided out-of-network was 3.0 to 5.8 times higher than the medical/surgical services.

The need to have more providers in-network is apparent, yet one's resistance to join a network is understandable especially given that primary care and medical/surgical providers are paid more than behavioral health providers. The Milliman report also noted that between 2013 and 2015, primary care providers were paid 20.7% to 22.0% higher rates for office visits than behavioral health providers, and medical/surgical specialty care providers were paid 17.1% to 19.1% higher rates for office visits than behavioral providers. In a recent survey of employers conducted by the National Alliance of Healthcare Purchaser Coalitions, only 48% of responding Illinois employers stated that their "health plan or behavioral health organization has equalized reimbursement rates for mental health/substance use disorder specialists and medical surgical providers for similar services," leaving as many as 52% with a need to audit their plans and ensure reimbursement equity.

If those payment rates are not disheartening, there's more. Earlier this year researchers for the Congressional Budget Office analyzed data from the Health Care Cost Institute—which included claims from 39 million Aetna, Humana, and UnitedHealthcare members—and found that commercial plans paid in-network providers 13% to 14% less than fee-for-service Medicare for psychotherapy or evaluation and management services. And in 2015, in Illinois, PPO payment levels were 21.5% lower for behavioral health providers performing a moderate complexity evaluation and management service as compared to a primary care physician performing the same service.

The Road Ahead: Provider Strategies

So, how can we work together to turn the tide on mental health and create an informed and prepared community? Here are five strategies that providers should consider:

1. Let the carriers know immediately when you have room to accept new patients if in network. This issue is of such concern that employers have taken to paying advocates to help their employees find a provider that can see them within weeks instead of months.
2. Know the clear parameters regarding what effective treatment entails as recently defined

LEFT: Denise Giambalvo is the vice president of the Midwest Business Group on Health. RIGHT: Cheryl Irmiter, PhD, is the executive director of the Institute of Medicine of Chicago.

by the United Behavioral Health ruling in California. The standards of care include treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms; patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective; when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care; the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; and there is no specific limit on the duration of such treatment.

3. Leverage technology to extend your regional reach. Incorporating technology into the provider office bridges the distance between the patient and mental health provider. For example, video conferencing used for mental health visits has proven popular with college students who do not want to change their provider when they attend school away from home.
4. Primary care physicians (PCP) are in a unique position to create immediate access. As an example, the American Psychiatric Association Foundation's Center for Workplace Mental Health promotes the use of a collaborative care model as a solution to improving access and clinical outcomes. The first place a patient enters the system is generally through the primary care practitioner. Directing patients with mild to moderate mental illness to PCPs who have added nurse practitioners or physician assistants who specialize in psychiatry to their office allows for appropriate time to be dedicated to diagnosis and the coordination of care with psychiatrists and other mental health providers.
5. Contact Illinois senators and representatives asking them to support S.286 – [ital]Mental Health Access Improvement Act of 2019[ital] that was introduced in the Senate on January 31, 2019. This bill permits marriage and family therapists (MFTs) and mental health counselors to be paid under Medicare. To date, only clinical social workers (MSWs) have been permitted to bill through Medicare. MFTs and mental health counselors will also be permitted to create discharge plans and will be excluded from the skilled nursing payment system. Legally documenting these changes recognizes that the education and training for MSWs, MFTs and mental health counselors is equivalent, which allows for greater access to services primarily for the Medicare population in rural areas and for our senior population.

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Retreating the tide of mental health and substance use disorders for our Illinois population is not going to happen just from improving access to providers. It will require bringing together health care providers and systems, health plans, employers and community leaders to work towards change that will have a longterm sustainable impact. We invite you to get involved in our Mental Health Collaborative and engage with Illinois employers to build a better system for their employees and families.

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