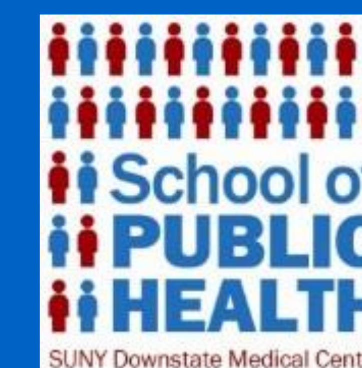
Achieving Mental Health Parity for Medicaid Beneficiaries

Viola Woo



Public Health Significance

The COVID-19 pandemic continues to negatively affect the well-being and mental health of millions of Americans. As the single largest payer of the behavioral health services in the United States, the Medicaid program is a lifeline for many people with mental health conditions. Medicaid provides health coverage to 27% of adults with a serious mental illness, helps to manage their condition, and puts them on a path to recovery. Although Congress enacted several laws to improve access to mental health and substance use disorder services, many Medicaid beneficiaries are still facing barriers to mental health services, such as the Institution for Mental Diseases (IMD) exclusion which prohibits the use of federal Medicaid funds to treat enrollees ages 21 to 65 in psychiatric hospitals or residential treatment facilities that have more than 16 beds. Also, many children covered by Medicaid do not receive behavioral health screenings during well-child visits due to the lack of adequate training and resources for pediatric primary care providers to identify and treat behavioral problems in children.

Objectives

- To discuss how two evidence-based models: Collaborative Care and Child Psychiatry Access Program could address the existing barriers that prevent Medicaid beneficiaries from achieving full parity.
- To explore limitations of those two models.
- To provide policy recommendations on how to expand access to mental health services for all Medicaid beneficiaries.

Evidence-Based Models

Collaborative Care Model (CoCM)

- To integrate specialty mental health care into primary care settings using a team-based approach that involves a behavioral health care manager and a psychiatric consultant who work with primary care physicians.
- The key features include:
  - Care coordination and management by care managers
  - Regular patient monitoring using clinical rating scales
  - Regular psychiatric caseload reviews with a psychiatric consultant in-person or through telehealth
  - Use of stepped care to approach complex or treatment-resistant cases

Child Psychiatry Access Program (CPAP)

- To increase the use of psychiatrists and strengthen primary care physicians' ability to address behavioral health problem in children.
- The key features include:
  - Telephonic consultation with a psychiatrist or licensed behavioral clinician
  - Face-to-face psychiatric or behavioral health consultations
  - Written summaries of consultations shared with primary care physicians
  - Care coordination for assistance with referral to community-based behavioral health services

Model Limitations

- **Funding and referral obstacles**. Both models are not financially self-sufficient through routine fee-for-service reimbursement mechanisms and rely on state-level initiatives or alternative sources of funding. Provider costs for outreach and team supervision are not directly covered by Medicaid state plan authorities.
- **Billing and budget restrictions**. Medicaid may be able to reimburse for consultations between professionals regarding the delivery of care coordination or treatment if the costs are part of covered services. Within the context of the current COVID-19 pandemic, the implementation timeframe for new payment mechanisms has its own challenge, as the billing codes for Collaborative Care took over 15 years to be developed and implemented.
- **Telehealth implementation barrier.** The issues of parity remain to be one of the largest barriers to the widespread implementation of telehealth. Prior to COVID-19, only five states had implemented telehealth parity laws. Recent analyses showed that at least additional 21 states expanded their telehealth services through COVID-19 emergency orders; however, only 13 required parity.
- **Lack of cohesive telehealth legislation.** Many states are not waiting for the passage of federal legislation and introduced their own legislation during the pandemic. Not surprisingly, no two states are alike in how telehealth is treated despite some similarities in the language used. Some states have incorporated telehealth-related policies into law while others address issues in their Medicaid program guidelines.

Policy Recommendations

- **Repeal or modify IMD exclusion.** To achieve mental health parity for Medicaid, the IMD exclusion, a discriminatory law, should be repealed or modified to allow for payment of mental health treatment in inpatient settings, regardless of the number of beds.
- **Establish more health homes in states.** Due to the uncertainty of the pandemic, states could use the CoCM and CPAPs models to design health homes and offer a continuum of health home services to meet the increasing mental health care needs of Medicaid beneficiaries.
- **Increase transparency of telehealth funding.** Although Congress plans to provide a second round of an additional $249.95 million in 2021 as part of the Coronavirus Aid, Relief, and Economic Security Act, the federal government should increase the transparency of funding allocations, define evaluation metrics that target "hardest hit" areas, and address the needs of unfunded applications.

Conclusion

Mental health disparity exists when physical and mental health are treated as separate entities. The Medicaid program has elements that barred its beneficiaries from obtaining benefits to care for their mental health, and the CoCM and CPAP models attempt to close the gap. To ultimately achieve mental health parity for all, one must recognize physical and mental health as interconnected, and address other existing barriers such as mental health stigma and widespread lack of knowledge about mental illness.