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Medicare and Mental Health: The Fundamentals

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OVERVIEW — *This background paper provides a review of mental health coverage in the Medicare program. It examines the prevalence of mental disorders among Medicare beneficiaries, treatment available through Medicare, and the cost of such treatment. A brief summary of relevant policy issues is provided, including Medicare's outpatient mental health limitation and the potential effect of the prescription drug benefit on the provision of mental health services.*

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Medicare and Mental Health: The Fundamentals

The Medicare prescription drug benefit has drawn attention to the mental health care needs of Medicare beneficiaries. This visibility is likely to become more pronounced once the initial tab for psychotropic drugs under Part D is tallied. Press coverage highlighted the transition problems faced by mentally ill beneficiaries dually eligible for Medicare and Medicaid, as well as the high prices paid by Medicare drug plans for psychotropic drugs. Although psychotropic drugs are an important dimension of mental health treatment, providing appropriate mental health services to Medicare's disabled and aged beneficiaries is a broader challenge than simply ensuring access to medications. Many mental health professionals contend that Medicare's benefit structure is not optimally designed to support the kinds of mental health services demonstrated to be most effective for disabled and older Americans.

As the prescription drug utilization and spending patterns of Medicare beneficiaries unfold over time, a broader examination of Medicare's mental health coverage and payment policies may occur. When Medicare was first established in 1965, its benefit package was closely modeled after the typical commercial health insurance product of the time—a product that offered very limited coverage for mental health services. Traditional health insurance policies often singled out mental health services for more restricted benefits because of concerns that prevailing treatments were of questionable efficacy and that subjective diagnostic standards made the benefit particularly vulnerable to overuse. In creating the Medicare program, few policymakers saw little impetus to depart from this conventional wisdom regarding the structure of mental health benefits.

Over the past 40 years, a number of changes have taken place in the financing and delivery of mental health services. Science has become increasingly adept at explaining how behavioral manifestations of mental illness are linked to biological mechanisms that disrupt brain and nervous system functions. As this evidence base has expanded, the diagnosis and treatment of mental health disorders has improved. Scientific and clinical advances, combined with legislative mandates and a growing understanding of how mental disorders influence general health status, have also increased insurers' willingness to pay for mental health treatments. A variety of employer-sponsored health insurance products have evolved to provide more extensive coverage for mental health while managing utilization in more sophisticated ways. Despite these changes, Medicare's coverage for mental health services has evolved only modestly since the program's inception.

Medicare's benefit structure has, until recently, concealed the impact of mental illness on beneficiary health, service use, and overall program costs. Mental disorders are at least as prevalent among beneficiaries as they are in the general population, yet Medicare spending on mental health has not matched that of other payers. Program policies that do not support preferred models of care have likely affected beneficiaries' treatment and outcomes for some time. Outpatient mental health coverage restrictions, originally intended to minimize inappropriate service utilization, have the potential to foster an excessive reliance on pharmacological interventions and could contribute to higher utilization of other, more expensive health care services, such as hospitalizations.

New spending on psychotropic drugs and demographic changes in the beneficiary population will soon collide to raise the prominence of mental health issues within Medicare. The number of Medicare beneficiaries with mental illness is expected to grow substantially as a result of a variety of factors, including the large cohort of "baby boomers" aging into the program, longer life expectancies and the increasing prevalence of dementia and other cognitive disorders that come with advanced age, and an increase in the number of Americans qualifying for Social Security benefits (and thus for Medicare) on the basis of disability due to mental illnesses.[1] At the same time, Part D–related expenses for psychotropic drugs are likely to more than double current mental health spending by Medicare. The convergence of these trends suggests a large increase in mental health spending over the next 15 years.

Managing the cost and quality of care for chronic diseases in a largely fee-for-service context has long proved to be a difficult struggle for Medicare—and this struggle is abundantly apparent with respect to mental disorders. The diverse mix of services, providers, and care modalities inherent in mental health treatment, along with the cognitive limitations of people with mental disorders, combine to make utilization management and care coordination especially challenging.

A Word of Caution

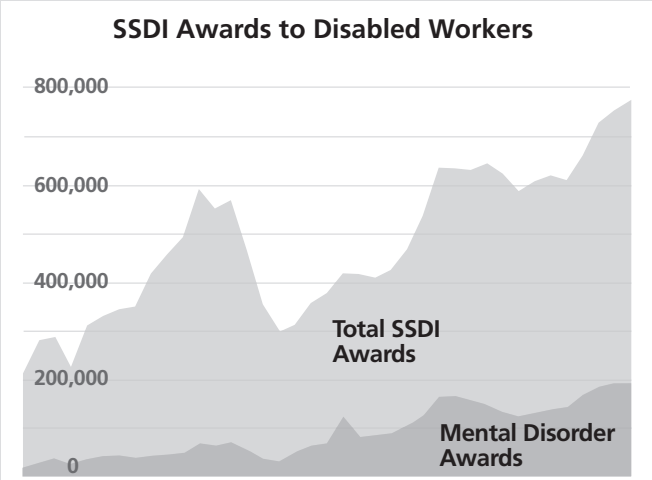
Prevalence estimates for mental disorders within the Medicare population are likely to be understated. Prevalence of mental disorders in the general adult population has been determined through methodologically robust epidemiological studies that relied on standard clinical diagnostic criteria to identify persons with mental disorders and assessed the severity of confirmed cases. In contrast, prevalence estimates for the Medicare population rely solely on service utilization history to identify persons with mental health diagnoses. In reality, people who may not actually require treatment receive services—and people who need care do not receive it—yielding imprecise estimates of disease prevalence as a result of both over- and undercounting of cases. Rigorous studies of the prevalence of mental disorders in the general population indicate that undercounting dominates, suggesting that prevalence estimates for Medicare beneficiaries are conservative.

MENTAL DISORDERS AND MEDICARE BENEFICIARIES

Medicare beneficiaries appear as likely to experience mental health problems as the general adult population.[2] Over a 12-month period, approximately 26 percent of Medicare beneficiaries report having some type of mental disorder,[3] compared to 26.2 percent of all noninstitutionalized

Growth in Disability Awards Related to Mental Disorders

Beneficiaries with disabilities account for a relatively small proportion of all Medicare beneficiaries, but this group has grown rapidly in recent years. The number of disabled Medicare beneficiaries more than doubled between 1990 and 2005, with increasing numbers of disability awards due to mental illness being a major source of this growth. Disabled beneficiaries currently represent nearly 14 percent of all persons who are covered by Medicare. Growth in the number of beneficiaries with disabilities has been attributed to a number of policy changes rather than changes in underlying disease prevalence. Policy changes clarified Social Security's disability determination criteria, resulting in more approvals and fewer terminations. Several of these changes focused specifically on liberalizing the disability determinations for mental disorders, such as tying determinations to functionality assessments and mandating review by a specialty mental health provider in all appealed denials. People judged to be disabled and awarded Social Security Disability Insurance benefits are eligible for Medicare on the basis of their disability.



**Data were not available for the years 1964, 1965, 1966, 1974, 1979, and 1980. The trends are shown as continuous, but the data have been extrapolated.*

Source: *Social Security Administration, "Annual Statistical Report on the Social Security Disability Insurance Program, 2004," March 2006, p. 98; available at www.ssa.gov/policy/docs/statcomps/di_asr/2004/index.html#editions.*

adults over the age of 18.[4] These prevalence estimates reflect the inclusive definition of mental disorder used in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which identifies a wide variety of mental health diagnoses, including mood disorders (such as depression), anxiety disorders, psychoses, cognitive impairments (such as Alzheimer's disease), and substance abuse. The severity of these disorders can vary significantly, both within and across diagnostic categories.

As is the case in the general adult population, a relatively small proportion of all Medicare beneficiaries experience severe mental disorders (such as schizophrenia or major depression) that result in significant functional impairment. About 9 percent of Medicare beneficiaries have a severe mental disorder, compared to 6 percent of the general adult population (Figure 1, following page).[5] However, the overall prevalence rate of severe illness among Medicare beneficiaries obscures important differences in the burden of disease in the aged beneficiary population relative to those who are eligible for Medicare due to disability.

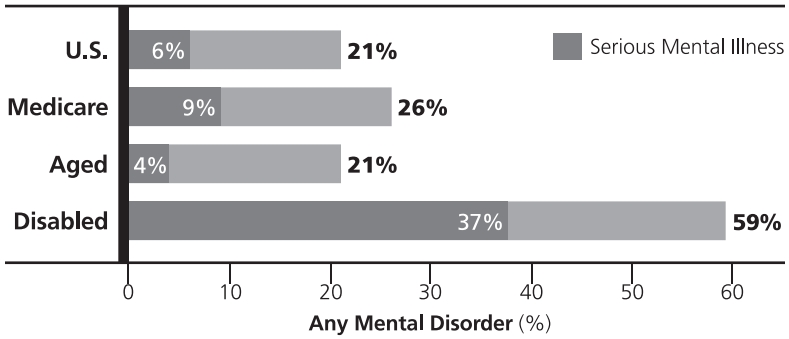
Mental Disorders Among Disabled Beneficiaries

Severe mental illness is highly prevalent among Medicare beneficiaries under the age of 65 who qualify for Medicare because of a disability. Approximately 37 percent of disabled Medicare beneficiaries have a severe mental disorder,[6] compared to only 4 percent of aged beneficiaries.[7] The high rate of mental disorders in the disabled Medicare population is primarily driven by the large proportion of disabled beneficiaries who qualify for Medicare because of a long-lasting and disabling mental illness. Since 1987, both the number and proportion of disability awards due to mental illness have increased dramatically. Mental disorders were the leading reason disabled workers received Social Security Disability Insurance (SSDI) in 2004.[8]

People who qualify for Medicare based on a physical disability may also have comorbid, potentially severe, mental disorders, and the prevalence of all types of mental disorders appears high for this population. An estimated 59 percent of all disabled beneficiaries have some type of mental disorder, compared to 21 percent of aged beneficiaries.[9] The rate of severe mental illness among the physically disabled is not well documented.

Even with Medicare's limited benefits, care for disabled beneficiaries with mental disorders is costly. Excluding persons with end-stage renal disease,

FIGURE 1
Prevalence of Mental Disorders



Sources: William E. Narrow et al., *"Revised Prevalence Estimates of Mental Disorders in the United States,"* Archives of General Psychiatry, *59, Feb 2002; Ronald C. Kessler* et al., *"Prevalence and Treatment of Mental Disorders, 1990 to 2003,"* New England Journal of Medicine, *352, no. 24 (June 15, 2005), pp. 2515–2523; Henry J. Kaiser Family Foundation,* Medicare Chartbook *(Menlo Park, CA: Henry J. Kaiser Family Foundation, 3rd ed., Summer 2005), available at www.kff.org/medicare/upload/Medicare-Chart-Book-3rd-Edition-Summer-2005-Report.pdf.; Ronald C. Kessler* et al., *"Estimating the Prevalence and Correlates of SMI in Community Epidemiological Studies," chap. 12 in* Mental Health, United States, 2002, *Ronald W. Manderscheid and Marilyn J. Henderson, (Eds.), DHHS Publication No. SMA04-3938 (Rockville, MD: U.S. Department of Health and Human Services, 2002), available at http://mentalhealth.samhsa.gov/publications/allpubs/sma04-3938/Chapter12.asp; and Sandra M. Foote and Christopher Hogan, "Disability Profile And Health Care Costs Of Medicare Beneficiaries Under Age Sixty-Five,"* Health Affairs, *20, no.6 (November/December, 2001), pp. 242–253, available at http://content.healthaffairs.org/cgi/reprint/20/6/242.pdf.*

FIGURE 2
Disabled Medicare Beneficiaries Under 65: Medicaid Eligibility and Health Care Costs, 1995

Medicaid Eligible	Beneficiary Type	Medicare Cost Per Person Per Year
43%	All Disabled	$ 3,832
	DISABLED WITH:	
62%	Any Mental Disorder	$ 4,689
73%	Mental Retardation	$ 3,872
53%	Severe Mental Illness	$ 4,454
59%	Dementia	$11,488

Source: Sandra M. Foote and Christopher Hogan, "Disability Profile And Health Care Costs Of Medicare Beneficiaries Under Age Sixty-Five," Health Affairs*, 20, no.6 (November/December, 2001), pp. 245; available at http://content.healthaffairs.org/cgi/reprint/20/6/242.pdf.*

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Medicare's per capita spending on disabled beneficiaries is somewhat lower than its spending on aged beneficiaries.[10] However, disabled beneficiaries with mental disorders are more costly for the Medicare program than the typical disabled beneficiary: Per capita spending on disabled beneficiaries with mental disorders is over 22 percent higher than average spending per disabled beneficiary.[11] (See Figure 2 for Medicare spending on disabled beneficiaries across types of mental disorders.)

Mental Disorders Among Aged Beneficiaries

Aged beneficiaries are far less likely to exhibit mental disorders than disabled beneficiaries but, because of the size of the aged population, most of the Medicare beneficiaries with mental disorders are over the age of 65. Prevalence of serious mental illness is more equally divided across aged and disabled Medicare beneficiaries. Nearly half of all beneficiaries with severe mental illness and about two-thirds of those with any form of mental disorder are aged. (See Figure 3 for distribution of Medicare beneficiaries with mental disorders.)

Significant cognitive impairments, such as dementia, clearly contribute to the prevalence of severe mental illness among aged beneficiaries, but the extent to which other severe psychiatric conditions influence disease prevalence has not been

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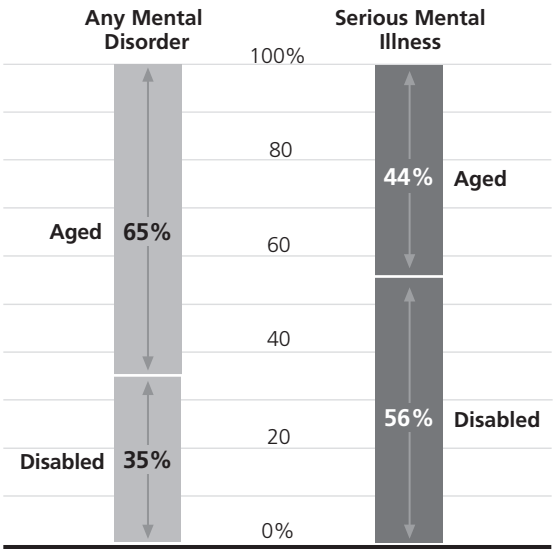
FIGURE 3
Distribution of Medicare Beneficiaries with Mental Disorders, by Eligibility Class



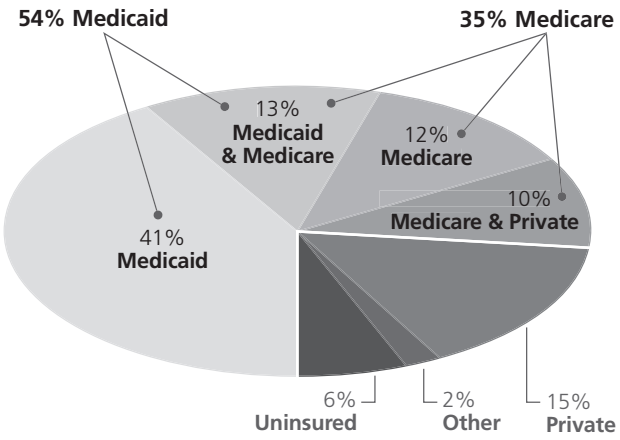
Source: Authors' calculations based on disease prevalence rates cited in this paper and population statistics in CMS, "Medicare Enrollment: National Trends—Medicare Aged and Disabled Enrollees by Type of Coverage," 2005; available at www.cms.hhs.gov/MedicareEnRpts/Downloads/HISMI05.pdf.

Disability, Medicare, and Medicaid

Workers who become severely disabled before age 65 and can no longer work are eligible for Social Security Disability Insurance (SSDI) payments after five months of unemployment. SSDI recipients are subsequently eligible for Medicare coverage after they qualify and receive SSDI benefits for 24 months. Approximately 34 percent of all such disabled adults with mental disorders are Medicare beneficiaries.

For the Social Security Administration (SSA) "disability" is the inability to work at a job that pays at least $900 per month (in 2007) because of a medically determinable physical or mental impairment that is expected to result in death or to continue for at least 12 months. Not all physical and mental conditions are included. For example, drug addiction and alcoholism are not qualifying conditions. Further, people with serious conditions meet the criteria only after their disease is in an advanced stage. Maintaining disability status can be particularly difficult for mentally ill persons who can be stabilized and able to work when they are receiving appropriate medical treatment.

Source of Health Insurance Coverage for Persons Disabled by Mental Disorders



Source: Richard G. Frank and Sherry Glied, "Changes In Mental Health Financing Since 1971: Implications For Policymakers And Patients," Health Affairs, *25, no.3 (May/June, 2006), p. 606.*

Dually eligible — Many low-income beneficiaries who qualify for Medicare due to a disability also qualify for Medicaid. Most states provide Medicaid coverage for aged, blind, and disabled individuals with limited income who qualify for Supplemental Security Income (SSI) from SSA. There is no wait time for SSI eligibility. Approximately 35 percent of SSI recipients qualify as a result of a mental disorder. Approximately 13 percent of all disabled adults with mental disorders are dually eligible for Medicare and Medicaid. Nearly 40 percent of disabled Medicare beneficiaries with mental disorders are also eligible for Medicaid, compared to 30 percent of disabled beneficiaries who do not have a mental disorder.

Eligible for Medicaid but NOT Medicare — Some disabled people are ineligible for SSDI and Medicare because they do not have a sufficient work history but they may be eligible for SSI and Medicaid, depending on their income level and their state's eligibility criteria. This group also includes disabled children and people who receive SSDI but have not yet met the two-year waiting requirement for Medicare benefits. About 40 percent of all disabled adults with mental disorders are eligible for Medicaid but not Medicare.

Eligible for Medicare but NOT Medicaid — Disabled persons with a work history who have fulfilled the two year wait period will be eligible for Medicare, but some of these individuals will be ineligible for Medicaid because their income or assets are too high. Approximately 21 percent of all disabled adults with mental disorders are eligible for Medicare but not Medicaid.

Ineligible for Medicare and Medicaid — Some disabled people will not qualify for Medicaid or Medicare. This group includes those in the process of fulfilling the two-year waiting period, as well as those who do not meet the SSA criteria for disability determination. Approximately 22 percent of disabled adults with mental disorders are ineligible for either Medicare or Medicaid.

Continued from p. 7

fully documented. Available data suggest that one-quarter to one-half of severe mental disorders among the aged are due solely to cognitive limitations. Beneficiaries with dementia may have co-occurring psychiatric disorders, such as depression. The prevalence of other serious mental disorders, such as schizophrenia, appears to be lower in the aged population, most likely because people with these conditions have high rates of premature mortality and life-spans that are, on average, 20 years shorter than the U.S. average.[12]

Although access concerns often center on the needs of vulnerable individuals with severe mental disorders, mental disorders among aged beneficiaries are more frequently mild to moderate in severity. The three most common mental disorders experienced by Medicare beneficiaries over the age of 65, in order of prevalence, are anxiety, dementia or other cognitive impairments, and depression. The prevalence of dementia doubles every 5 years beyond age 65, becoming the most common mental health diagnosis after age 80.[13] The severity of more common disorders, such as dementia, can vary considerably, and only a small proportion of those afflicted are likely to face significant functional impairments.

While the most common types of mental disorders are not usually severe and disabling, people with these mild to moderate mental health diagnoses tend to have high rates of other illnesses. The relationship between mental health disorders and physical disorders such as diabetes, heart disease, and cancer is not fully understood. In some cases, a single disease process may be fundamentally responsible for both mental and physical symptoms. In other cases, underlying mental disorders may undermine adherence to medical protocols (for example, medication management) and healthy lifestyle choices, such as diet and exercise, which are known to influence the onset and management of other chronic diseases. In still other cases, preexisting physical disorders may lead to decreased functionality and increased social isolation, which may subsequently trigger mental health complications. Left untreated, mild to moderate mental disorders can escalate into more serious mental conditions, complicate the treatment of physical health conditions, compromise patient outcomes, and increase the cost of care.

MEDICARE POLICIES RELATED TO MENTAL HEALTH SERVICES

Medicare covers a wide range of mental health services, but special restrictions and limitations are often applied to differentiate psychiatric benefits from comparable physical health services. The impact of Medicare's coverage and payment policies on access to mental health services, quality of care, and patient outcomes is frequently unclear and sometimes hotly debated. The following reviews key issues related to Medicare's coverage of and payment for mental health services.

Inpatient Hospital Services

The acute care services needed to diagnose and stabilize individuals in a mental health crisis have traditionally been provided in inpatient settings. Follow-up treatment planning and referrals for monitoring or additional treatment in the community may also begin in an inpatient facility. Care is delivered through the combined expertise of multidisciplinary teams that include, among others, nurses, psychiatrists, psychologists, and social workers. The relative contributions and mix of disciplines appears to vary considerably across inpatient settings and geographic areas, depending upon care models, patient mix, and workforce characteristics.

The Medicare statute imposes a 190-day lifetime limit on services received in specialty psychiatric hospitals.

Many mental health experts believe that most inpatient psychiatric admissions could be avoided if appropriate community-based services were utilized properly. However, such services are often in short supply or difficult to access. The nature of mental disorders can lead patients to delay, resist, or refuse necessary treatment until a crisis precipitates intervention. In some cases, patients can be hospitalized involuntarily if a court determines that their mental illness has resulted in an immediate danger to themselves or others. Involuntary hospitalizations typically require admission to a locked, secure psychiatric unit.

Life-time limit on inpatient psychiatric services — Under Part A, Medicare pays for inpatient psychiatric care provided in both freestanding psychiatric hospitals and in dedicated psychiatric units of general acute hospitals. These providers are called inpatient psychiatric facilities (IPFs). Medicare will also cover inpatient psychiatric services provided in nonspecialized, medical/surgical beds of general hospitals (commonly referred to as "scatter beds"). Medicare pays for 100 percent of inpatient psychiatric services, subject to a deductible and copayment for extended stays.

Medicare does not cover long-term custodial care for any condition and imposes a 90-day limit on all inpatient hospital coverage for each episode of illness (known as a "benefit period," which begins on the day the beneficiary enters a hospital or skilled nursing facility and ends when the beneficiary has been out of the hospital for 60 consecutive days).[14] This limit applies to both psychiatric and general inpatient services. For general hospital services, there are no coverage limits on the total number of benefit periods a beneficiary is entitled to in his or her lifetime. However, Medicare limits lifetime treatment in freestanding IPFs to 190 days.[15] Stays in general hospitals for psychiatric services are not subject to the 190-day limit. The lifetime psychiatric limit was intended to limit the federal government's role in paying for long-term custodial support of the mentally ill. The limit was not imposed on hospital-based units because these facilities have only rarely been used for long-term care purposes.

The extent to which the 190-day limit hinders access to inpatient psychiatric services is not clearly understood. Although few beneficiaries reach

the 190-day lifetime limit, the policy is most likely to affect beneficiaries disabled by mental illness. These beneficiaries have more frequent psychiatric hospitalizations in a given year and are more likely to be enrolled in Medicare for a longer period of time than aged beneficiaries. Although beneficiaries who reach the 190-day limit could still be covered for psychiatric care provided in general hospitals, consumer advocates and providers are concerned that the limit may undermine choice of physician and jeopardize access to care, particularly in communities where the general hospitals lack psychiatric capacity.

Prospective payment — Medicare recently revised its reimbursement policy for IPFs, moving in 2005 from a cost-based system, with limits, to a per diem prospective payment rate, referred to as the inpatient psychiatric facility prospective payment system (IPF-PPS).[16] The per diem rate varies, depending on the patient's psychiatric diagnosis-related group—which accounts for cost differences across patients that are due to their diagnoses, procedures, and other factors—and on whether the patient has any of 17 coexisting general medical conditions that are associated with higher average costs. The per diem rate is higher in the early days of a psychiatric stay, in recognition of the costs associated with stabilizing a psychiatric patient.[17] Care provided in scatter beds is reimbursed under the per case hospital inpatient prospective payment system (PPS).

The impact of the IPF-PPS on access to care is uncertain at this time, since it is still in its three-year phase-in period. Psychiatric providers are cautiously monitoring its effect on a market that has experienced significant fluctuation in inpatient psychiatric capacity over the past two decades. Some worry that the IPF-PPS may encourage general hospitals (which tend to have higher average cost structures than freestanding facilities) to further reduce inpatient psychiatric capacity in favor of more reliably profitable medical services or to shift beds from specialized units to scatter beds, which will not be reimbursed under IPF-PPS. In 1995, nearly one-third of all Medicare inpatient psychiatric discharges were from scatter beds; this proportion has increased as dedicated psychiatric capacity in both freestanding facilities and general hospitals has decreased over the last decade. Some experts have expressed concerns that the care delivered through scatter beds is not as effective as the care delivered in more specialized facilities. Adding to their concern is the inability of most scatter beds to accommodate involuntary admissions because they lack the security measures required to contain patients who have been hospitalized against their will.

Others believe that the payment system may be advantageous to freestanding hospitals that have lower cost structures and more flexibility to target services to patient needs. Some believe that, while less efficient providers might eliminate psychiatric services, organizations that have developed the expertise and economies of scale to deliver psychiatric services in the most efficient manner could expand their operations, resulting in little overall change in capacity levels.

Partial Hospitalization

Partial hospitalization programs, used in lieu of inpatient hospitalizations, provide structured, intensive outpatient services. These programs, sometimes referred to as day programs, offer a range of medically appropriate services "wrapped around the particular needs of the patient."[18] The services generally reflect a multidisciplinary team approach to patient care under the direction of a physician and are typically much more intensive than those offered through the private practice of an individual mental health provider, such as a psychiatrist or psychologist.[19] Partial hospitalization programs do not provide around-the-clock nursing care, but supervised residential facilities may be offered through affiliated organizations.

Some advocates question the effectiveness of partial hospitalization programs. The lack of around-the-clock supervision may make these programs inappropriate for patients who have not been stabilized. At the same time, the institutional nature of these programs hinders the development of behavioral skills and coping strategies in a real-world, community-based context. Furthermore, partial hospitalization programs often do not include the kinds of psychosocial services (such as vocational training and housing assistance) that are known to support recovery from mental disorders because such programs tend to focus solely on clinical services that are reimbursable through Medicare and commercial insurers.

Regulatory concerns — Partial hospital services were added as an explicit Medicare-covered benefit through the Omnibus Budget Reconciliation Act of 1987. Previously, mental health services delivered through hospital-based partial hospitalization programs were sometimes covered as a Part A (inpatient) benefit, and freestanding partial hospitalization programs were sometimes covered as a Part B (outpatient) benefit, depending on the policies of Medicare contractors charged with administering claims.

Partial hospitalization coverage and reimbursement policies have been the source of considerable controversy over the past decade. Providers complained that the Centers for Medicare & Medicaid Services (CMS) was slow to issue a national review standard when the benefit was first established, allowing Medicare contractors to implement variable review procedures that limited access in some areas and inadequately regulated services in others. After payments to freestanding partial hospitalization programs rose sharply between 1993 and 1997, increasing nearly 500 percent (from $60 million to $349 million), a series of investigative reports revealed that several providers billing for this care delivered care that failed to include the mandated set of partial hospitalization services and was not sufficiently intensive and therapeutic in nature.[20] Much of this substandard care was delivered to patients who did not meet the medical necessity criteria for partial hospitalization services. Once apprised of fraud and abuse problems, CMS intensified scrutiny and decertified many providers across the nation. Also, prospective payment for partial hospitalization services, implemented in 2000, established a fixed payment amount for the bundle

of services offered through the program[21] and minimized opportunities and incentives for fraud.

Outpatient Services

Outpatient mental health can include a diverse mix of clinical services, including diagnostic testing, psychotherapy, targeted case management, medication management, and psychosocial services. These services are provided by primary care physicians, nurse practitioners, and physician assistants, as well as by specialty mental health providers, such as psychiatrists, clinical psychologists, psychiatric nurse specialists, and social workers. The specific scope of practice for these professional disciplines is dictated by state licensure laws and can vary substantially from state to state.

Under Medicare, outpatient psychotherapy services are subject to a 50 percent coinsurance.

Medicare Part B pays for professional services delivered in hospital and outpatient settings and, since 1989, has allowed billing from a broad range of nonphysician mental health service providers subject to state licensing parameters.[22] However, most mental health services covered by Medicare are provided by primary care physicians. More than half (51.6 percent) of patients treated for major depression are seen in the general medical sector and are cared for exclusively by primary care or other nonpsychiatrist physicians.[23] It is also estimated that 67 percent of psychopharmacological drugs are prescribed by primary care physicians.[24]

Coverage limitations — Medicare has an outpatient mental health limitation that imposes a 50 percent coinsurance on psychotherapy services (including individual, family, and group psychotherapy).[25] Other mental health services (such as inpatient therapy services, diagnostic testing, psychological evaluation, and brief visits to monitor the efficacy of prescribed medications) are subject to the standard 20 percent coinsurance.[26] Psychosocial services are generally not covered by Medicare.

The higher coinsurance level for the most common forms of outpatient mental health treatment was originally established to deter inappropriate utilization. Policymakers believed that these services were particularly vulnerable to overutilization for a variety of reasons, including the noninvasive nature of such services, the lack of objective biomarkers to validate diagnoses of mental disorders, and biases regarding the legitimacy of mental disorders and mental health treatment.[27] Differential cost sharing for mental health services was once common practice in commercial insurance products, but many private health insurance plans have moved away from this approach as a result of the adoption of more effective, targeted utilization management techniques; the enactment of state laws requiring parity for mental health coverage; and a growing recognition that untreated mental illness can fuel overall health care spending.

The Office of the Inspector General (OIG) within the Department of Health and Human Services (DHHS) recently found that Medicare carriers have

adopted inconsistent policies regarding the application of the limitation, which has led to wide geographic variation in beneficiary copayment obligations.[28] Among the 57 carriers studied, nine different policies for the application of the limitation were identified. In over one-half of the service areas, carriers subjected evaluation and management services to patients with Alzheimer's disease to the limitation, contrary to federal regulations. Although CMS has issued guidance related to the limitation, the OIG found that this guidance was not sufficiently detailed to ensure uniform implementation across carriers and recommended that new guidance be issued.

MedPAC has recommended that the outpatient mental health limitation be eliminated.

Patient advocates have expressed concern that more onerous cost-sharing obligations for outpatient mental health benefits under Medicare discourage beneficiaries from seeking necessary services and may significantly limit access to treatment for beneficiaries who lack the financial resources or supplemental insurance to fulfill the 50 percent coinsurance requirement.[29] The restriction applies only to psychotherapy services but, especially given inconsistent policies among carriers, concerns have been raised that both patients and providers may believe the higher copayment requirement applies to all outpatient mental health services, discouraging use of diagnostic and other services not subject to the higher copayment.

Access barriers are perhaps most significant for those dually eligible for Medicare and Medicaid.[30] While Medicaid is responsible for covering the Medicare coinsurance of dual eligibles, state Medicaid programs can elect to withhold such payment if the amount paid by Medicare meets or exceeds the Medicaid payment rate for that service. Because Medicaid reimbursement rates for professional services are generally very low relative to Medicare, mental health service providers may be unable to recoup the coinsurance payment from either Medicaid or low-income dually eligible beneficiaries. Although this dynamic also holds true for outpatient treatment of physical health conditions, the 50 percent effective "discount" on mental health providers' service fees is far more substantial than the 20 percent "discount" imposed on physical health services.

The Medicare Payment Advisory Committee (MedPAC) has recommended that the outpatient mental health limitation be eliminated,[31] finding that the modest increase in program costs likely to result from this action ($500 million in 2002) is justified in light of the access improvements and cost-sharing simplifications that would be achieved. Skeptics question whether a more generous outpatient mental health benefit would significantly improve appropriate access and worry that inappropriate utilization could increase.

Ambiguous billing requirements — The willingness of mental health providers to serve Medicare beneficiaries may be further compromised by confusion regarding reimbursement policies and practices that result in protracted adjudication processes and a high rate of claims denials. Up

to 20 percent of claims for medication management services and up to 50 percent of claims for group therapy services are denied. Denials are made for a variety of reasons, and some proportion of these denials are likely valid. The DHHS OIG concluded that one-third of outpatient mental health services provided to Medicare beneficiaries were medically unnecessary, billed incorrectly, rendered by unqualified providers, or improperly documented. Group therapy services and psychological testing were found to be particularly problematic.[32]

Up to 20 percent of claims for medication management services and up to 50 percent of claims for group therapy services are denied.

Many providers believe that local policies set by Medicare carriers for outpatient mental health services are too vague, too narrowly defined, or too often misapplied, resulting in inappropriate denial of claims or costly resubmissions in order to supply necessary documentation. Providers complain that mental health services are subject to variable and poorly articulated payment rules. Medicare limits coverage to services that are medically "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[33] Relatively few criteria for making specific coverage decisions are set at the national level. Rather, Medicare carriers are given a fair degree of latitude in establishing rules to assess medical necessity and set service-specific requirement to ensure the appropriateness of services. Inconsistency in coverage policies across regions is not unique to mental health services, but mental health providers believe that the diversity of practices related to specialty mental health services adds to the confusion.

Providers also believe that carriers implement established policies improperly. For example, some carriers have policies stating that psychotherapy services for patients with cognitive impairments will not be covered if the severity of those cognitive limitations precludes the patient from deriving meaningful benefit from the therapy. Approximately 30 percent to 40 percent of people with dementia also have co-occurring mental disorders such as depression or psychosis[34] that may be helped through psychotherapy, but these comorbid disorders often go undiagnosed or undertreated.[35] Providers report that Medicare carriers routinely deny claims for mental health services delivered to any individual with dementia, regardless of severity level, despite evidence that patients with mild to moderate dementia benefit from psychological interventions that improve functioning and coping. Documentation requirements to validate severity level are not clearly delineated.

Screening services — Mental health screenings to identify conditions that may not be readily apparent to providers are not covered for most existing Medicare beneficiaries, but a new "Welcome to Medicare," one-time physical examination that includes depression screening is covered for any new beneficiary joining the program after January 1, 2005. In general, Medicare does not cover preventive health screenings, except for certain, statutorily defined services. This initial preventive physical examination

was added as a benefit by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and includes a broad range of preventive services. Although depression screening is explicitly identified as a component of the physical, Medicare does not require or recommend any specific screening tool.

Primary care physicians believe that many of the standardized, validated depression screening tools are too cumbersome to administer during a short office visit. The American Academy of Family Physicians has advised an approach recommended by the U.S. Preventive Services Task Force.[36] This approach, the PHQ-2, involves asking two questions: "Over the past two weeks, have you felt down, depressed or hopeless?" and "Over the past two weeks, have you felt little interest or pleasure in doing things?" Answers can either be yes/no or scaled from zero (not at all) to three (nearly every day). An affirmative answer to either question should prompt seven additional questions that provide more detailed evaluation for depression. The extent to which the "Welcome" physical in general and the depression screen in particular will be used is as yet unclear. Patient advocates have raised concerns that even if these screenings are helpful for new beneficiaries, coverage is not available for either screening beneficiaries enrolled before January 2005 or conducting periodic reassessments.

Psychiatric practice incentives — Psychiatrists have increasingly discontinued offering psychotherapy as a component of their practice, preferring to focus on more lucrative medication management services. The financial incentives established by Medicare and other payers encourage psychiatrists to provide psychopharmacologic treatments in contrast to psychotherapy. Reimbursement rates show a clear economic advantage to providing medication with brief follow-up visits and a clear financial disincentive to provide psychotherapy[37]. Psychiatrists earn about $100 less an hour for providing one 45- to 50-minute session of psychotherapy than for providing three medication management visits in the same time. Some private managed care organizations expressly prohibit psychiatrists from providing psychotherapy. Inadequate psychotherapy training in some psychiatric residency programs appears to reinforce the trend away from psychotherapeutic approaches. These forces have made the delegation of psychotherapy services—if they are offered at all—to nonphysician providers common practice, with little coordination between therapists and prescribing physicians.

Many worry that this practice of "splitting" treatment has a negative impact on the quality of patient care and patient outcomes. Opinions differ as to the best way to resolve this problem. Some would advocate for psychiatrists to increase their involvement in providing psychotherapy. Others believe that the delegation of psychotherapy to less highly compensated, yet qualified, professionals is economically efficient and desirable but worry that these providers are not properly trained to monitor prescription drug use. Still others advocate giving limited prescription

privileges to psychologists. Some would argue that more should be done to build a team approach to service delivery.

Reimbursement of nonphysician providers — The central role of nonphysician providers in delivering psychotherapy suggests that these are the providers most likely to be influenced by Medicare's outpatient mental health limitation. For many of them, the financial disincentives of the higher copayment level are compounded by other reimbursement policies that decrease their payment levels relative to those of physicians. Nonphysician providers recognized by Medicare receive different rates for their services. For example, psychologists are paid 100 percent of the physician fee schedule, whereas social workers receive 75 percent of the physician rate. In addition to psychologists and social workers, Medicare also makes direct payment to nurse practitioners with the equivalent of a master's degree in psychotherapy and to clinical psychiatric nurse specialists. Other types of mental health service providers, such as licensed professional clinical counselors and marriage and family therapists, can only be paid indirectly by Medicare (for example, through a physician who employs, supervises, and pays them) and only in limited circumstances.

Although pharmacological interventions are most effective when delivered in combination with psychotherapy, nearly half of all patients taking psychotropic drugs receive no other form of treatment.

It has been argued that expanding the number of professional disciplines approved for direct payment from Medicare and raising the payment rates for professions paid below the physician fee schedule could improve access to mental health services, particularly in rural areas with health provider shortages. However, MedPAC recently recommended against such expansions, finding that, although utilization would probably rise, the increase in program costs likely to result from this action would not represent a prudent use of resources.

Prescription Drugs

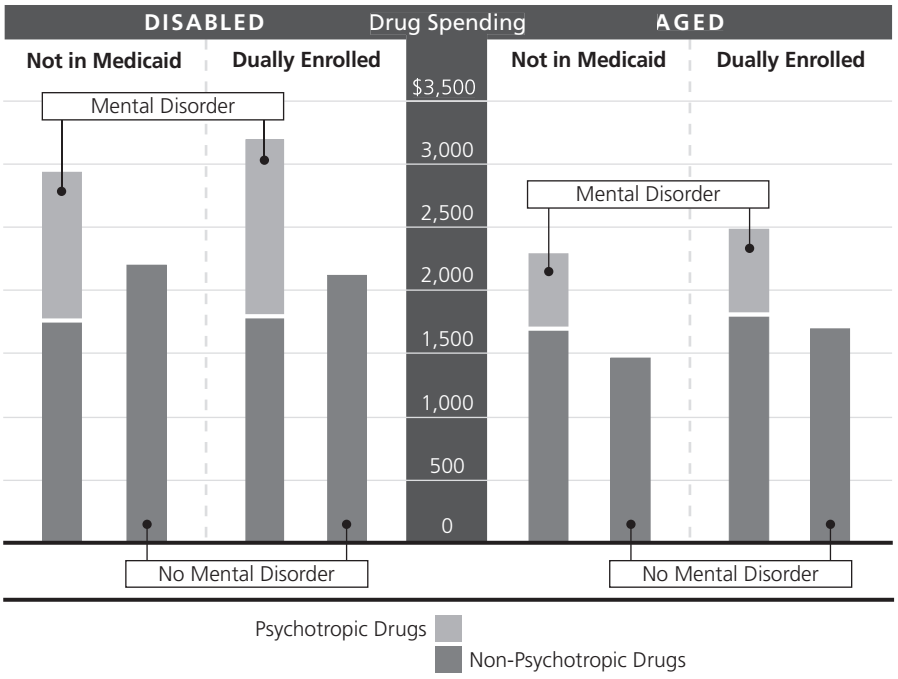
Psychotropic drugs, broadly defined, include any chemical substance that alters brain function. Psychotropic medications commonly used to treat mental disorders include antidepressants, antipsychotics, antianxiety agents, and stimulants. Increasingly a central component in the treatment of mental illness, such drugs were used in 75 percent of mental health treatment cases in 2001.[38] Pharmacological interventions are most effective when delivered in combination with psychotherapy.[39] However, for nearly half of all patients taking psychotropic drugs, medication is the only form of treatment received.[40]

Psychotropic medications can be particularly complicated to monitor, and establishing effective treatment regimens for vulnerable patients with co-occurring neurological disorders is complex. Individuals with severe mental impairments may resist changing medications because treatment often

requires considerable trial and error before an effective medication or medication combination can be identified. Disruptions in medications can be dangerous for these individuals, resulting in rapid deterioration, impaired functioning, increased health care utilization, and overuse of more expensive urgent care services and inpatient hospitalizations.

Medicare Part D began covering outpatient prescription psychotropic and other drugs in January 2006. Coverage is provided through either private, stand-alone prescription drug plans or drug plans offered by Medicare Advantage managed care plans (both types referred to here as "drug plans.") In general, individual plans have a great deal of latitude in determining which drugs are included on a plan's formulary and cost-sharing requirements, but the formulary and benefit design must be approved by CMS. Beneficiaries can select from the drug plans available in their geographic region. Dually eligible enrollees were automatically enrolled in drug plans in an attempt to avoid gaps in coverage as these beneficiaries transitioned from Medicaid to Part D coverage.

FIGURE 4
Average Annual Drug Spending Among Medicare Beneficiaries



Source: Adapted from exhibit 5 in Julie Donohue, "Mental Health In The Medicare Part D Drug Benefit: A New Regulatory Model?" Health Affairs*, 25, no. 3 (May/June 2006), p. 711.*

Protections — CMS recognized that private health plans would have some incentive to discourage enrollment by high-risk, costly populations, including those with mental illness, and implemented protections to minimize risk selection. Beneficiaries with a mental disorder have high per capita drug expenditures,[41] spending, on average, 61 percent more on drugs than beneficiaries without mental illness.[42] (See Figure 4 for average drug spending among Medicare beneficiaries.) In order to minimize the development of benefit designs and enrollment strategies biased against such high-cost patients, CMS required drug plans to conform to a variety of safeguards.

- **Protected drug classes.** Plans are required to cover "all or substantially all" drugs available in six special classes: antidepressants, antipsychotics, anticonvulsants, antineoplastics, antiretrovirals, and immune suppressants.[43] These drug classes are essential to vulnerable groups known to have high prescription drug costs, such as people with mental illness, HIV/AIDS, and cancer.

- **Utilization management.** Drug plans are precluded from imposing utilization management (such as prior authorization, quantity limits, and step therapy) on individuals who were stabilized on drugs in protected drug classes before being enrolled in the drug plan.[44] Plans must also continue coverage for protected medications during the annual benefit period, even if the medication is removed from the formulary. However, plans can apply utilization management tools on any prescription initiated after enrollment in the plan (such as new or different medications or dosage changes). It is not clear how long these protections will remain in place, and plans are not required to provide all doses and forms of a medication (for example, continuous release formulations), which can be particularly problematic for psychotropics because many are prescribed "off-label" at dosage levels that have not been evaluated by the Food and Drug Administration.[45]
- **Cost sharing.** Plans have flexibility in determining placement of drugs on cost-sharing tiers within the formulary. However, plans are explicitly prohibited from using their formularies to discriminate against any class of beneficiaries, and CMS has reviewed drug plans' cost-sharing requirements to ensure that protected drug classes are not systematically assigned to the highest cost-sharing tiers.

"Benzos" exclusion — Although Part D mandates coverage for many of the psychotropic drugs used to treat mental illness, some types of psychotropic drugs (such as antidementia medications) are not in a protected class, and benzodiazepines are statutorily excluded from coverage. Benzodiazepines, which are tranquilizing agents, have been the subject of controversy for several decades. These medications can lead to dependency, and drug-related adverse events (such as oversedation, falls, and hip fractures) may be more common in older patients taking this drug. Nonetheless, benzodiazepines continue to be widely used today, and a growing clinical consensus has developed around their appropriate use. (See Table 1 for an overview of psychotropic drug use by therapeutic category and eligibility class.) Abrupt termination of benzodiazepines can lead to severe withdrawal reactions.[46] In large part because of these clinical concerns, all state

TABLE 1
Percentage of Medicare Beneficiaries Using Psychotropic Drugs by Therapeutic Category and Eligibility, 2002

		DISABLED		AGED	
		Dually Eligible	Other	Dually Eligible	Other
Any Psychotropic Drug Use		**53.1%**	**47.8%**	**31.0%**	**22.6%**
Use by Therapeutic Category*	Antidepressants	39.8%	38.1%	20.6%	15.9%
	Antipsychotics	22.6	8.6	5.0	1.4
	Antimanics	16.3	12.9	4.5	2.3
	Dementia Drugs	0.1	0.4	3.4	2.2
	Benzodiazepines	10.7	11.7	9.0	6.6
	Barbiturates	0.5	0.4	0.2	0.1

**Percentages of use in therapeutic categories will exceed drug use total because some beneficiaries use multiple categories of drug.*

Source: Adapted from exhibit 2 in Julie Donohue, "Mental Health In The Medicare Part D Drug Benefit: A New Regulatory Model?" Health Affairs, *25, no. 3 (May/June 2006), p. 710.*

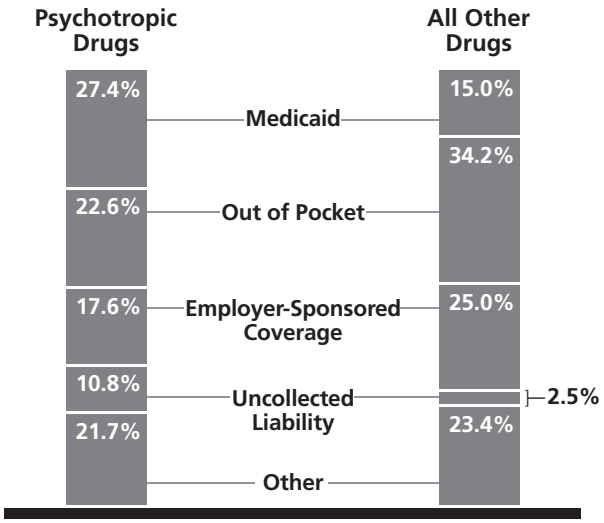
Medicaid programs have historically provided some level of coverage for benzodiazepines, despite the fact that the Medicaid statute allows states to exclude coverage of these drugs at their discretion.

Transitions from Medicaid to Medicare — Advocates have raised concerns about how coverage changes could affect the more than 6 million beneficiaries who are dually eligible for Medicaid and Medicare, 39 percent of whom have mental disorders. Access to psychotropic drugs is likely to improve for many Medicare beneficiaries who did not have prescription drug coverage before the implementation of Part D but, for dually eligible people, the transition could be problematic. Enrollment in Part D was mandatory for the dual eligibles who had received drug coverage through state Medicaid programs before 2006. Duals in some states may encounter new formulary rules and higher cost-sharing requirements. Some Medicaid programs exempt psychotropics from utilization management restrictions, and pharmacists are legally required to fill prescriptions, regardless of the individual's ability to pay the copayment amount. Sources of drug spending for Medicare beneficiaries are shown in Figure 5.

Under Medicare Part D, dual eligibles will continue to be exempt from paying premiums or deductibles (as they were under Medicaid) if they are enrolled in below-average premium plans. However, they are responsible for low copayments ($1 for generic drugs and $3 for brand name drugs, depending upon their income) and pharmacists are now able to require copayments before filling prescriptions. Studies have shown that even small copays can significantly lower utilization of prescription drugs among low-income populations.[47] These copayments, though seemingly small, can be a significant burden for duals with multiple chronic conditions who struggle to cover costs of several medications with SSDI or Social Security subsidies that are often inadequate to cover housing and food costs.[48]

Risk adjustment — Federal payments to drug plans are intended to minimize the disincentives associated with enrolling high-cost patients, such as those with mental disorders, by (i) tying payment level to the risk associated with individual enrollees and (ii) limiting the collective risk incurred by plans through the use of risk corridors and reinsurance payments for larger-than-expected catastrophic expenses. A new risk adjustment model designed for Part D adjusts payments based on age and specific comorbidities. The risk adjuster accounts for 23 percent of the variation in drug spending. Although the Part D risk adjuster appears to offer an improvement over older risk adjustment models and is considered to offer fairly generous protection, the extent to which it obviates risk selection incentives is not yet clear. Patient advocates worry

FIGURE 5
Sources of Prescription Drug Spending for Medicare Beneficiaries, 2002



Source: Adapted from exhibits 3 and 4 in Julie Donohue, "Mental Health In The Medicare Part D Drug Benefit: A New Regulatory Model?" Health Affairs, *25, no. 3 (May/June 2006), p. 712.*

that plans may still have financial incentives to use aggressive utilization management tools and pricing practices to discourage enrollment by persons with mental illness.[49]

Care Management

Efforts to improve the management and integration of the multiple mental health services covered under Medicare are limited. Medicare's struggle to coordinate care and control costs under a largely fee-for-service program lacking robust utilization management mechanisms has led Congress to explore the utility of private market disease management programs, which focus on coaching patients, rather than attempting to influence provider practices directly. The recent Medicare Health Support program authorized by the MMA pays participating disease management vendors and insurance plans a monthly per beneficiary fee for managing a population of chronically ill beneficiaries.

To date, no disease management effort has focused on a mental disorder, and few have incorporated mental health screening and care coordination to address the impact of mental comorbidities on physical conditions like diabetes. Given the prevalence of mental disorders in the Medicare population and the association of mental disorders with higher health care spending, a strengthened emphasis on mental health could prove useful.

Medicare managed care plans do not appear to have made great strides beyond the fee-for-service program. Mental health benefits, care management techniques, and outcomes have not been rigorously studied in Medicare managed care plans. Available evidence suggests that Medicare +Choice (now Medicare Advantage) plans provide poorer quality mental health services than employer-sponsored managed care plans.[50] In only one area—mental health—do Medicare managed care plans score lower than their employer-sponsored counterparts on quality of care measures. Fewer Medicare beneficiaries receive appropriate follow-up after hospitalization for a mental illness and fewer receive appropriate management of their antidepressant medications. These findings suggest that Medicare managed care plans have not taken steps to optimize use of appropriate mental health services and have likely modeled their benefits on the existing fee-for-service structure. This is not surprising, as more generous benefits relative to the traditional program could lead to adverse risk selection for the plans, which have no incentive to attract high-need patients with mental disorders.

Managing care for beneficiaries with severe mental illnesses is especially challenging because these patients need psychosocial, rehabilitative, and supportive services that are not typically covered through traditional insurance programs outside of Medicaid. Such services recognize that the nature of mental illness interferes with treatment compliance and assists people at various stages of the recovery process to reduce distress and prevent relapse or rehospitalization. Studies have shown psychosocial models to be

more effective at identifying and delivering mental treatment, improving activities of daily living, and reducing utilization of inpatient and other, nonpsychiatric health care services.[51] The addition of these services, while cost-effective in terms of the outcome improvements achieved, may not be cost-saving. Therefore, it will be difficult for managed care organizations to implement evidence-based practices if the costs of psychosocial support services are not factored into their capitation rates.

While dual eligibles have some access to rehabilitative and psychosocial services through Medicaid and local state agencies, care management for these beneficiaries is complicated by the complexity of coordinating coverage and payment policies across Medicare and Medicaid. A recent MedPAC report identified a number of conflicts, inconsistencies, or unclear policies that have the potential to hinder care delivery for dual eligibles.[52] MedPAC recommended that many of these coverage and payment issues could be alleviated if dual eligibles were enrolled in the same plan for both Medicare- and Medicaid-covered services and the plan took steps to integrate benefits. This integration has occurred in demonstration projects, such as the Program of All-Inclusive Care for the Elderly (PACE) and the Wisconsin Partnership Program. However, the cost-effectiveness of these plans has not been well established and they serve only a small fraction of dual eligibles.

A recent MedPAC report identified a number of conflicts, inconsistencies, or unclear policies that have the potential to hinder care delivery for dual eligibles.

Medicare Advantage Special Needs Plans (SNPs), authorized by the MMA, offer another potential avenue to better manage care for Medicare beneficiaries with mental disorders, but a SNP focused on this population has not yet been developed. SNPs provide an opportunity to integrate acute and long-term care services and increase coordination of Medicare and Medicaid financing and benefit structures. These plans are subject to the same rules and requirements as other Medicare Advantage plans but they are able to provide products focused exclusively on specialized populations, such as the dual eligibles, the institutionalized, and other chronically ill populations. SNPs may limit enrollment to one of the special needs populations, tailoring benefits and provider networks to best meet the needs of these vulnerable groups. Concerns have been raised that SNPs are not required to coordinate with state Medicaid programs and may do little to integrate care for vulnerable populations.

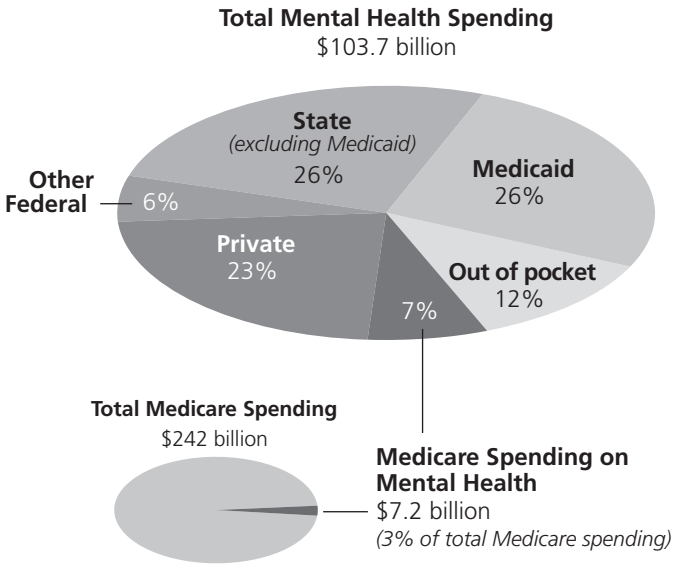
MEDICARE SPENDING FOR MENTAL HEALTH SERVICES

Medicare expenditures for mental health services reflect the program's benefit design. Before the introduction of Part D, Medicare spending on mental health accounted for a relatively small proportion of total mental health expenditures and an even smaller proportion of total Medicare

spending. Medicare spending on all mental health services in 2001 was $7.2 billion, representing 3 percent of all Medicare spending ($242 billion). In contrast, mental health as a proportion of all health care expenditures accounted for 12 percent of Medicaid funds and 4 percent of spending by private insurance in 2001.[53] Mental health spending across payers is presented in Figure 6.

The limited nature of Medicare's mental health benefits has shielded the program from the mental health costs of its beneficiaries. Although roughly 20 percent of all persons with mental disorders are covered by Medicare,[54] the program contributes only 7 percent of total spending on mental health services. This disproportionately low funding rate is attributed to the absence of a prescription drug benefit prior to 2006, limited coverage for outpatient services, and other benefit design features that may decrease covered spending and limit service utilization for mental health services.

FIGURE 6
Mental Health Spending by Payer Class, 2001



Source: Tami L. Mark et al.,*"U.S. Spending For Mental Health And Substance Abuse Treatment, 1991–2001,"* Health Affairs Web Exclusive *(March 29 2005), p. W5-137.*

Total mental health spending by Medicare beneficiaries[55] has historically been heavily skewed toward inpatient services, with 56 percent of the total going to inpatient care and only 30 percent toward outpatient services. This relationship is in contrast to national trends showing a reversal in inpatient and outpatient spending over the past decade, during which inpatient spending declined from 40 percent to 24 percent while outpatient spending increased from 36 percent to 50 percent of all mental health spending.[56]

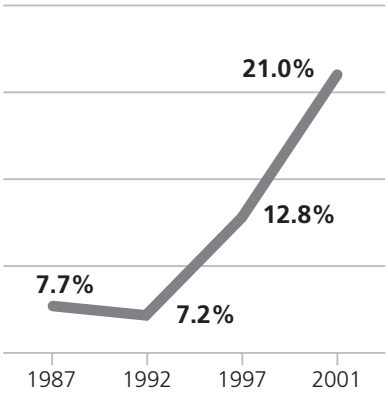
Medicare's mental health costs, while small relative to those of other payers, have been rising rapidly in recent years. The growth rate for Medicare spending on mental health services increased from 3 percent to 7 percent over the past decade, making it second only to Medicaid's. This growth is attributed to the rising number of Medicare beneficiaries who qualify for the program as the result of a mental health disability.[57]

With the advent of Part D, the growth of mental health spending under Medicare will accelerate significantly. Medicaid spending on psychotropic medications for dually eligible beneficiaries totaled more than $6.3 billion in 2002—an amount almost equal to total mental health expenditures by Medicare in 2001. This suggests that Medicare spending for mental health services will at least double as a result of Part D. Spending increases will likely be even higher in light of psychotropic drug expenditures associated with non–dual eligibles and apparent increases in psychotropic drug prices relative to those paid by state Medicaid programs. Because these

drugs were in a protected class, drug plans contend that they had little leverage to negotiate price on these products with manufacturers. Plans were mandated to cover a broad range of products in protected classes and, therefore, had little latitude to offer volume guarantees in exchange for price discounts.

Although prescription drug costs have not been a significant cost factor for Medicare until recently, it is important to note that psychotropic medications account for almost all growth in mental health spending for other public and private insurance plans over the last 15 years. In 1987, 7.7 percent of all mental health care spending in the United States was for psychotropic medications. By 2001, spending on psychotropic drugs accounted for 21 percent of total mental health spending.[58] Between 1992 and 1997, total U.S. spending on psychotropic drugs grew at twice the rate of total drug spending and, since 1997, spending growth for psychotropic medications has outpaced both total health care spending and total drug spending.[59] In 2003, more than $18 billion was spent on antidepressant and antipsychotic drugs.[60] Figure 7 displays growth in psychotropic drug spending as percentage of total mental health spending.

FIGURE 7
Psychotropic Drug Expenses as a Percentage of Overall Mental Health Spending, 1987–2001



Source: Richard G. Frank, Rena M. Conti, and Howard H. Goldman, "Mental Health Policy and Psychotropic Drugs," Milbank Quarterly, *83, no. 2 (2005), pp. 271–296; available at www.macfound.org/atf/cf/%7bb0386ce3-8b29-4162-8098-e466fb856794%7d/mental%20health%20ftf%203%2006.pdf.*

CONCLUSION

A dramatic increase in spending for mental health services under Medicare, resulting largely from the introduction of the prescription drug benefit, has the potential to trigger a much broader assessment of the program's mental health policies. As Medicare expenditures for mental health begin to more accurately reflect the burden of disease borne by beneficiaries, policymakers may take a much closer look at the value of the services being purchased. The conclusions they reach could well hinge on an assessment of the effectiveness and efficiency of the services delivered, along with an exploration of the extent to which financing incentives are contributing to these clinical practices: Are the "right" mental health services being delivered to the "right" Medicare beneficiaries at the "right" time at the "right" price?

While the same questions could be posed for any service covered by Medicare, mental health services have often been singled out for special consideration, and the influence of these "exceptional" policies is unclear. Medicare and other insurers have often treated mental health services differently from other services because mental health care can differ significantly from the traditional medical model. Medicare's mental health policies are often debated in a piecemeal, disjointed fashion, frequently as footnotes to more global policy changes. There may be some benefit to considering Medicare's mental health policies more holistically in order to better consider how these policies interact and reinforce (or contradict) each other.

In monitoring protections developed under Part D to prevent discrimination against persons with mental illness and other costly conditions, policymakers

may find it necessary to consider how policies related to other services are influencing psychotropic drug utilization. Assessing the impact of restrictions on outpatient mental health services, tracking the influence of prospective payment on inpatient psychiatric capacity, exploring mechanisms to better leverage Special Needs Plans and other care management strategies, and examining eligibility policies for disabled persons are among the issues that may come under further scrutiny as Medicare's spending on those with mental disorders continues to rise.

ENDNOTES

1. Marilyn Moon, "Growth in Medicare Spending: What Will Beneficiaries Pay?" Urban Institute, January 7, 1999; available at www.urban.org/url.cfm?ID=407788.

2. Estimates of mental health disorders in this paper include all diagnosable mental and substance abuse disorders listed in American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association: Arlington, VA, 4th ed., 2000). Statistics that specifically refer to adults with serious mental illness , serious and persistent mental illness, or substance abuse disorders are noted. Estimates of mental disorders in the general population are based on rigorous epidemiological studies that rely on clinically guided surveys using standardized diagnostic criteria to identify mental disorders. Estimates of mental disorders among Medicare beneficiaries are from Kaiser Family Foundation analysis of 2005 Medicare Current Beneficiary Survey (MCBS) Cost and Use File. See Henry J. Kaiser Family Foundation (KFF), *Medicare Chartbook* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 3rd ed., Summer 2005); available at www.kff.org/medicare/upload/Medicare-Chart-Book-3rd-Edition-Summer-2005-Report.pdf.

3. KFF, *Medicare Chartbook.*

4. Ronald C. Kessler *et al.,* "Prevalence, Severity, and Comorbidity of 12-Month *DSM-IV* Disorders in the National Comorbidity Survey Replication" *Archives of General Psychiatry,* 62, no. 6 (June 2005), pp. 617–662.

5. Prevalence rate for Medicare beneficiaries calculated by author based on a weighted average of prevalence rates in elderly and disabled population, with relative weights derived from Centers for Medicare & Medicaid Services (CMS), "Medicare Enrollment: National Trends 1966–2005," available at www.cms.hhs.gov/MedicareEnRpts/Downloads/HISMI05.pdf. Prevalence rate for general population from Ronald C. Kessler *et al.*, "Prevalence and Treatment of Mental Disorders, 1990 to 2003," *New England Journal of Medicine*, 352, no. 24 (June 15, 2005), pp. 2515–2523.

6. Sandra M. Foote and Christopher Hogan, "Disability Profile And Health Care Costs Of Medicare Beneficiaries Under Age Sixty-Five," *Health Affairs,* 20, no.6 (November/December, 2001), pp. 242–253; available at http://content.healthaffairs.org/cgi/reprint/20/6/242.pdf.

7. Ronald C. Kessler *et al.,* "Estimating the Prevalence and Correlates of SMI in Community Epidemiological Studies," chap. 12 in *Mental Health, United States, 2002*, Ronald W. Manderscheid and Marilyn J. Henderson, Eds., DHHS Publication No. SMA04-3938 (Rockville, MD: U.S. Department of Health and Human Services, 2002); available at http://mentalhealth.samhsa.gov/publications/allpubs/sma04-3938/Chapter12.asp.

8. Social Security Administration, "Annual Statistical Report on the Social Security Disability Insurance Program, 2004," March 2006; available at www.ssa.gov/policy/docs/statcomps/di_asr/2004/index.html#editions.

9. Authors' calculations based on data in KFF, "Medicare Chartbook."

Endnotes / continued ▸

Endnotes / continued

10. Medicare spending per aged beneficiary is $6,367; for each disabled beneficiary under the age of 65 without end-stage renal disease, Medicare spends $5,419. See Medicare Payment Advisory Committee (MedPAC), *A Data Book: Healthcare spending and the Medicare program,* June 2006, p.19. Once disabled beneficiaries reach age 65, they are classified as aged, regardless of disability status.

11. Foote and Hogan, "Disability Profile And Health Care Costs," p. 245.

12. Authors' calculations based on disease prevalence rates cited in this paper and population statistics obtained from CMS, "Medicare Enrollment: National Trends. Medicare Aged and Disabled Enrollees by Type of Coverage," 2005; available at www.cms.hhs.gov/MedicareEnRpts/Downloads/HISMI05.pdf. See also Craig W. Colton and Ronald W. Manderscheid, "Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states," *Preventing Chronic Disease*, 3, no. 2 (April 2006); available at www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.

13. Alzheimer's Disease International, "Factsheet 3: The prevalence of dementia," April 1999; available at www.alz.co.uk/adi/pdf/3preval.pdf.

14. Medicare provides an additional 60 hospital days (lifetime reserve days) for coverage beyond the 90-day limit; these 60 days can only be used once in the beneficiary's lifetime.

15. Section 1812(b)(3) of the Social Security Act.

16. Before 2005, Medicare paid for inpatient services in two ways: (i) care in scatter beds in general hospitals were paid under the inpatient prospective payment system (PPS) and (ii) care in general and freestanding IPFs were paid under TEFRA (the Tax Equity and Fiscal Responsibility Act of 1982) rules, with payment based upon the hospital's base year costs (first full fiscal year of operation) and then updated to the current fiscal year by the annual allowable rate of increase. If costs were below the target cost per case, the providers received a bonus payment of 50 percent of the difference between the target and the actual cost per case, up to 5 percent of the target amount. If costs exceeded the target rate, Medicare provided additional payments equal to half of the amount by which the hospital's costs exceed the target amount, up to 10 percent of the target amount. Hospitals could also apply for additional Medicare exceptions payments. Many facilities established in the early 1980s consistently exceeded their TEFRA limits, and higher payments under TEFRA rules led to a steady growth in the number of PPS-exempt facilities.

17. For more detailed information about payment methodology, see MedPAC, "Payment Basics: Psychiatric Hospital Services Payment System," September 2006; available at www.medpac.gov/publications/other_reports/Sept06_MedPAC_briefs_psych.pdf; and CMS, "Final Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) Fact Sheet," December 22, 2004; available at www.cms.hhs.gov/InpatientPsychFacilPPS/Downloads/IPFPPSFactsheet.pdf.

18. Assertive Community Treatment Association, "ACT Home"; available at www.actassociation.org/.

19. CMS, *Medicare Benefit Policy Manual*, "Hospital Services Covered Under Part B," chapter 6, 2005; available at www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf.

20. Office of Inspector General (OIG), *Review of Partial Hospitalization Services Provided Through Community Mental Health Centers,* Report no. OEI-A-04-98-02146). Rockville, MD: Office of Inspector General, U.S. Department of Health and Human Services, 2001; available at http://oig.hhs.gov/oas/reports/region4/49802146.pdf.

21. For billing instructions for partial hospitalization services, see CMS, "Hospital Outpatient Services," §100, chap. 4 in *Medicare Claims Processing Manual,* revised September 18, 2006; available at www.cms.hhs.gov/manuals/downloads/clm104c04.pdf.

22. The Office of the Inspector General has raised concerns that state licensure laws may not provide sufficient detail regarding providers' scope of practice to allow rigorous claims adjudication and quality monitoring.

Endnotes / continued ▸

Endnotes / continued

23. Ronald C. Kessler *et al.,* "The epidemiology of major depressive disorders," *Journal of the American Medical Association*, 289, no. 23 (June 18, 2003), pp. 3095–3105.

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26. In 2002, Medicare authorized payment for six current procedural terminology (CPT) codes for health and behavior assessment and intervention (H&B) services to prevent, treat, or manage behavioral health issues related to physical (rather than mental) health conditions. Interventions provided under these codes might include helping patients cope with medical illness and medical procedures, improving management of chronic conditions, or increasing adherence to medication and treatment protocols. Significantly, reimbursements for the H&B services are billed under medical services and are not subject to the 50 percent copay requirement for outpatient mental health services.

27. Outpatient mental health benefits were once subject to both high cost sharing and low spending limits until the late 1980s, when Congress raised and ultimately eliminated the original limits on total payments for outpatient psychiatric services. Before 1987, Medicare covered an annual maximum of only $250 (50 percent of the first $500) of outpatient mental health expenses. The $250 annual payment cap was increased to $1,100 with the enactment of the Omnibus Budget Reconciliation Act (OBRA) of 1987. Two years later, OBRA 1989 eliminated the annual limit and also allowed licensed clinical psychologists and certified social workers to bill Medicare for mental health services. These factors led to a substantial increase in Medicare payments for mental health services in nursing homes during the early and mid-1990s. Many providers do not believe the repeal of the annual limits had a major impact on access, because beneficiaries are still responsible for a 50 percent copayment for outpatient therapy services, which serves as a significant deterrent to utilization.

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