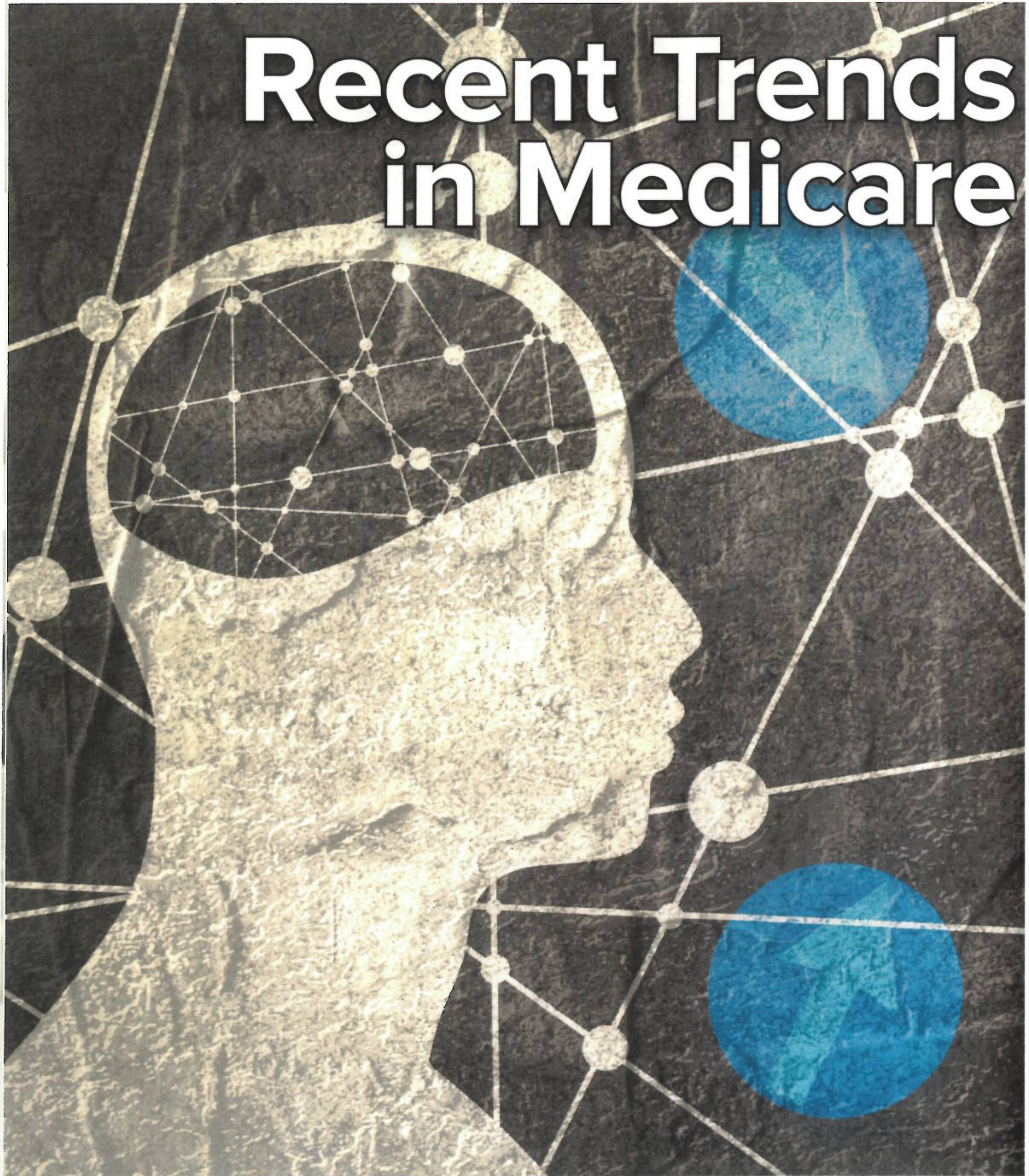
Recent Trends in Medicare

and Behavioral Health

PART ONE: Historical and Current Analysis

The Medicare system remains largely unresponsive to the needs of patients with behavioral issues in spite of modifications since its inception.

Massive growth in the population of older adults over the next quarter century combined with spiraling health care costs have fueled great concern about the future solvency of a bedrock program: Medicare. As the number of older adults served by Medicare rises, the need for behavioral health services will increase as well. About 20 percent of older adults have a diagnosable mental and/or substance use disorder, including dementia (World Health Organization, 2013). Professionals must respond to a group of older adults that is racially diverse, often financially unprepared for retirement, and living longer with chronic illness (Friedman, 2011). To understand how Medicare needs to transform to serve an evolving population of older adults, it's important to understand the current program and how it got here.

Who Gets Medicare

Not only are older Americans living longer than in the past, they are doing so with multiple health problems. It has become almost impossible to talk about Medicare without also mentioning the baby boomers, born between 1946 and 1964. Approximately ten thousand baby boomers become eligible for Medicare every day, a number that is expected to stay steady for the next nineteen years (United States Census Bureau, 2015).

This influx will force Medicare to become a more significant payer in the years to come.

The Census Bureau (2015) projects that by 2042 "minorities" will outnumber whites in the United States. The proportion of older adults from minority cultures will increase from 16 percent to 25 percent. Can the systems of care for older adults in the United States be responsive to the needs of minorities who have historically been the victims of disparities in health care?

Not all Medicare recipients are older than sixty-five. Some people qualify for Medicare on the basis of a disability. In 2011, 43.7 percent of people receiving Social Security Disability Income (SSDI) had an underlying mental impairment. In 2016, there were approximately 59 million Medicare beneficiaries, of which about 11 million were under sixty-five and disabled, according to the National Alliance of Mental Illness infographic "Mental Health by the Numbers."

Low-Income Beneficiaries

Medicare beneficiaries are a highly heterogenous group, but many are alike in their poverty. Approximately 18 million Medicare beneficiaries live on annual incomes below 150 percent of the federal poverty line, which is less than $18,000 a year for a single person ("Health Care Spending," 2016).

For this impoverished cohort, Medicare's Part B annual premium and hospital deductibles represent a high share of income, even before considering the additional costs of physician visits, medications, and uncovered services.

Medicare has no limit on out-of-pocket costs, and its core benefits exclude dental, vision, hearing, and long-term care services and supports. An estimated 40 percent of low-income Medicare beneficiaries spend 20 percent or more of their income on premiums and health care costs ("Health Care Spending," 2016).

The group of Medicare beneficiaries that consumes the highest amount of spending is the dual-eligible population: those who are eligible for both Medicare and Medicaid. They are on Medicaid because of their limited income, and are enrolled in Medicare because they are permanently disabled. They tend to have several chronic conditions and are often referred to as super utilizers of the public health system (Chen, 2016). Medicare is the primary payer of their health care, and Medicaid is the payer of last resort.

Behavioral Health Covers Many Things

Behavioral health problems can be wide ranging. They include:

- Anxiety and mood disorders, which often co-occur with dementia in its early and middle states.
- Psychotic conditions, such as schizophrenia and severe mood disorders like bi-polar depression.
- Substance use disorders.

However, a diagnosis of emotional distress (which often precedes depression and/or anxiety) does not qualify for treatment under Medicare.

Some of these mental and substance use disorders begin early in life, some become more severe later in life, and others emerge in old age. Assuming that the prevalence of mental and substance use disorders among older adults remains constant, the number of older adults with diagnosable mental illness in the U.S. will increase from a reported eight million in 2010 to fourteen million in 2030 (Friedman, 2011).

Untreated Mental Health Issues

Today, the majority of patients with behavioral health conditions are forced to seek treatment in emergency rooms or primary care clinics where providers do not have the resources or training to offer adequate care. Many are discharged without care. Untreated mental illness is not only a major factor in homelessness and incarceration, but also has a significant impact on health costs and overall outcomes.

Left untreated, mental illness can have terrible impacts on physical health. People with mental disorders are more likely to have co-occurring physical illness and are at a high risk for disability, premature death, and far higher medical costs than those with physical disorders alone. This isn't a small or insignificant issue. Boomers have high rates of depression and have one of the highest suicide rates of any demographic in the country ("Morbidity," 2006).

Most older adults want to live and remain in their communities. Ageism, stigma, and ignorance toward mental illness prevent them from seeking treatment. Contrary to the underlying ageist assumptions of our culture, people can live well in old age, but mental illness is a barrier to well-being.

Mental Health Coverage Limited

Medicare was originally designed to provide affordable healthcare to seniors and it has arguably succeeded in that effort. Despite the rising cost of Medicare throughout the years, the increase in the cost of private insurance has continued to guarantee that Medicare remains relatively inexpensive.

This doesn't negate the fact that there are systemic

problems with Medicare. First, Medicare limits mental health coverage to a few restricted services. Outpatient psychotherapy and psychiatric services, and inpatient psychiatric hospitalization (including partial hospitalization) are often the extent of mental health services covered under the Medicare fee schedule (Murphy, 2018).

Medicare places a 190-day limit on receiving services in a psychiatric hospital. There are no such lifetime limits on any specialty inpatient hospital stays. The limit does not apply to psychiatric wards or units in general hospitals. However, this has been seen as an outright discriminatory practice and barrier for beneficiaries with severe mental illness, who may quickly exceed the 190-day limit if they have a chronic mental illness.

Services Difficult to Find

Sadly, only about 20 to 25 percent of older adults with mental disorders receive adequate care from mental health professionals. This poor utilization of mental health services has a number of contributing factors: low access to providers, lack of affordability, few services in home and community settings, and restricted access to medications. These barriers combine with a vast shortage of geriatric psychiatrists (Friedman, 2011).

Medicare doesn't cover effective community-based services such as assertive community treatment, case management, intensive outpatient psychotherapy, day treatment, psychosocial rehabilitation, and many other evidence-based services. Group homes and residential treatment for those with severe mental illness are also not covered (Murphy, 2018). These are critical services that help those with mental illness remain in the community, and, more importantly, out of hospitals, nursing homes, prisons, and emergency departments.

Archaic payment rules prevent many mental health clinicians from being able to serve the Medicare population. In most states, only psychologists, psychiatrists, and advanced social workers may bill Medicare for mental health services. Licensed counselors, marriage and family therapists, and peer counselors represent one of the largest and growing groups of mental health clinicians but are denied Medicare reimbursement. Additionally, a great many psychiatrists opt out of Medicare because reimbursements are too low.

Another failing of the Medicare system is that it doesn't cover services billed under a primary substance use disorder diagnosis or reimburse services provided by substance use counselors. The baby boomer generation is at high risk of substance abuse. And Evans (2018) notes that Medicare rarely pays for critical services such as:

- psychosocial detox,
- case management,
- recovery coaching,
- peer support services,
- intensive outpatient psychotherapy,
- Integrated Dual Diagnosis Treatment, or
- residential treatment for substance use disorders.

This is despite the fact that the Mental Health Parity and Addiction Equity Act and the Affordable Care Act both require that such restrictions end.

A lot of Medicare services are provided in primary care settings. This may be appropriate given the high levels of comorbid (occurring simultaneously) physical health issues in the Medicare population. But unfortunately, clinicians often do not have the training or resources to adequately respond to these patients' behavioral health needs. Moreover, 66 percent of primary care providers report that they are unable to connect patients with outpatient behavioral health providers due to a shortage of mental health providers (Friedman, 2018).

The movement toward effective integration of physical and behavioral health is still being tested through demonstration projects. Thus far, most such integration efforts have focused on basic mental health services, such as screening and brief interventions. Such strategies are effective with some, but fall far short of the intense needs of those with chronic mental illness and severe substance use disorders.

Medicare Legislation

Medicare has changed somewhat from its inception in the mid-sixties. Back then, the average American lived a few months beyond seventy years, and monthly Medicare premiums were three dollars. A review of policy changes over the years from a Medicare timeline (2015) offered by The Kaiser Family Foundation can illustrate how the program has morphed into what it is today.

1965: CREATION OF MEDICARE AND MEDICAID

President Lyndon B. Johnson signed the Social Security Amendment of 1965 into law, creating the

Medicare and Medicaid programs. Medicare Part A (hospital) and Medicare Part B (physician services) are often referred to as Original Medicare. Managed by the federal government, it provides eligible individuals with health coverage and access to doctors, hospitals, or other health care providers who accept Medicare.

Original Medicare is a fee-for-service plan, meaning that health care providers are paid a set fee for each service. Medicare pays its share of an approved amount up to certain limits, and the patient pays the rest.

1972: EXPANSION OF ELIGIBILITY FOR MEDICARE

Medicare was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney treatment, and people sixty-five or older who select Medicare coverage. Until this time, people with severe disability were for the most part dependent on segregated institutions or a myriad of distinct state government or charity programs. Care wasn't seen as an entitlement.

2003 MEDICARE MODERNIZATION ACT

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) made the biggest changes to the Medicare program in thirty-eight years. Under the MMA, private health plans approved by Medicare became known as Medicare Advantage plans. These plans are sometimes called "Part C" or "MA plans."

2006 MEDICARE PART D PRESCRIPTION DRUG BENEFIT

The MMA also expanded Medicare to include an optional prescription drug benefit, "Part D," which went into effect in 2006. Part D covers a variety of medications, including oral and injectable medications used to treat mental health symptoms and conditions. Private Medicare drug plans are required to cover all of these categories frequently used for mental health treatment: antidepressant, anticonvulsant, and antipsychotic medications.

2008: PASSAGE OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

This act prohibited certain discriminatory practices that limit insurance coverage for behavioral health treatment and services. It required many insurance plans that cover mental health or substance use disorders to offer coverage for those services that's no more restrictive than the coverage for medical/surgical conditions. *This law originally did not apply to Medicare coverage in any way.*

2008: MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)

This act put an end to discriminatory mental health coverage that had previously required patients to pay for up to 50 percent of approved services, as opposed to the 20 percent copayment that applied to other types of outpatient services. The law phased out the coverage disparity over five years, and there is now 100 percent parity in copayments for physical and mental health outpatient services.

2010: PASSAGE OF THE AFFORDABLE CARE ACT (ACA)

The ACA law recognized mental and substance use coverage and treatment as an essential health benefit. In addition to expanding avenues for obtaining affordable healthcare coverage, the ACA also prohibits insurance companies from denying coverage to people with pre-existing conditions. This change benefits many people who were previously locked out of the private market, including those who had been excluded because of a documented mental health diagnosis. This is significant as mental health disorders were some of the most common pre-existing conditions instigating denials prior to the full implementation of the ACA.

Now, if an insurer covers a certain number of visits to the doctor and a certain time period for inpatient treatment of a physical condition, it must offer the same for mental health care. Where the law doesn't go far enough is in support service and wrap-around services that are needed in the treatment of mental health. There is no coverage for residential housing or case management needed for certain treatment. The ACA added a free annual "wellness visit" along with two new preventive screenings: alcohol misuse screenings and counseling, and screenings for depression (Pollack, 2013).

In addition to mandatory coverage of mental health services, the ACA fills in other gaps in the earlier parity law. The new rules clarify, for instance, that parity must be applied at all treatment levels, including intermediate settings that do not fall neatly into inpatient and outpatient categories. Also, the ACA specifies that insurance plans must be consistent across treatments for physical and mental illness when considering what is "medically necessary."

The ACA also improves access to important psychiatric medications by eliminating the coverage gap

in Medicare Part D. The law immediately required pharmaceutical manufacturers to give a 50 percent discount on brand-name drugs for beneficiaries while in the coverage gap, and gradually increases payment for both generics and brand name drugs until the gap closes in 2020.

The law also placed limits on beneficiary out-of-pocket spending. Most Medicare Advantage plans now impose a catastrophic limit on their policies. Original Medicare has no cap on out-of-pocket spending. Finally, under the ACA, participants can add or keep their children on their health insurance policy until they turn twenty-six.

Today, Medicare covers a range of behavioral health services. These include: inpatient treatment (under Medicare Part A); provider services (under Medicare Part B) such as outpatient therapy, counseling, testing, evaluation, and management; and prescription drugs (under Medicare Part D) for beneficiaries who opt to join a Medicare drug plan. Medicare will also cover partial hospitalization in some circumstances. Beneficiaries who receive their services under a Medicare Advantage plan may receive additional services, but face different cost-sharing rules (Murphy, 2018).

Policy Goal

IMPROVE CARE COORDINATION

The mental health needs of older adults and persons with disabilities who are recipients of both Medicare and Medicaid are often overlooked in traditional medical settings, leading to ramped-up costs and inadequate care. These individuals are caught between two programs that often don't talk with one another, yet this group accounts for more than 40 percent of Medicaid spending and 27 percent of Medicare spending (Chen, 2016).

About 44 percent of dual-eligible beneficiaries ("duals") have at least one mental or cognitive condition, and more than half have two or three. Social stigma and inadequate screening mechanisms prevent many beneficiaries from accessing behavioral health services. For example, nearly half of the dual-eligible population under sixty-five has severe mental disorders, and this group's health care costs are about double compared to young duals without severe mental health needs (Chen, 2016).

In 2010, the SCAN Foundation looked at 2010 Medicare claims data to compare average Medicare spending after controlling for a number of comorbidities. The researchers looked at three categories of Medicare beneficiaries age sixty-five and older: the first with no severe mental illness (SMI), the second with no severe substance use disorders, and a third that had both severe mental illness and substance use disorders ("Medicare spending," 2013).

Medicare beneficiaries with SMI, and especially those with both SMI and substance use disorders (SUD), require high utilization of medical services, and the costs of care for beneficiaries with both diagnoses increase with the number of chronic conditions. Medicare spends five times more on beneficiaries age sixty-five and older with both SMI and SUD than for similar beneficiaries without these diagnoses. In 2010, Medicare spent $43,792 per such older beneficiary with SMI and SUD, compared to $8,649 for the average beneficiary age sixty-five and above (World Health Organization, 2018). Researchers also found that most Medicare spending among older beneficiaries with combined SMI/SUD goes to physical, not behavioral, healthcare. Often, SMI affects adherence to treatment plans from various medical providers across settings. For these beneficiaries, coordinated care for physical, behavioral, and mental health would result in more cost-effective care, higher rates of adherence, and better health outcomes overall.

While care coordination or case management is not currently covered by Original Medicare, the Affordable Care Act created several demonstrations through the Centers for Medicare and Medicaid Innovation to test new payment and delivery models of integrated care. These models are being carefully assessed to ensure that financial incentives align with the health needs of beneficiaries with mental illness.

ENHANCE ACCESS AND AFFORDABILITY

More than one-third of all Medicare beneficiaries are enrolled in Medicare Advantage plans, and that number is rising. Our current administration wishes to privatize Medicare and has increased financial incentives to support the growth of private plans. Medicare Advantage plans have limited networks that make finding a mental health professional difficult. Adding to the problem, many mental health providers, particularly psychiatrists, will not accept any insurance (Friedman, 2018). One recent study published in the Journal of the American Medical Association found that only 55 percent of the nation's psychiatrists accepted insurance compared with 88 percent of physicians in other medical specialties.

With the passage of the Affordable Care Act and the decision by thirty-six states and the District of Columbia to expand Medicaid, millions of Americans who previously had no health insurance now have access to health coverage. Combined with the federal parity law requirements, Americans should have

better access to mental health care than at any time in history. Yet studies have consistently shown that despite improvements, people with mental health conditions who have health insurance still struggle to find mental health providers and services in their health plan networks. Work requirements threaten Medicaid expansion and a recent court ruling is putting the protections of the ACA in doubt. In this time of tumult, no one knows what will happen to behavioral health coverage under Medicare even as America's aging population continues to swell.

Look for Part Two of this article in the next issue of *CSA Journal*, when the author discusses the future of Medicare.

Joel Mekler has more than thirty years of human resources and health insurance industry experience. After a long and rewarding career in public service, Joel currently serves as a Medicare counselor for the Pennsylvania State Health Insurance Assistance Program. In this role, he advises Medicare beneficiaries, their families, and caregivers on a wide array of Medicare options. Joel served as an insurance counselor during the initial phase of the Affordable Care Act and for the Medicare Part D Prescription Drug Program. Most recently, he has been involved in the rollout of Community Health Choices, a Medicaid managed care program in western Pennsylvania. In addition, Joel writes a weekly column called "Medicare Moments" for a local newspaper. He received his certification as a CSA® in 2011.

REFERENCES

A Medicare timeline. (2015, March 24). The Henry J. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicare/timeline/medicare-timeline/

Center for Medicare Advocacy. (n.d.) *Medicare coverage of mental health and substance abuse services*. Retrieved from http://www.medicareadvocacy.org/medicare-info/medicare-coverage-of-mental-health-services/

Centers for Medicare and Medicaid Services. (2017, August). *Medicare and your mental health benefits*. Retrieved from https://www.medicare.gov/Pubs/pdf/10184-Medicare-Mental-Health-Bene.pdf

Chen, D. (2016, May 24). Meeting the Mental Health Needs of Dual Eligibles: An Opportunity for Advocates. Retrieved from http://www.justiceinaging.org

Evans, A. C. (2018, April 11). *Combatting the opioid crisis: Improving the ability of Medicare and Medicaid to provide care for patients.* Retrieved from https://www.apa.org/advocacy/substance-use/opioid-committee-hearing.pdf

Friedman, M. B. (2011, January 6) *Meeting the mental health challenges of the elder boom*. Retrieved from https://www.vibrant.org/wp-content/uploads/2018/11/Meeting-The-MH-Challenges-of-the-Elder-Boom-PF.pdf

Friedman, M. B. (2018, September 13). *The future of geriatric behavioral health*. Retrieved from http://www.michaelbfriedman.com/mbf/images/10_Policy_Issues_About_Geriatric_Behavioral_Health.pdf

Frank, R. (2017, January 19). *What the 21st century act means for behavioral health*. Retrieved from https://www.health.harvard.edu/blog/21st-century-cures-act-means-behavioral-health-2017011910982

Kessler, R., Chiu, W.T., Demler, O., & Walters, E. (2005, June). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey replication (NCS-R). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847357/

Medicare Spending for Beneficiaries with Substance Use Abuse and Severe Mental Illness. (2013, February). SCAN Foundation Data Brief Series February 2013 No.38. Retrieved from www.scanfoundation.org

Mental Health by the Numbers. (n.d.). National Alliance of Mental Illness. Retrieved from https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

Morbidity and mortality in people with serious mental illness. (2006, October). National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. Retrieved from https://www.nasmhpd.org/

Murphy, A. (2018, October 1). *How does Medicare cover mental illness.* Retrieved from https://blog.medicarerights.org/medicare-cover-mental-health-services/

Pollack, H. (2013, May 17). *The ACA and Mental Health Coverage*. Retrieved from https://healthinsurance.org

United States Census Bureau. (2015, March 3). Projections of the size and composition of the U.S. population: 2014 to 2060: New Census Bureau report analyzes U.S. population projections. Retrieved from https://www.census.gov/library/publications/2015/demo/p25-1143.html

U.S. Department of Health and Human Services. (2005). *Mentally healthy aging: A report on overcoming stigma for older adults.* Retrieved from http://adaiclearinghouse.org/downloads/Mentally-Healthy-Aging-A-Report-on-Overcoming-Stigma-for-Older-Americans-214.pdf

World Health Organization. (2013). *Mental health of older adults, addressing a growing concern.* Retrieved from https://www.who.int/mentalhealth/world-mentalhealth-day/WHO paperwmhd 2013.pdf

World Health Organization. (2018, October 4). *Management of physical health conditions in adults with severe mental disorders*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/275718/9789241550383-eng.pdf?ua=1

Yasamy, M. T., Dua, T., Harper, M., & Saxena, S. (2013). *Mental health of older adults, addressing a growing concern*. World Health Organization. Department of Mental Health and Substance Abuse. Retrieved from https://www.who.int/mental_health/world-mental-health-day/WHO_paper_wmhd_2013.pdf