

Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement

Beth McGinty

Associate Chair for Research and Practice
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health

ABSTRACT

ISSUE: The COVID-19 pandemic has increased psychological distress among U.S. adults and will likely increase the need for mental health services among Medicare beneficiaries.

GOAL: To provide an overview of Medicare beneficiaries' mental health needs and benefits as well as initiatives to improve the financing and delivery of mental health services in Medicare.

KEY FINDINGS: Several recent policy changes have enhanced Medicare beneficiaries' access to mental health services, including coinsurance parity for outpatient mental health visits, the closing of the prescription drug "doughnut hole," and newly introduced financing mechanisms to support depression screening and mental health care management. But gaps remain, including the 190-day lifetime limit for inpatient psychiatric stays; lack of coverage of services delivered by licensed professional counselors; poor access to mental health providers in Medicare Advantage plan networks; and limited coverage for telemental health services.

CONCLUSIONS: The COVID-19 pandemic highlights gaps in Medicare mental health coverage as well as opportunities for improvement. Policies to expand coverage of telemental health should be rigorously studied and potentially made permanent as a strategy to increase access to mental health services.

TOPLINES

- ▶ COVID-19 has heightened the need for mental health services for Medicare beneficiaries.
- ▶ Policy options for helping beneficiaries' obtain needed mental health care include removing insurance barriers, improving mental health provider networks in Medicare Advantage, and expanding access to telemental health.



INTRODUCTION

The COVID-19 pandemic is significantly raising Americans’ level of psychological distress, and it will likely heighten the need for mental health treatment among Medicare beneficiaries in particular. During the initial phase of the COVID-19 crisis in April 2020, the prevalence of serious psychological distress among adults age 55 and older was nearly double pre-COVID levels; among Hispanic and low-income adults, rates were more than triple.¹ This is especially concerning given that mental illness is already more common among these groups of Medicare beneficiaries.

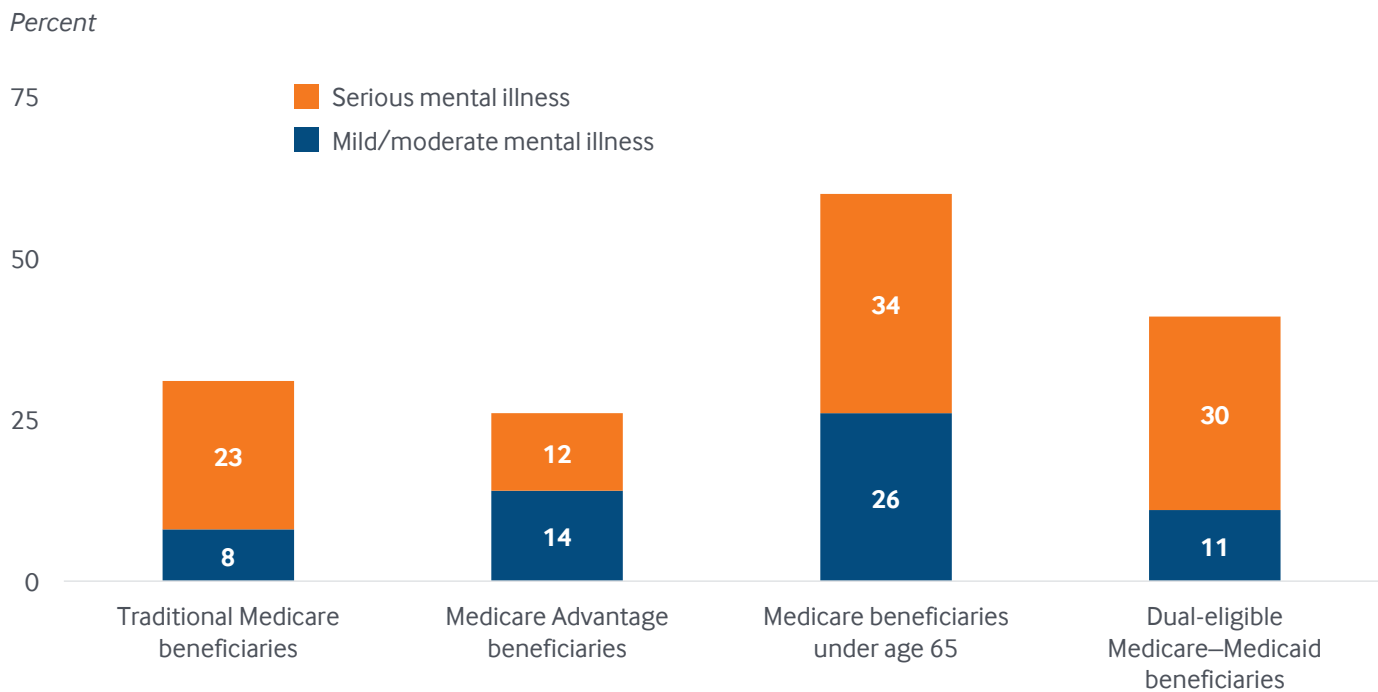
In this brief, we summarize the burden of mental illness in the Medicare population and issues with mental health provider availability and payment. We then provide an

overview of the evidence surrounding Medicare’s benefits and recent financing and delivery initiatives as they pertain to mental health. Finally, we discuss Medicare’s mental health care successes in the context of COVID-19 and make recommendations for policy improvements and additional future research.

MENTAL ILLNESS IN THE MEDICARE POPULATION

About one in four Medicare beneficiaries have mental illness. While varying data sources and measures across studies make comparisons challenging, the prevalence of mental illness appears to be slightly higher among beneficiaries in traditional Medicare versus Medicare Advantage managed care plans (Exhibit 1).² Those in traditional Medicare are

Exhibit 1. Prevalence of Mental Illness Among Medicare Beneficiaries



Notes: As no comprehensive data source including data on mental illness prevalence among all of the beneficiary groups in the exhibit exists, prevalence estimates shown are based on different national-level data sources, years of data, and definitions of mental illness and serious mental illness that vary slightly by data source.

Data: **Traditional Medicare beneficiaries:** José F. Figueroa et al., “Association of Mental Health Disorders with Health Care Spending in the Medicare Population,” *JAMA Network Open* 3, no. 3 (Mar. 2020): e201210. **Medicare Advantage beneficiaries:** Judy Ng et al., *Racial and Ethnic Disparities in Mental Health Among Diverse Groups of Medicare Advantage Beneficiaries* (Centers for Medicare and Medicaid Services, Dec. 2017); and Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program* (MedPAC, June 2019). **Medicare beneficiaries under age 65:** Social Security Administration, *SSI Annual Statistical Report, 2011* (SSA, Sept. 2012); and Juliette Cubanski, Tricia Neuman, and Anthony Damico, *Medicare’s Role for People Under Age 65 with Disabilities* (Henry J. Kaiser Family Foundation, Aug. 2016). **Dual-eligible Medicare–Medicaid beneficiaries:** Centers for Medicare and Medicaid Services, *Physical and Mental Health Condition Prevalence and Comorbidity Among Fee-for-Service Medicare–Medicaid Enrollees* (CMS, Sept. 2014); and Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (CBO, June 2013).

more likely to have a serious mental illness that results in significant impairment, such as schizophrenia, bipolar disorder, or major depressive disorder.

The prevalence of mental illness is greatest among beneficiaries under age 65 who qualify for Medicare because of disability, as well as among low-income beneficiaries who are dually eligible for Medicare and Medicaid.³ Higher proportions of American Indian/Alaska Native and Hispanic beneficiaries have mental illness relative to other racial and ethnic groups.⁴

Mental and physical health conditions frequently co-occur, and comorbidity often worsens both mental and physical health outcomes.⁵ Thus, it is critical to support and facilitate beneficiaries' access to both high-quality specialty mental health care as well as general medical services.

MENTAL HEALTH PROVIDER AVAILABILITY AND PAYMENT

More than 112 million Americans live in areas of the country where mental health care providers are in short supply,⁶ and experts predict increasing shortages in psychiatrists, clinical and counseling psychologists, mental health social workers, mental health counselors, and other specialty mental health professionals through 2025.⁷ In rural areas, mental health provider shortages are especially severe, even though the prevalence of mental illness among beneficiaries is similar in rural and urban areas.⁸

Psychiatrists are less likely to accept insurance than other physician specialties, and the percentage accepting insurance has declined over time. In 2009–2010, about 55 percent of U.S. psychiatrists accepted Medicare, compared to 74 percent in 2005–2006 (more than 85 percent of other physicians accepted Medicare in both periods).⁹ Low rates of Medicare acceptance among psychiatrists are likely driven by the high demand for psychiatric care and low supply of psychiatrists, allowing many psychiatrists to take only cash patients, as well as by the greater number of solo practices with less billing infrastructure relative to other physician specialties.

Commercial insurance typically reimburses general medical services at a higher rate than Medicare, which

incentivizes providers to take on a greater share of commercially insured patients. The picture is more complex for mental health services. The share of psychiatrists who take commercial insurance is essentially identical (55.3% in 2009–2010) to the share who accept Medicare.¹⁰ While traditional Medicare's payment rates for mental health services are higher than in-network rates for Medicare Advantage or commercial insurance, commercial insurers' out-of-network service rates are higher than Medicare Advantage plan rates.¹¹

MEDICARE AND MENTAL HEALTH: POLICY OVERVIEW

Recent Initiatives

Cost-sharing for outpatient mental health services.

The 2008 Medicare Improvements for Patients and Providers Act (MIPAA) instituted a phase-out of unequal cost-sharing for mental health versus general medical outpatient services; as of January 2014, Medicare beneficiaries pay 20 percent coinsurance for both types of outpatient treatment. This policy change has been associated with increases in outpatient mental health follow-up care after a psychiatric hospitalization, particularly among Medicare enrollees living in areas where income and educational attainment are below average.¹²

Primary Care Medical Homes. The Primary Care Medical Home (PCMH) is a care delivery model designed to improve treatment of chronic conditions, including, but not limited to, mental health conditions. Research suggests it has the potential to improve both mental and physical health care for people with mental illness.¹³ The 2015 Medicare Access and CHIP Reauthorization Act incentivized the model's adoption by making clinicians practicing in a recognized PCMH eligible for higher fee-for-service Medicare payments.

Medicare accountable care organizations. The 2010 Affordable Care Act encouraged formation of Medicare accountable care organizations (ACOs). As of January 2020, there were 558 Medicare ACOs serving more than 12.3 million Medicare beneficiaries.¹⁴ ACOs were designed to improve mental health care management, coordination,

and delivery through shared savings and losses tied to the achievement of quality benchmarks and spending targets. However, the evidence suggests Medicare ACOs have had little to no effect on mental health care delivery. Possible reasons are the lack of alignment between payments and mental health performance metrics and the limited number of mental health specialty providers included in ACO provider networks.¹⁵

Affordable Care Act annual wellness visit. This yearly preventive care-focused visit, introduced in 2011, is reimbursed at a higher rate and free to beneficiaries. Depression screening is one of the preventive services that can be included in the visit and is required for a beneficiary's initial wellness visit. While the ACA's annual wellness visit has the potential to improve depression identification and treatment, studies show that uptake among Medicare beneficiaries overall has been low, increasing from 7.5 percent in 2011 to 15.6 percent in 2014.¹⁶

CMS behavioral health integration billing codes. A strong body of evidence shows that integrated care models like Collaborative Care, which integrates depression care into general medical settings, can improve mental health treatment delivery and outcomes.¹⁷ Historically, however, the care management processes central to integrated care have not been reimbursed by Medicare or most other insurers. In 2017, the Centers for Medicare and Medicaid Services (CMS) introduced behavioral health integration billing codes allowing general medical providers to bill Medicare for mental health care planning and management services. Uptake to date has been extremely low: during 2017–2018, 0.1 percent of beneficiaries with mental illness received a service billed to one of the new codes.¹⁸

Medication coverage. Antidepressants and antipsychotics are two of six “protected classes” of drugs in Medicare Part D, which means they must be covered. The 2018 proposed Medicare Advantage and Part D Drug Pricing Rule would have allowed Part D plans to exclude these protected drug classes from their formularies if prices increased beyond a set threshold.¹⁹ However, the final rule issued in May 2019 did not implement this change.²⁰ Evidence demonstrates that the protected-class status for antidepressants and antipsychotics has raised drug costs for both the Medicare program and its beneficiaries.²¹ However, it is possible

that in the absence of protected status, Part D plans might exclude drugs in these classes as a way to avoid high-need, high-cost enrollees. The effects of this policy on clinical care for beneficiaries with mental illness are unclear and need further study.

The so-called Medicare doughnut hole, or gap in Part D prescription drug coverage, was closed in January 2020. While this change does not apply specifically to mental health, evidence suggests that it will increase beneficiaries' access to needed psychotropic medications. Prior to the policy change, beneficiaries typically reduced their use of antidepressants when they entered the coverage gap.²²

Gaps in Medicare Mental Health Coverage

Inpatient day limits. Medicare beneficiaries are limited to 190 days of inpatient psychiatric hospital care in their lifetime, a much stricter limit than the 90-day-per-benefit-period limit on general medical hospitalizations. People with chronic mental illness, particularly younger beneficiaries who qualify for Medicare because of a disability, may exceed this limit and may be subject to high out-of-pocket costs for needed inpatient care. This is predominantly an issue for beneficiaries who are not dually eligible for Medicaid: state Medicaid programs pay for inpatient psychiatric services for most dual-eligible beneficiaries who have exceeded Medicare's 190-day limit. The Congressional Budget Office (CBO) estimated that eliminating the Medicare 190-limit would increase federal spending by \$3 billion over 10 years.²³

Medicare Advantage mental health provider networks. Medicare Advantage beneficiaries often lack access to in-network mental health providers and instead turn to higher-cost out-of-network care. One analysis of physician networks in Medicare Advantage health maintenance organizations (HMOs) and local preferred provider organizations (PPOs) offered in 20 counties across the U.S. in 2015 found that, on average, Medicare Advantage networks included only 23 percent of psychiatrists in a county — a smaller share than for all other 27 physician specialties examined.²⁴ In 2014, nearly 30 percent of all psychotherapy services received by Medicare Advantage beneficiaries were out-of-network.²⁵

Medicare mental health provider payment issues.

- *Licensed professional counselors.* Medicare does not reimburse licensed professional counselors (LPCs). There are more than 140,000 LPCs in the U.S., and reimbursing services delivered by this professional group could address provider shortages.²⁶ The CBO has estimated the cost of covering LPCs at \$100 million over five years.²⁷ As of June 2020, Congress is considering legislation (Mental Health Access Improvement Act of 2010, H.R. 945/S. 286) to reimburse LPCs in Medicare.²⁸
- *Clinical psychologists.* To be reimbursed in outpatient rehabilitation facilities, partial hospitalization programs, and other treatment settings outside a psychologist's own office, Medicare requires that clinical psychologists be supervised by a psychiatrist, a potential barrier to care delivery in regions with psychiatrist shortages. Congress is considering legislation (Medicare Mental Health Access Act, H.R. 884/S. 2772) to remove this supervision requirement; no cost estimate is available at this time.

Lack of coverage; few Medicare Advantage plans offered for serious mental illness. Medicare does not cover psychiatric rehabilitation, peer support services, or assertive community treatment (specialized care delivered by an integrated care team), though many of these services are covered by Medicaid for dual-eligible beneficiaries. One way to incorporate coverage of these services is through Medicare Advantage Special Needs Plans (SNPs), which tailor their benefits to people with specific characteristics. To date, only one SNP (Brand New Day), based in California, targets beneficiaries with serious mental illness. The plan uses a medical home model for these enrollees, incorporating case management, assertive community treatment, supported employment, and psychosocial interventions for co-occurring substance and physical health conditions, alongside mental health services. Compared to traditional Medicare, the SNP reduced utilization and costs for beneficiaries with serious mental illness and improved management of their chronic medical conditions.²⁹

Coverage of telemental health services. Medicare covers mental health services delivered via teleconference technology for only a small subset of rural beneficiaries — and those beneficiaries must receive their telemedicine services at select health care facilities, not at home. For this subgroup, coverage has increased mental health service use.³⁰ Given that research showing telemental health services can improve consumer outcomes,³¹ expanding Medicare coverage of such services could ameliorate provider shortages. But it will likely be insufficient to address the overall shortage of mental health providers, since many of these providers already operate at full capacity.

OPPORTUNITIES FOR IMPROVEMENT IN THE COVID-19 ERA

The stressors brought on by the COVID-19 pandemic have increased mental health service needs. This makes recent Medicare policies that reduce out-of-pocket costs for outpatient mental health services and medications more important than ever. Depression screening in the annual wellness visit also takes on heightened importance, given the need to identify and treat people with depression related to the COVID-19 pandemic.

Opportunities to coordinate mental and physical health care through behavioral integration billing codes and PCMHs could help support COVID-19 testing and treatment for people with mental illness. At the same time, the greater need for mental health treatment during the pandemic could exacerbate barriers to mental health care, including the 190-day inpatient psychiatric hospital limit, Medicare Advantage plans' narrow provider networks, and lack of coverage of licensed professional counselors.

Medicare telemental health coverage has been substantially expanded in response to COVID-19, with the majority of services, including group counseling, covered by Medicare and reimbursed at the same rate as in-person services. Medicare policy changes also have enhanced accessibility of telemental health services by:

- Waiving originating-site requirements and thus allowing beneficiaries to receive telemedicine services from home.

- Waiving HIPAA requirements that telemental health services be delivered over secure, audiovisual software platforms and instead permitting delivery by telephone and other means.
- Allowing providers to conduct telemental health visits with new patients.
- Allowing providers licensed in one state to deliver telemedicine services to consumers in a different state.

As of June 2020, it unclear whether these policies will be continued after the COVID-19 pandemic abates.

POLICY RECOMMENDATIONS

- 1. Remove insurance barriers.** Removing policies that limit Medicare beneficiaries to 190 days of care at inpatient psychiatric facilities, exclude mental health counselors from Medicare reimbursement, and require psychiatrist supervision of clinical psychologists in some settings will likely increase access to evidence-based services and improve consumer outcomes. As noted above, removing these barriers also would increase Medicare costs; however, mental health services currently account for only about 1 percent of program expenditures.
- 2. Improve mental health provider networks in Medicare Advantage.** Medicare Advantage criteria for network adequacy should be revisited with the goal of improving access to in-network specialty mental health providers. To aid consumers in identifying plans with adequate networks, CMS could incentivize plans to make comprehensive, up-to-date provider directories available by incorporating measures of directory adequacy in their star rating system.
- 3. Provide technical assistance to help practices increase uptake of depression screening and behavioral health integration services.** While reimbursement mechanisms for these services now exist through the annual wellness visit and behavioral health integration billing codes, uptake has been low. Additionally, studies suggest that reimbursement mechanisms have alone not been sufficient to prompt the practice transformation needed to support integration of systematic depression screening and mental health case management services into general medical settings.
- 4. Reward Medicare ACOs for meeting mental health quality metrics and ensure that specialty mental health providers are included in ACO networks.** The absence of financial incentives explicitly tied to quality metrics and the lack of in-network mental health providers are the two most commonly cited reasons for ACOs' failure to meaningfully improve the quality of mental health care they deliver to patients. Requiring ACOs to stratify general medical quality metrics by consumers' mental illness status also could help to incentivize high-quality general medical care for this group.
- 5. Consider making permanent the telemental health policies put in place in response to COVID-19.** Policies expanding telehealth access and payment parity for in-person and telehealth services during the COVID-19 crisis also could expand access once the crisis abates.

LOOKING FORWARD: RESEARCH PRIORITIES

Rigorous analysis of how the policy recommendations above influence care delivery, consumer outcomes, and costs will be necessary. Future research should include evaluations of implementation strategies to support uptake of systematic depression screening and behavioral health integration activities like care management, as well as studies of strategies to improve mental and physical health outcomes for beneficiaries enrolled in primary care medical homes and accountable care organizations. Additional research is needed on models for delivering psychosocial services, like supportive employment, for Medicare beneficiaries with serious mental illness; one potential option could be to incentivize additional mental-illness-focused Special Needs Plans.

Finally, further investigation is needed to identify telehealth policies most likely to increase access to mental health services and improve consumer outcomes. This line of research should explore consumer preferences for telemental health services versus in-person treatment.

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ABOUT THE AUTHOR

Beth McGinty, Ph.D., M.S., is associate professor and associate chair for research and practice in the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. She also serves as co-deputy director for the Center for Mental Health and Addiction Policy Research and as associate director for the ALACRITY Center for Health and Longevity in Mental Illness at the Bloomberg School. Dr. McGinty received a doctorate in health and public policy from the Bloomberg School and a master of science degree in health and behavior studies from Columbia University.

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For more information about this brief, please contact:

Beth McGinty, Ph.D., M.S.
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health
bmcginty@jhu.edu



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