BRIEF

Approaches to Meet Behavioral Health Needs in Medicare Advantage

NOVEMBER 2022

Analysis by ATI Advisory for:

BETTER MEDICARE ALLIANCE

About this Study

Behavioral health is an important issue in the Medicare population, with more than a third of Medicare beneficiaries experiencing behavioral health needs. These needs increased during COVID-19 with estimates that serious psychological distress nearly doubled among older adults and tripled among low-income groups during the early days of the pandemic.

In addition, Medicare Advantage enrollment is growing, with 45 percent of Medicare beneficiaries now choosing the program. As a result, it is important to understand the role of the program in meeting behavioral health needs. In response,

Better Medicare Alliance and ATI Advisory undertook the current study, reviewing quantitative data and existing policy, and conducting structured interviews with six organizations: two Medicare Advantage Plans, an integrated delivery system that includes a Medicare Advantage product, a provider organization, a vendor, and an advocacy organization.

This study highlights innovations occurring in Medicare Advantage to meet behavioral health needs, as well as key policy opportunities to improve access for the entire Medicare population.

The behavioral health needs among Medicare beneficiaries have significantly outpaced the public policy and infrastructure in place to meet them. Provider supply is insufficient to meet current demand for services, typical care delivery processes inhibit effective coordination between behavioral health and physical health, and coverage policies hinder the ability to prevent escalation of behavioral health needs.

Medicare Advantage plans have adopted innovative approaches to these policy and infrastructure barriers. Strategies ATI identified in this study include: offering peer support coaches; combining medical, social, and screening data into a "data lake" to build predictive algorithms and tailor solutions; using behavioral health equity steering committees; and, assigning a "care partner" to all beneficiaries with behavioral health needs. However, even with these innovations, opportunities for improvement remain, given individual need and gaps in the overall system infrastructure.

The opportunities below were identified for policymakers to consider, detailed further in the report. Many of these opportunities are possible through administrative authority and could have a meaningful impact on access to behavioral health services.

- **Addressing Insufficient Provider Supply.** The Centers for Medicare & Medicaid Services (CMS) and Congress could improve behavioral health provider supply through fee schedule improvements, expanding the types of behavioral health providers eligible for Medicare reimbursement, and providing technical assistance to states to expand cross-state licensure.
- **Addressing Coordination and Communication Challenges.** CMS and Congress could facilitate provider ability to coordinate between behavioral health and physical health services by modifying current billing codes to incentivize care coordination and facilitating the development of health information technology (HIT) platforms that incorporate behavioral needs and data sharing considerations.
- **Encouraging a Culture of Prevention Rather than Treatment.** CMS could improve preventive access to behavioral health care through fee schedule refinement, modifying the annual wellness visit (AWV), and exploring the potential to develop quality measures reflective of behavioral health prevention.

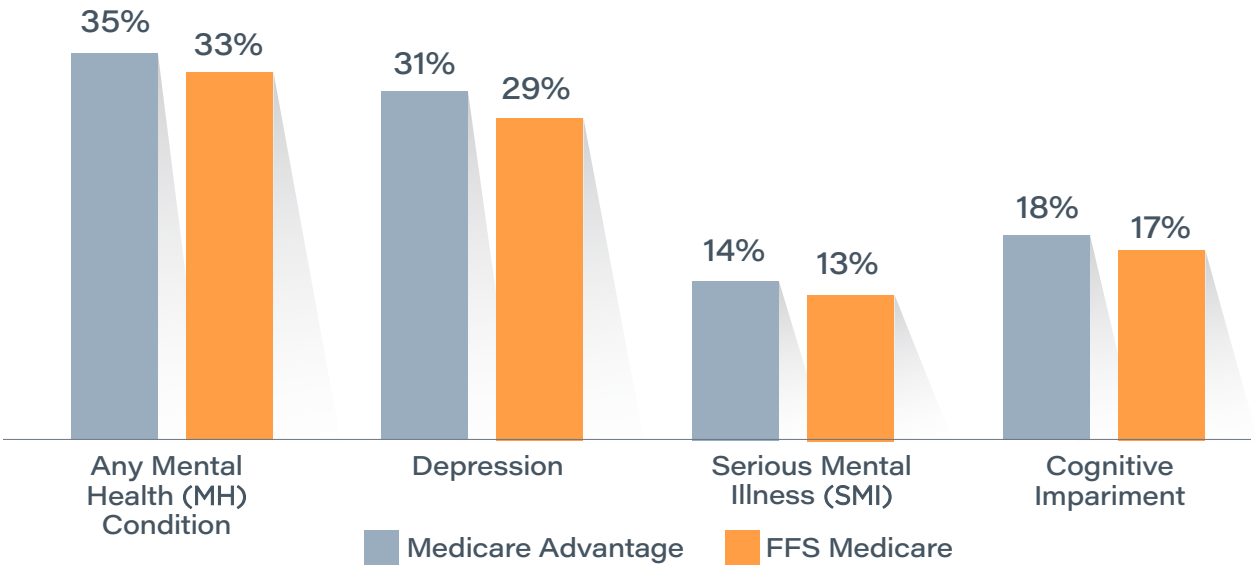
Introduction to the Issue

Behavioral health need among the Medicare population is significant and continues to grow. COVID-19 exacerbated existing access issues in behavioral health care and created new ones. Between loss of family members, stress, and economic insecurity, serious psychological distress nearly doubled among older adults and tripled among low-income groups during the early days of the pandemic.[ii]

Because 45 percent of Medicare beneficiaries are enrolled in Medicare Advantage, it is important to understand how Medicare Advantage plans meet the needs of the 11 million beneficiaries with behavioral health conditions.[iii] To quantify behavioral health needs and opportunities for improvement, the research team performed data analysis and interviewed stakeholders with expertise and experience in behavioral health in the context of the Medicare program (see Methods for more detail).

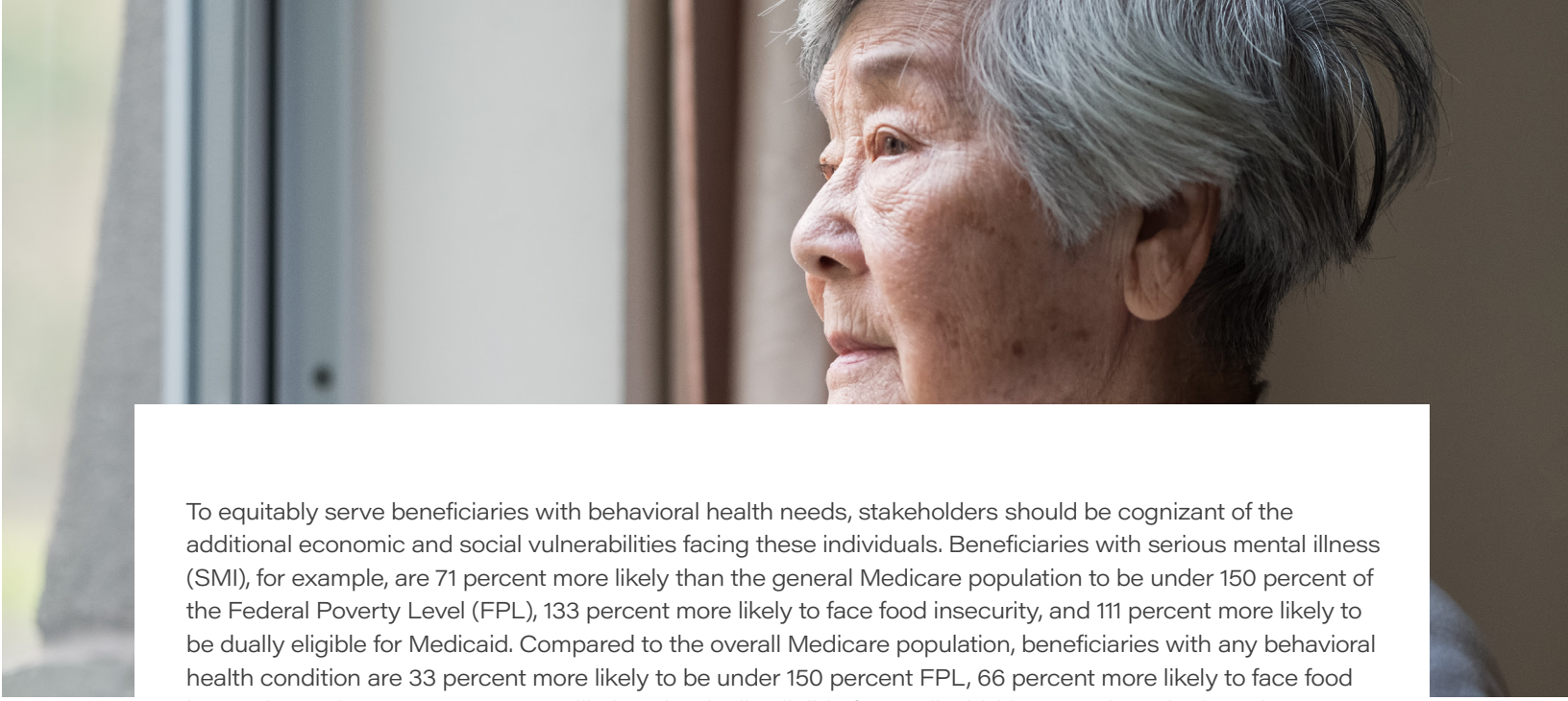
Over a third of all Medicare Advantage beneficiaries had a behavioral health condition in 2019 (**Figure 1**). Beneficiaries with behavioral health conditions experience a variety of needs and were 41 percent more likely to have 10 or more unique prescriptions in 2019 (data not shown).

Figure 1: Percentage Rate of Behavioral Health Conditions and Cognitive Impairment by Program



Note: Serious Mental Illness (SMI) includes beneficiaries who report having a mental or psychological disorder (not depression). Any behavioral health condition includes SMI, depression, anxiety and other conditions. Cognitive impairment is defined as Alzheimer's or dementia diagnosis and/or trouble deciding. See Methods for more details.

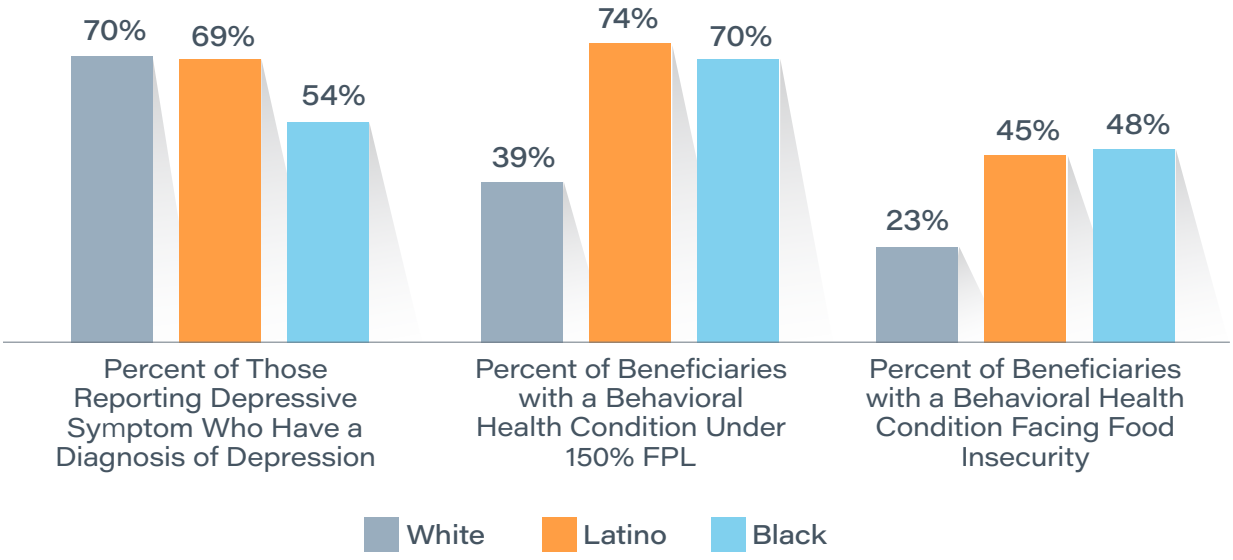
Note: Throughout this brief, we use "behavioral health" condition to refer to any mental health condition, inclusive of substance use disorder (SUD), or opioid use disorder (OUD). The Medicare Current Beneficiary Survey (MCBS) does not include SUD or OUD variables. Please see Methods for more detail.



To equitably serve beneficiaries with behavioral health needs, stakeholders should be cognizant of the additional economic and social vulnerabilities facing these individuals. Beneficiaries with serious mental illness (SMI), for example, are 71 percent more likely than the general Medicare population to be under 150 percent of the Federal Poverty Level (FPL), 133 percent more likely to face food insecurity, and 111 percent more likely to be dually eligible for Medicaid. Compared to the overall Medicare population, beneficiaries with any behavioral health condition are 33 percent more likely to be under 150 percent FPL, 66 percent more likely to face food insecurity, and are 62 percent more likely to be dually eligible for Medicaid (data not shown). These issues are relevant to both Medicare Advantage and fee-for-service (FFS) Medicare as the prevalence of behavioral health conditions including depression, anxiety, and SMI is similar across programs (**Figure 1**).

The significant racial and ethnic disparities in behavioral health needs are also well documented. Across the entire Medicare population (Medicare Advantage and FFS Medicare), Black Medicare beneficiaries reporting depressive symptoms, for example, are less likely to be diagnosed with depression than white Medicare beneficiaries. Black and Latino Medicare beneficiaries face additional financial challenges as well; over seven in ten Black and Latino beneficiaries with behavioral health conditions are under 150 percent FPL compared to less than four in ten white beneficiaries with similar behavioral health conditions. Furthermore, Black and Latino beneficiaries with behavioral health conditions face food insecurity at twice the rate of their white counterparts (**Figure 2**).

Figure 2: Racial Disparities in Depression Diagnosis Rates and Social Determinants of Health of Beneficiaries with Behavioral Health Conditions



Medicare Coverage of Behavioral Health Services

The Medicare program covers a variety of services to help diagnose and treat behavioral health conditions. However, the program has come under scrutiny for the limits of this coverage and the lack of parity between behavioral health services and other medical services.[iv] Because the Medicare Advantage program is able to (and does) offer services beyond what is covered in FFS Medicare, it is well-positioned to fill gaps in services by, for example, providing telehealth or transportation to appointments (**Figure 3**).

Figure 3: Available Benefits in FFS Medicare and Medicare Advantage

Benefit	FFS Medicare	Medicare Advantage
Psychotherapy and family counseling (if related to treatment)	✓	✓
Psychiatric evaluation, diagnostic tests	✓	✓
Medication management	✓	✓
Annual depression screening and wellness visit	✓	✓
Partial hospitalizations and hospitalizations	✓	✓
For OUD: medication, counseling, drug testing, and individual and group therapy	✓	✓
For alcohol misuse: annual screening with up to four brief counseling sessions	✓	✓
Telehealth for beneficiaries in rural areas	✓	✓
Telehealth (public health emergency waivers allow FFS Medicare to reimburse more virtual care)	Temporary[2,3,4]	✓
Transportation to or from behavioral health care services		✓
Behavioral health care from Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs)		✓
Activity therapy		✓
Additional preventative care		✓
Peer supports/support groups		✓
Digital solutions		✓
Non-medical supports such as housing, food, and caregiver respite		✓

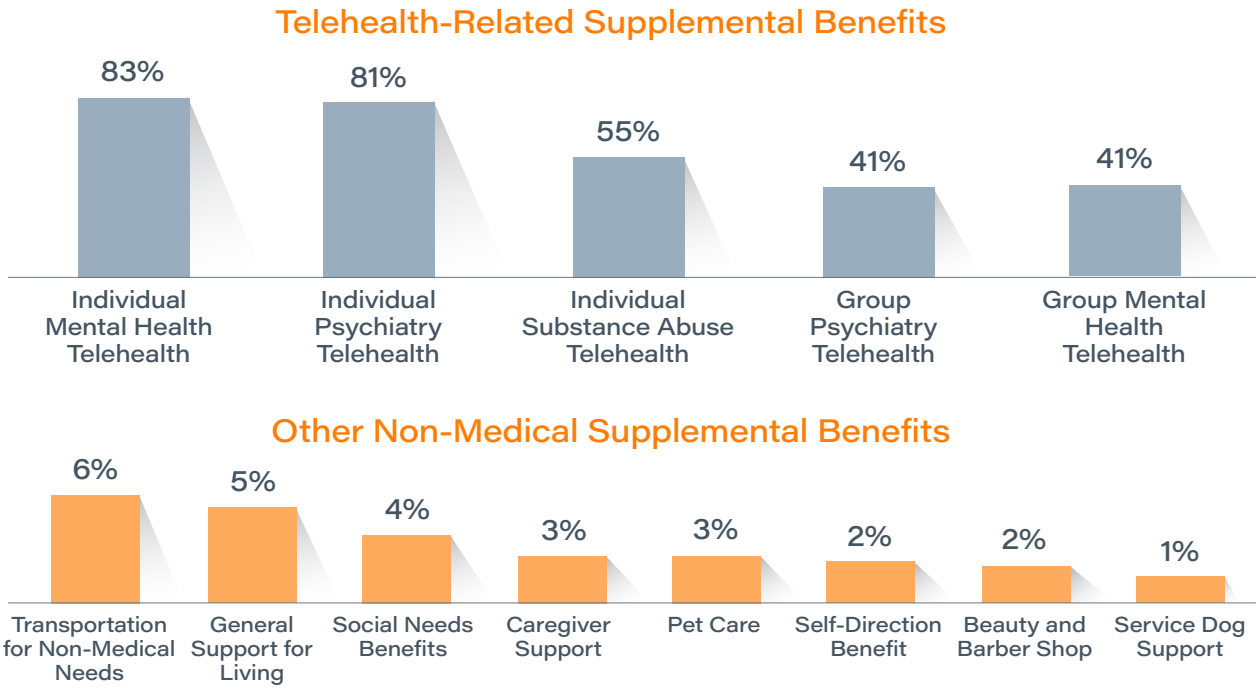
[2] During the COVID-19 Public Health Emergency (PHE), waivers allowed FFS Medicare to reimburse more services for all beneficiaries (i.e., even those in urban areas) rendered remotely. For more on telehealth flexibilities, see the ATI Advisory and BMA report: Telehealth During a Time of Crisis: Medicare Experiences Amid COVID-19.

[3] CMS's CY 2023 Physician Fee Schedule proposed rule (July 2022) indicates that CMS intends to continue to make payments for services included on the Medicare Telehealth Services list furnished via an audio-only telecommunications system for a 151-day period beginning on the first day after the end of the PHE.

[4] CMS's CY 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule continues payment under the OPPS for remote behavioral health services provided by clinical staff of hospital outpatient departments after the conclusion of the PHE.

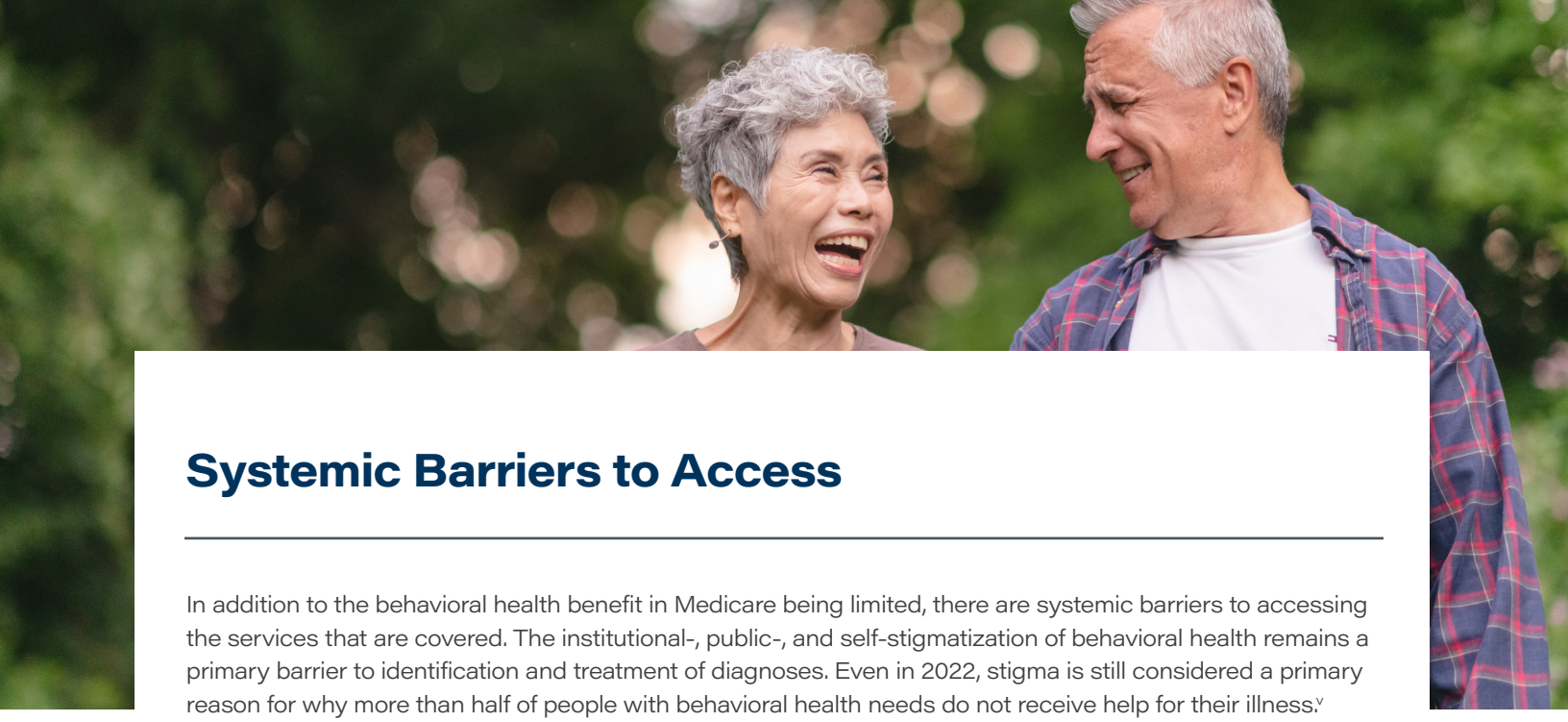
Medicare Advantage plans typically offer services beyond FFS Medicare in two ways: a plan's filed supplemental benefits or the plan's care model. Figure 4 shows the percent of plans that offer telehealth-related behavioral health supplemental benefits in 2022. Over four in five plans offer individual psychiatry and mental health telehealth, while two in five offer group psychiatry and mental health telehealth. A smaller percentage of plans offer social Special Supplemental Benefits for the Chronically Ill (SSBCI) that may have significant impacts on beneficiaries' mental health.[5]

Figure 4: Percent of Plans Offering Filed Supplemental Benefits Nationally



In addition to filed supplemental benefits, health plans offer clinical/care model approaches to meet the needs of Medicare beneficiaries. These programs often are not filed benefits but include mental health mobile apps and alternative therapies, among other approaches detailed next.

[5] For more information on what each of these SSBCI may entail, please see Plan Year 2022 Medicare Advantage New, Non-Medical Supplemental Benefits (atiadvisory.com).



Systemic Barriers to Access

In addition to the behavioral health benefit in Medicare being limited, there are systemic barriers to accessing the services that are covered. The institutional-, public-, and self-stigmatization of behavioral health remains a primary barrier to identification and treatment of diagnoses. Even in 2022, stigma is still considered a primary reason for why more than half of people with behavioral health needs do not receive help for their illness.[v] Stigma is a particularly common barrier to receiving care in diverse racial and ethnic communities.[vi]

In addition, there are infrastructure and policy barriers impeding Medicare beneficiary access to behavioral health services. These include insufficient provider supply, which is exacerbated by credentialing and licensure requirements, challenges coordinating between behavioral health and physical health, and an ingrained culture focused on treatment rather than prevention.

1. **Insufficient Provider Supply.** Current behavioral health provider capacity meets only 28 percent of America's behavioral health needs, and shortages are expected to get worse.[vii] This includes psychiatrists, mental health social workers, counselors, and other specialty behavioral health professions. Supply is particularly bad in the Medicare program. As a profession, psychiatrists are the most likely specialty type to-opt out of Medicare, with 7.2 percent of psychiatrists opting-out of Medicare in 2020 compared to the next highest specialty type (plastic surgery) at 3.6 percent.[viii] As a result, behavioral health providers comprise the largest portion of specialties opting-out of Medicare, and as a portion this has risen significantly over time (26% of specialty types opting-out in 2005 were behavioral health, versus 43% in 2022).[ix,x] Notably, providers who opt-out of FFS Medicare are not allowed to contract with Medicare Advantage plans.

   There are several contributing factors to the insufficient supply of behavioral health providers under Medicare, including:

   - The Medicare fee schedule is considerably lower than what many behavioral health providers can receive for their services without accepting insurance, creating disincentives for behavioral health providers to participate in Medicare.[xi] As one interviewee reported, a consequence of this is individuals are often limited to appointments with "providers in training" to meet capacity needs.
   - Medicare policy further limits the types of providers beneficiaries can see. Licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs), for example, are not reimbursed by FFS Medicare. LPCs and LMFTs make up an estimated 40 percent of master's education behavioral health providers.[xii] Expanding the provider list to include these nationally certified professionals would add 200,000 new potential providers to FFS Medicare networks across all states. [xiii]
   - Credentialing requirements limit behavioral health provider supply. Tele-behavioral health services can help address unmet demand, but state-by-state licensure requirements and renewal processes make multi-state licensure onerous for providers. Interviewees described the benefits of interstate compacts, like PSYPACT, as a major step forward, but not all states participate in these compacts.

Supply is especially insufficient for Medicare beneficiaries of color. Although Black, Latino, Asian, and Native American individuals experience adverse behavioral health outcomes at disproportionately higher rates than white individuals in the U.S., an overwhelming majority of U.S. behavioral health providers are white.[xv,xvi] In 2019, 83 percent of active psychologists in the U.S. were white.[xvii] This lack of diversity exacerbates existing health disparities; racial and ethnic patient-provider concordance is correlated with patient engagement and retention in behavioral health treatment.[6] Very few people of color are able to access a behavioral health provider who looks like they do.[xviii]

2. **Coordination Challenges.** System incentives do not support coordination between behavioral health and physical health. For example, payment approaches do not incentivize coordination, and processes to coordinate are manual, often involving telephonic and facsimile back-and-forth. This is in part due to low rates of electronic health record (EHR) and information technology use. Because they were not eligible for federal incentives for EHR adoption under the HITECH Act of 2009, behavioral health providers have much lower rates of EHR use and many existing EHRs do not accommodate protected health information required in behavioral health care. For example, federal regulation restricts the sharing of health information on substance-use disorder (SUD); however, EHRs have not been tailored to allow for the segmentation of this protected information from the rest of a patient's record so that some information, if not the protected information, can be shared with other providers.[xx,xxi]

3. **Treatment-focused Culture**. While the physical health policy environment has shifted toward preventive care, Medicare behavioral health services and coverage remain heavily treatment focused. This inhibits providers and Medicare Advantage plans from moving upstream in a Medicare beneficiary's potential behavioral health decline. For example:

   - Medicare has several Star Ratings measures related to preventive physical health care, but no Star Rating measures currently reflect behavioral health prevention efforts. This is partly due to the lack of robust or standardized quality measures in behavioral health in general, exacerbated by a sentiment in the provider community that behavioral health is more "art than science" and improvement or quality care is not necessarily measurable.
   - Screening for behavioral health symptoms is often limited to individuals in active treatment. While Medicare's annual wellness visit (AWV) includes screening for depression, it includes no other behavioral health diagnoses and requires screening for depression only during the initial AWV – not during any of the subsequent AWVs.[xxiii] The stigma of self-identifying with behavioral health symptoms or risk factors further inhibits the value of screening.
   - Current Medicare fee schedules do not afford primary care providers sufficient time for probing conversations that could identify and address behavioral health needs before they escalate. Often value-based arrangements can offer incentives that address these gaps in Medicare fee schedules, but a lack of behavioral health quality measures coupled with inconsistent and unreliable screening have inhibited a shift to behavioral health value-based arrangements between providers and Medicare Advantage plans.

> *"The diagnostic criteria for post-traumatic stress disorder (PTSD) requires an individual meet full diagnostic criteria for at least one month following the trauma, however in some cases individuals may not begin to show symptoms until 6+ months following the trauma. Discussions about mitigation strategies to avoid escalation aren't covered by Medicare during this six-month window, a critical time for prevention."*
>
> *-Study Interviewee*[xxii]

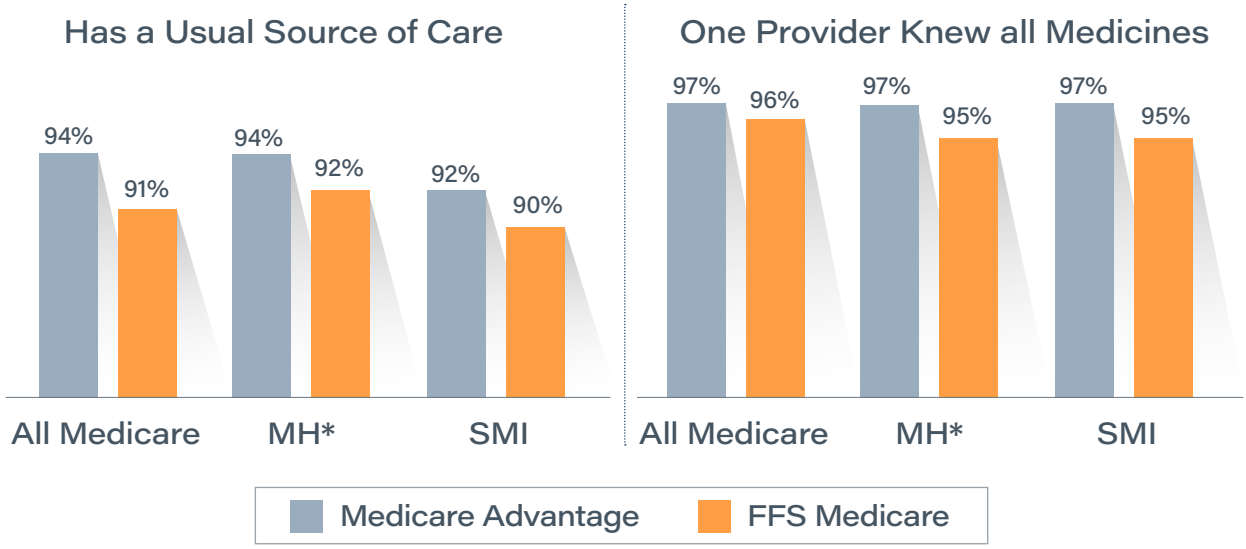
[6] Racial and ethnic concordance refers to having a shared identity between a provider and a patient regarding their race and ethnicity, whereas racial and ethnicity discordance refers to patients and providers having different racial and ethnic identities

Medicare Advantage Plan Approaches to Addressing Behavioral Health Needs

While Medicare Advantage plans are affected by the challenges described above, as risk-bearing entities, Medicare Advantage plans are able to identify and address behavioral health needs more comprehensively than is possible in FFS Medicare due to their ability to coordinate care and services across providers. Medicare Advantage plans also offer intensive care management, leverage data to predict need, and screen individuals through more frequent touchpoints than typically occur in FFS, such as the health risk assessment process.

Compared to FFS Medicare, beneficiaries in Medicare Advantage with any behavioral health condition are more likely to have both a usual source of care and a provider who knows all their medications while beneficiaries with SMI are similarly likely to have a usual source of a care and a provider who knows all their medications (**Figure 5**).

Figure 5: Care Coordination Metrics by Behavioral Health Condition and Program



To understand Medicare Advantage approaches to addressing behavioral health needs, the study team conducted interviews with six organizations that included two Medicare Advantage Plans, an integrated delivery system that includes a Medicare Advantage product, a provider organization, a vendor, and an advocacy organization.

The case studies that follow detail specific solutions identified as part of the interviews with Medicare Advantage plans and the integrated delivery system. Medicare Advantage plans use a diverse array of care and delivery strategies to address the behavioral health needs of their beneficiaries in this environment of systemic barriers to accessible and well-coordinated care. Strategies differ across the continuum of care but are consistently designed to meet enrollees where they are to facilitate identification for and engagement with treatment.

CASE STUDY 1:
Large, National Health Plan

Case study one reflects a national Medicare Advantage plan that estimates 50 percent of its Medicare membership experience mental illness and 12 percent experience serious mental illness. The organization has prioritized intentional behavioral health network and case management growth in recent years, with a key focus on identifying enrollees with undiagnosed or unmet behavioral health needs. The organization combines screening information from the health risk assessment (HRA), engagement of primary care providers with a more personal understanding of an enrollee's needs, and other data sources into a "data lake" from which they build predictive algorithms to identify individuals with actionable behavioral health needs.

Once an enrollee with behavioral health needs is identified, the Medicare Advantage plan engages them directly or through a network of vendors with tailored solutions. Based on enrollee progress (for example, improvement in mental wellbeing, engaging in a program, or enrollee satisfaction with the vendor), the Medicare Advantage plan may seek out an alternative vendor for the individual's needs or the individual's case manager will conduct outreach.

Prevention	Identification	Treatment
Supplemental Benefits: In addition to benefits offered through the care model, filed social needs, non-medical transportation, self-direction, pet care, general supports for living, beauty/barber shop, and mental health telehealth non-medical supplemental benefits.[7] **Team-based Care Management:** Enrollees who qualify for care management are managed by an interdisciplinary team (IDT), which includes a behavioral health provider. Care managers are provided with a social resource directory of local community resources to address social determinants of health needs.	**Screening:** Use of General Anxiety Disorder (GAD) and Patient Health Questionnaire (PHQ) screeners on a recurring basis to gauge level of depression and/or anxiety symptoms and any changes in status. **Predictive Analytics:** Use of claims, HRA, and social determinants of health data to identify enrollees who might be appropriate for behavioral health interventions but are not identified via screening.	**Coaching:** Peer support "coaches" available for enrollees experiencing SUD. **Apps/Digital Platforms:** Multiple vendor partners used to address specific behavioral health needs, like SMI or SUD. Plan regularly adjusts and updates vendor solutions based on efficacy and enrollee satisfaction and tailors solutions to population and diagnosis. **Therapy:** ▪ Brick-and-Mortar ▪ Telehealth: National tele-behavioral health vendor available to enrollees, but most virtual behavioral health visits occur with in-network providers that also have brick-and-mortar offices.

Intervention Highlight: Digital Application ("App") for Individuals with Serious Mental Illness

For enrollees with serious mental illness, the health plan uses a digital app loaded onto an enrollee's smart phone to provide additional virtual services and monitor the enrollee's behavioral health status.

- Avenue a virtual wrap-around services like therapy sessions and psychiatric video consultations.
- App conducts passive monitoring of enrollee's use of the phone (both within app and in other apps) to proactively identify decompensation or decline in the enrollee's mood or behavior
- App includes daily screening so that both enrollee and health plan can track improvements or declines over time.

The health plan regularly evaluates the efficacy of the digital app, including:

- How frequently enrollees use the app
- Enrollees' use of the wrap-around services in the app
- Whether (and how frequently) enrollees are using the emergency department
- Net Promoter Score (NPS) (i.e., enrollee satisfaction)
- Long-term cost and utilization metrics

[7] ATI Advisory analysis of CMS Q2 2022 Plan Benefit Packages.

CASE STUDY 2:
Regional Health Plan

Case study two reflects a regional Medicare Advantage plan (offerings in fewer than 10 states). The organization primarily serves individuals dually eligible for Medicare and Medicaid and estimates 75 percent of its membership has a behavioral health diagnosis.

The Medicare Advantage plan aims to proactively identify need using predictive analytics, diagnosis on claims, and in-person assessments, but acknowledges certain conditions, like trauma, are more difficult to identify. Across all states the plan serves, it uses an integrated, team-based approach that typically includes a behavioral health clinician, community health worker, occupational therapist, and as available, partnerships with human service providers. This team huddles daily to discuss high priority enrollees, and all enrollees have a "care partner" that engages them on a cadence specific to their needs (e.g., daily, weekly).

Rather than focusing solutions on diagnoses, the Medicare Advantage plan emphasizes acuity and unmet need, and designs behavioral health solutions around identified gaps such as social need, trauma supports, or local geographic access barriers such as insufficient inpatient bed availability. For example, the Medicare Advantage plan's staff psychiatric nurse practitioners serve as a "fallback" in instances where enrollees experience barriers to in-office care.

Prevention	Identification	Treatment
Supplemental Benefits: In addition to benefits offered through the care model, filed non-medical supplemental benefits for non-medical transportation as well as mental health telehealth.[8] **Team-based Care Management:** All enrollees are care managed by an IDT, which includes a behavioral health provider. **Value-based Provider Arrangements:** The health plan leverages value-based relationships with community human service providers to improve enrollee engagement and outcomes for about 10 percent of their membership.	**Screening:** Use of GAD and PHQ screeners on a recurring basis to gauge level of depression and/or anxiety symptoms and any changes in status. Also screen on a regular basis for SUD. **Predictive Analytics:** Use of HRA and social determinants of health data to identify enrollees who might be appropriate for behavioral health interventions but are not identified via screening.	**Therapy:** Rely on in-network providers for therapy services, whether in-person or virtual.

Intervention Highlight: Team-based Care Management

An IDT care manages all enrollees of this health plan. IDTs at this health plan are typically made up of a nurse practitioner, a registered nurse, a behavioral health practitioner, and a community health worker. Some enrollees requiring more intensive services also have physical or occupational therapists on their care management teams.

- IDTs have a daily huddle where they discuss enrollees based on risk stratification level (i.e., high-risk enrollees are prioritized).
- The IDT discusses individual enrollees at a variety of intervals (weekly, monthly, annually) depending on the intensity of the enrollees' needs.
- Because a behavioral health practitioner is always embedded on the IDT, all enrollees receive some level of behavioral health support.
- The IDT's behavioral health clinician can do an in-person assessment to identify an enrollee's needs.
- The behavioral health clinician can do "bridge therapy" to temporarily support enrollees as they are waiting to see a brick-and-mortar therapist or psychiatrist.

[8] ATI Advisory analysis of CMS Q2 2022 Plan Benefit Packages.

CASE STUDY 3:
Integrated Delivery Network

Case study three reflects a Medicare Advantage plan with an integrated delivery network. The plan estimates that a third of their enrollees have at least one behavioral health claim in the past two years, noting behavioral health screens are embedded into their clinician's daily workflows, and as a result every enrollee is screened for behavioral health needs. The plan also recently created a screening and referral process to make it easier for primary care providers to refer to behavioral health services.

Behavioral health is "part of the fabric" of the Medicare Advantage plan's approaches to care, and staff receive a considerable amount of training on how to talk about behavioral health, person-centered care, and screening. The plan has a behavioral health steering committee that evaluates plan programs and approaches and, using data on outcomes, adjusts and tailors approaches. For example, the plan identified that enrollees with English as their second language had long lengths of inpatient stays and in response, the plan is implementing a more targeted discharge planning program. An equity subcommittee works to ensure intentional emphasis on access in different communities and investment in expanding provider networks based on equity needs.

Prevention	Identification	Treatment

Supplemental Benefits: In addition to benefits offered through the care model, offer telehealth for individual mental health, psychiatric, and outpatient substance use disorder treatment.
 	
Team-based Care Management: Enrollees who qualify for care management are managed by an IDT, which includes a behavioral health provider.
 	
Value-based Provider Arrangements: Leverage value-based agreement experiences from their Medicaid line of business to develop their Medicare behavioral health value-based strategy.
	Screening: Use of GAD and PHQ screeners on a recurring basis to gauge level of depression and/or anxiety symptoms and any changes in status. Also screen on a regular basis for SUD.
	
	Training: Provide training for all staff on mental health first aid to respond to signs of behavioral health need and substance abuse.
	
	Community-based Initiative: Beauty Salon and Barber Shop Initiative to identify enrollees who could use behavioral health support (see below).
		Coaching: Behavioral health case managers perform coaching for anxiety, depression, SUD, grief, pain management, and attention deficit hyperactivity disorder (ADHD).
		
		Apps / Digital Platforms: Provide cognitive behavioral therapy (CBT) focused digital platform for enrollees with stress and anxiety. Also utilize a proprietary app/tablet to engage seniors, including those in Special Needs Plans (SNPs), via brain games and Zoom integration.
		
		Therapy:
		▪ Brick-and-Mortar
		▪ Telehealth:
		  ▪ Emphasis on virtual care follow-ups post-discharge to prevent readmission.
		  ▪ Use proprietary at-home virtual care solution

Intervention Highlight: Beauty Salon and Barber Shop Initiative

The organization launched a "Beauty Salon and Barber Shop Initiative" in a local community served by the integrated delivery network's health plan and provider organization. The organization provided Black-owned salons and barber shops with mental health first aid and engagement training.

- Particularly important to engage the Black community in preventive discussions around behavioral health given high levels of stigma and systemic inaccessibility to services.
- Through the trainings, participants are better able to recognize clients' behavioral health challenges and can engage clients in discussions regarding possible support.
- The integrated delivery network is conducting a mixed-methods evaluation of the initiative, conducting qualitative interviews through community focus groups and querying geo-tagged utilization data of behavioral health services in the community.

Policy Opportunities to Improve Access to Behavioral Health Care

Research and interviews conducted for this study identified key opportunities for policymakers to improve access to behavioral health services. While Medicare Advantage plans have some flexibility to innovate around existing barriers, policy reform efforts would improve access to care across the entire Medicare program and enable more equitable and preventive access to behavioral health care for all Medicare beneficiaries. Furthermore, without alignment between Medicare Advantage and FFS policies, there will be insufficient traction at the provider-level to address the systemic barriers to behavioral health access discussed earlier in this brief. CMS has administrative opportunities to address insufficient provider supply, improve coordination of services, and encourage a culture of preventive services.

1. **Address Insufficient Provider Supply.** Insufficient provider supply (including insufficient concordance in racial, ethnic, and cultural identity between providers and Medicare beneficiaries) creates a significant barrier to access. To improve supply, CMS should:

    - *Increase the Medicare fee schedule for behavioral health services.* Higher reimbursement for services could reduce the high rate of behavioral health providers opting out of the Medicare program. As of May 2022, approximately 43 percent of providers opting out of Medicare were behavioral health providers. Additionally, a 2021 survey found that 40 percent of behavioral health providers could not maintain operations beyond a year due to financial issues.[xxv]
    - *Expand the types of behavioral health providers covered under FFS Medicare to include licensed professional counselors and licensed marriage and family therapists.*[9,10] The exclusion of these provider types from FFS Medicare's fee schedule exacerbates existing provider supply challenges. Additionally, LPCs and LMFTs charge lower rates for their services; adding these provider types to FFS Medicare would expand access to lower-cost behavioral health care.[xxvi] While CMS's CY 2023 physician fee schedule proposed rule broadens the ability for LPCs and LMFTs to practice under general supervision (as opposed to direct supervision), Congress should consider establishing LPCs and LMFTs as Medicare providers. Expanding the types of covered providers under FFS Medicare would increase the number of behavioral health providers available for all Medicare beneficiaries.
    - *Provide technical assistance to states interested in participating in cross-state licensing for behavioral health providers.* States not currently participating in cross-state licensing compacts would benefit from understanding the access opportunities created through cross-state practice, as well as how to transition to cross-state licensing compacts. This would greatly reduce the administrative burden for providers to register as a practitioner individually for each state and expand the overall pool of available providers.

[9] This recommendation would require legislative/Congressional action. The Senate Finance Committee's recent bipartisan "Enhancing Mental Health Workforce" discussion draft legislation includes such a provision.

[10] In a step towards this recommendation, CMS's CY 2023 physician fee schedule proposed rule (July 2022) indicates that while CMS does not have the authority to create a benefit category for practitioner types, the agency intends to amend the direct supervision requirement to allow behavioral health services to be furnished under the general supervision of a physician or NPP when these services are provided by auxiliary personnel, like LPCs and LMFTs.

2. **Address Coordination & Communication Difficulties.** Behavioral health services are often provided in an uncoordinated manner, and lack of data sharing has prevented a shift to value-based care. To improve coordination, CMS should:

   - *Continue iterating on behavioral health integration billing codes to incentivize care coordination between physical and behavioral health providers.* In 2021, CMS implemented billable codes for primary care practices providing behavioral health care under the Collaborative Care Model (CoCM).[xxvii] However, all reimbursement for these activities goes to the primary care physician, not the care manager or psychiatric care consultant. Improved reimbursement that directly benefit both physical and behavioral health providers would better incentivize coordination. Relatedly, CMS's CY 2023 Medicare fee schedule proposed rule includes a new behavioral health integration billing code for clinical psychologists and clinical social workers.
   - *Facilitate behavioral health provider access to health information technology systems necessary for effective coordination.* For a myriad of reasons described in this report, EHRs often cannot accommodate behavioral health services or providers. These systems are costly to implement, and providers need technical assistance to effectively use the systems and incorporate into their workflows. CMS has an opportunity to promote better coordination of care for individuals with behavioral health needs. For example, CMS could partner with the Office of the National Coordinator (ONC) to create certification standards for behavioral health IT systems. This aligns with a recommendation from MACPAC in June 2022 and would help behavioral health providers understand what EHR features are desirable or important, particularly in the context of privacy and data sharing.[xxviii] As was done for other health care providers through the HITECH Act of 2009, Congress could authorize funds to improve EHRs for behavioral health care to improve electronic infrastructure.[11]

3. **Encourage a Culture of Behavioral Health Prevention.** CMS has made strides in advancing preventive care in the Medicare program for beneficiaries' physical health, but behavioral health coverage and payment policies continue to lag. CMS has an opportunity to better address behavioral health needs in the Medicare population by shifting the focus toward prevention. To accomplish this, CMS should:

   - *Adjust the fee schedule for Medicare AWVs and behavioral health integration billing codes to encourage uptake.* While these billing codes currently exist, uptake among providers has been low.[xxix] Increasing the reimbursement per service would further encourage use and more accurately reflect the value of behavioral health screening and integration.
   - *Include anxiety and SUD screening in Medicare AWVs, in addition to depression screening.* Including anxiety and SUD screening in AWVs will allow providers to identify behavioral health concerns earlier and provide opportunities to address symptoms before they escalate.
   - *Explore development and use of behavioral health prevention quality measures to monitor and incentivize use of services.* The lack of robust quality measures specific to behavioral health inhibits a shift toward quality based care. While it is important not to impose provider requirements that exacerbate the rates of behavioral health providers opting out of Medicare, CMS should consider the development of person-centered behavioral health quality measures and incentives for improved care delivery.

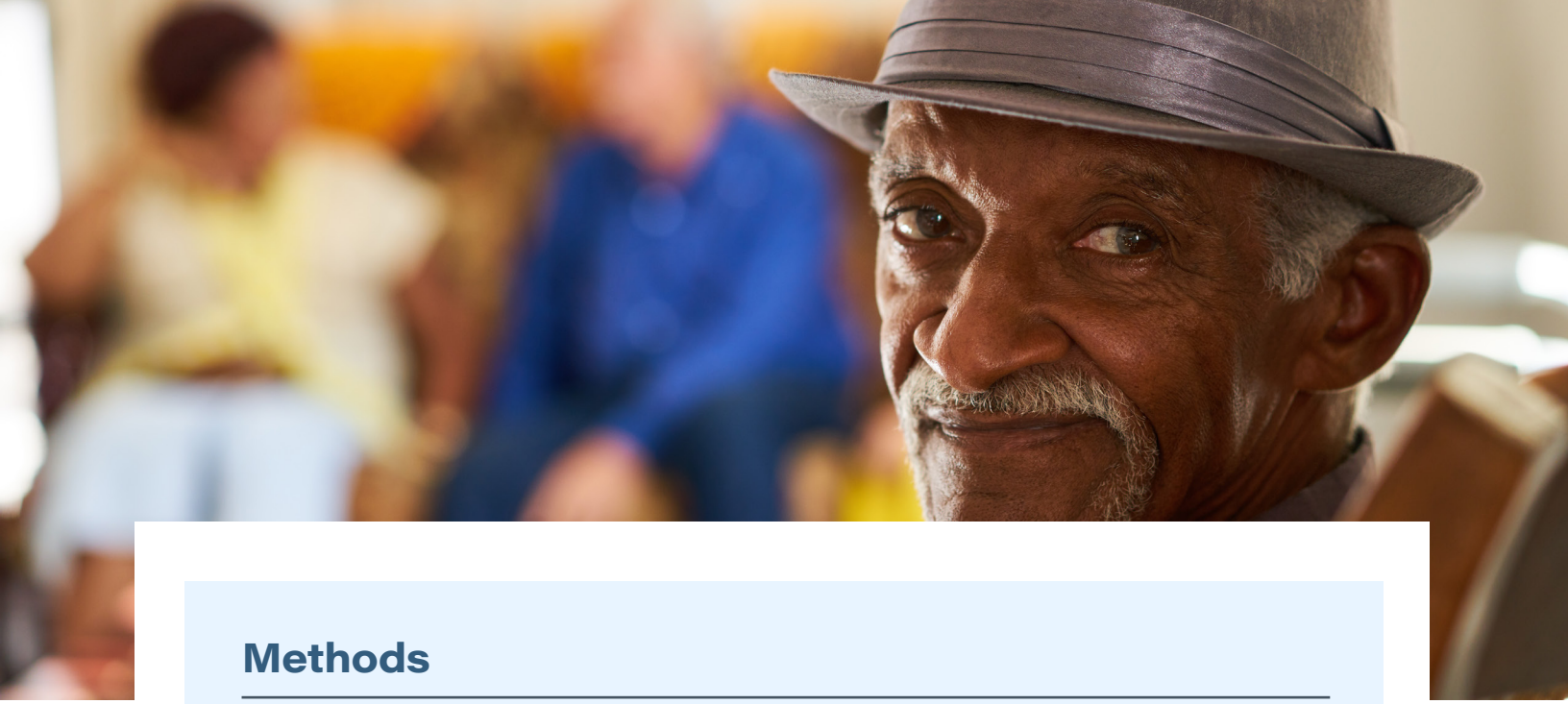
[11] This recommendation would require legislative/Congressional action.

Looking Ahead

This research illuminates systemic barriers to behavioral health access in the Medicare program and identifies administrative opportunities for CMS to expand Medicare beneficiary access to behavioral health. Nearly half the Medicare population experiences behavioral health needs, but policies in the Medicare program have not prioritized these needs.

This research also highlights innovative models and approaches Medicare Advantage plans use to address behavioral health needs among their enrollees. While these innovative approaches allow for coordination and preventive care not possible in FFS Medicare, Medicare Advantage plans and their enrollees are still negatively impacted by underlying Medicare policy and system infrastructure. CMS should continue to incentivize innovation in Medicare Advantage to allow plans to meet behavioral health needs of their enrollees (e.g., through supplemental benefits), but should also seek policy reform that improves appropriate and equitable access to care for all Medicare beneficiaries with behavioral health needs. CMS should also consider approaches to address the stigma associated with behavioral health, such as a public awareness campaign or leveraging a Medicare Learning Network (MLN) article to assist providers with best practices to mitigate stigma.

As behavioral health needs persist and demand for services grows, it will be important for CMS to focus efforts on appropriate access. Medicare Advantage has afforded a strong platform to address some of the gaps in current policy, but additional policy reform could improve access outcomes for the broader Medicare population with behavioral health needs



Methods

Throughout this brief, we use "behavioral health" condition to refer to any mental health condition, inclusive of substance use disorder (SUD), or opioid use disorder (OUD). To understand how Medicare Advantage plans meet the behavioral health needs of their beneficiaries, ATI Advisory conducted interviews with two plans, one integrated delivery network, a provider, a vendor, and an advocacy organization.

Using the 2019 Medicare Current Beneficiary Survey (MCBS), ATI Advisory examined how Medicare coverage arrangements are related to beneficiaries' demographics, behavioral health conditions, and experience with care. Our definitions for behavioral health conditions, serious mental illness and cognitive impairment are below (**Table 1**).

Table 1: MCBS Behavioral Health and Serious Mental Illness Definitions

MCBS Survey Cohort	Any Behavioral Health Condition	Serious Mental Illness (SMI)	Cognitive Impairment
Community	▪ Depression ▪ Mental Disorder ▪ GAD-2 score of 3+, Anxiety likely	▪ Mental Disorder ▪ PHQ-2 score of 3+, Major Depressive Disorder likely	▪ Alzheimer's ▪ Dementia ▪ Trouble Deciding
Facility	▪ Depression ▪ Anxiety ▪ Manic Depression ▪ Psychotic ▪ Schizophrenia ▪ PTSD ▪ Atypical Psychosis ▪ Anorexia	▪ Psych Disorder ▪ Schizophrenia	▪ Alzheimer's ▪ Dementia

Full MCBS methods are available at:
https://atiadvisory.com/wp-content/uploads/2022/04/2019-MCBS-Analysis-Research-Methods-April-2022.pdf

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