Published in final edited form as:

JAMA. 2009 October 7; 302(13): 1463–1464. doi:10.1001/jama.2009.1446.

Commentary: Applying Healthcare Reform Principles to Mental Health and Substance Abuse Services

Dr. Kavita Patel, MD, MSHS and

Office of Public Engagement and Intergovernmental Affairs, the White House.

Dr. Kenneth Wells, MD, MPH

Jane and Terry Semel Institute for Neuroscience and Human Behavior, the Departments of Psychiatry and BioBehavioral Sciences, David Geffen School of Medicine and of Health Services, UCLA School of Public Health, and the RAND Health Program.

The American political system is debating the desirability and feasibility of healthcare reform. Discussions focus on expanding coverage while reforming delivery to contain costs and assure quality.¹ There has been little discussion of how to apply reform principles to mental health and substance abuse (MHSA) conditions and services. The passage of federal parity bills for private plans and outpatient Medicare services² underscores the policy interest in assuring financial access and the timeliness of considering application of reform principles to these services. This commentary highlights features of MHSA conditions and services that affect consideration of reform principles.

1. Access to healthcare for all Americans

There are differences in MHSA services availability and financing between private and public sectors.³ Not all private plans cover all MSHA conditions and services, and MHSA coverage is often less generous than for medical conditions, though such coverage has improved over time.^{3, 4} Federal parity laws will further improve coverage for groups regulated by them and some states have mandated parity for plans subject to state laws. Nevertheless, some will face coverage loss or changes in switching jobs or moving geographically even after parity legislation, and the services provided will depend on other factors such as benefit management. Many providers practice outside of insurance so financial burdens can be high even for the insured. While private systems deliver services for many MHSA conditions, severe and persistently ill clients predominate in the public sector. With prioritization of public funds to sicker individuals, services may be limited or unavailable for those with moderate conditions such as for depression or anxiety disorders. Further, the scope of necessary MHSA services is broad for vulnerable clients. Severely ill adults may require MHSA, social, physical health and criminal justice services. Many children receive MHSA services through schools. To assure access, it will be important to fill gaps in services availability and funding, while supporting such non-traditional settings.

2. Delivery System Reform

Reform discussions emphasize the importance of multi-specialty groups and organized delivery systems, team management and care coordination, evidence-based practice, and information technology.¹ Organized systems typically provide diverse MHSA services, but most private MHSA services are managed through specialized behavioral health management firms.⁵ How such companies might coordinate with local groups under health reform is unclear. Special protections on MHSA records under the Health Insurance Portability and Accountability Act (HIPAA) complicate data sharing, particularly for outpatient practice.⁶ There is little regulation of psychotherapy and few incentives to use evidence-based modalities,

and under-use of and poor infrastructure to deliver many psychosocial interventions, such as family psychoeducation for schizophrenia, or collaborative care for depression and anxiety in primary care.^{3, 7, 8} There is little precedent for comprehensive services delivery across health domains in the public sector. Public mental health and substance services are often separately administered, complicating care for co-occurring disorders. There are important implications for delivery system reform. Public-private partnerships may be needed to achieve comprehensive delivery systems that can match client need with appropriate infrastructure. Behavioral health management firms may offer one strategy to fill gaps in services delivery, management and information technology. Given concerns about cost-containment strategies for sicker patients and mixed evidence for effects of such management on quality of care,⁵ it may be important to couple national management with local accountability for access and quality. In addition, provider and system capacity development is required across sectors to assure delivery of many evidence-based interventions. Given risks for social stigma, policies are needed to facilitate data sharing while protecting confidentiality and avoiding loss of employment or insurance eligibility.³

3. Reimbursement reform

Most public MHSA services are under-funded, such that client eligibility and services availability are restricted.^{3, 7} Options to increase access through managing benefits may be problematic for sicker MHSA clients. There are cost concerns about increasing use of newer psychotropic drugs, but for outpatient services, costs have been largely contained.⁴ Given recent passage of two federal MHSA parity bills, parity might be expected as a feature of broader reimbursement reform. But the “devil is in the details” and recent laws leave uncertainties as to conditions and services covered and gaps those covered by plans outside of those regulations. This suggests a need for analysis of reimbursement reform in the light of existing coverage mandates and gaps, including variations in Medicaid coverage. Prevention and early intervention services, such as suicide prevention are often funded by government or private programs rather than insurance.^{9, 10} How they will be supported as part of broad reform needs clarified.

4. Community-based accountability

MHSA conditions can interfere with client self-advocacy due to cognitive, mood, and motivational symptoms.³ Public sector systems often have advisory boards that include consumer and family advocacy organizations, and providers can serve an important role as advocates. The diversity of sectors and systems providing MHSA services for sicker clients, children, and the elderly suggests a need for inclusion of diverse stakeholders in local accountability processes. It will be important to identify effective community-based accountability models and consider how they may be supported and disseminated.

5. Comparative effectiveness

Much of the effectiveness data focus in MHSA benefit management has been on psychotropic medications, given high costs of newer agents and controversies about their effectiveness relative to less expensive choices. In addition, there are consumer and provider concerns over extensive off-label use of psychotropic medications in children, and corresponding limitations in efficacy data. Data on effectiveness and comparative effectiveness of psychosocial treatments are mainly relevant to provider training and program planning, and certain state initiatives.¹¹ Otherwise, with limited regulation or monitoring of practice, there are few mechanisms to tie effectiveness data to reimbursement policy or practice management.⁷ To achieve reform goals, it will be important to support research to fill gaps in evidence for children and vulnerable groups and to explore how to promote provision of evidence-based psychosocial

treatments, balancing data with patient and provider preferences, and availability of interventions.

Healthcare reform discussions have focused on additional issues. For example, the MHSA provider workforce is diverse, including psychiatrists, psychologists, nurses, social workers, counselors, and for prevention, teachers and community leaders. Increasing workforce capacity may require incentives to bring providers into insurance, workforce entry incentives especially for child providers and in underserved areas, development of communication infrastructure for distant services delivery.

Social stigma, privacy laws and limited information systems may challenge efforts to improve access and coordinate care for MHSA clients, suggesting important roles for policy, clinical, and community leaders in achieving goals of healthcare reform. Overall, delivery and financial reform is needed, with transparent management, to assure access and bring services together for clients across systems under coordinated care. Healthcare reform may coincide with implementation of new parity laws, offering a unique opportunity to improve financial access under more coordinated and comprehensive care in the private sector. Achieving a comparable scope in the public sector may require public-private partnerships supported by adequate funding and local accountability. Regional and national input by diverse stakeholders is needed to consider these and other options to meet reform goals for persons with MHSA conditions, followed by ongoing evaluation and revision of any substantial reform achieved.

Acknowledgments

The work was supported by NIH grants R01 MH078853-02 (CPIC); and 1P30MH082760-01. The opinions are those of the authors and do not necessarily reflect the views of the sponsoring funders or institutions. Drs. Wells and Patel do not have any financial, relationship, or affiliation conflicts of interest for this commentary.

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