The Challenge of Access to Behavioral HealthCare

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The Major Obstacles to Access

- Enforcing Wellstone Domenici Parity within ACA
- Reductions to DSH under ACA will disproportionately impact Psychiatric Beds
- ACA mandated performance measures often don’t fit for behavioral health
- Behavioral Workforce Shortages

Essential Benefit Plans (EBP) on the Insurance Exchanges

- The plan selected by a state to be its EBP benchmark for ACA may not comply with parity.
- States had until exchanges went live to make it comply with parity - then it became an EHB benchmark plan
- But so far its unclear if CMS will enforce this – especially since the final ACA rule stated that “We do not intend to require or request states to include specific services within EHB categories offered by their ABP.”
- States resisting ACA implementation will not enforce it either
- High deductibles and co-pays will be an obstacle

Alternative Medicaid Benefit (AMB) for Medicaid Expansion Groups

- Wellstone – Domenici Parity does not apply
- Unlessthe individual meets that states definition for "medically frail" and reverts to the standard Medicaid benefit
- Serious Mental Illness and Substance Use Disorders constitute Medically Frail
- But - states get to define which diagnosis is "SMI"
- Many states are not expanding Medicaid

ACA Performance Measures

- Ambulatory Care Sensitive Conditions do not include any Behavioral Health Conditions
- Screening and Follow-up for Depression is a mandated CMS Core Measures for BH organizations ?!?

CURRENT SHORTAGE

- Best data: Study by University of North Carolina commissioned by Health Resources and Services Administration (HRSA)
- Demonstrated shortages for all MH professionals, especially “prescribers”
  - 77% of U.S. Counties have “a severe shortage of prescribers, with over half their need unmet”
  - 96% of US counties have “some unmet need”

Current Supply and Need for Psychiatrists

- Estimated need of 25.9 psychiatrists/100,000 population
  - With current population of 300,000,000, this is 78,000.
- Current supply is ~ 48,000 (~ 16/100,000)
- Current gap = at least 30,000
- Much greater supply vs. need gap for child and adolescent psychiatry (~ 7,500 total)

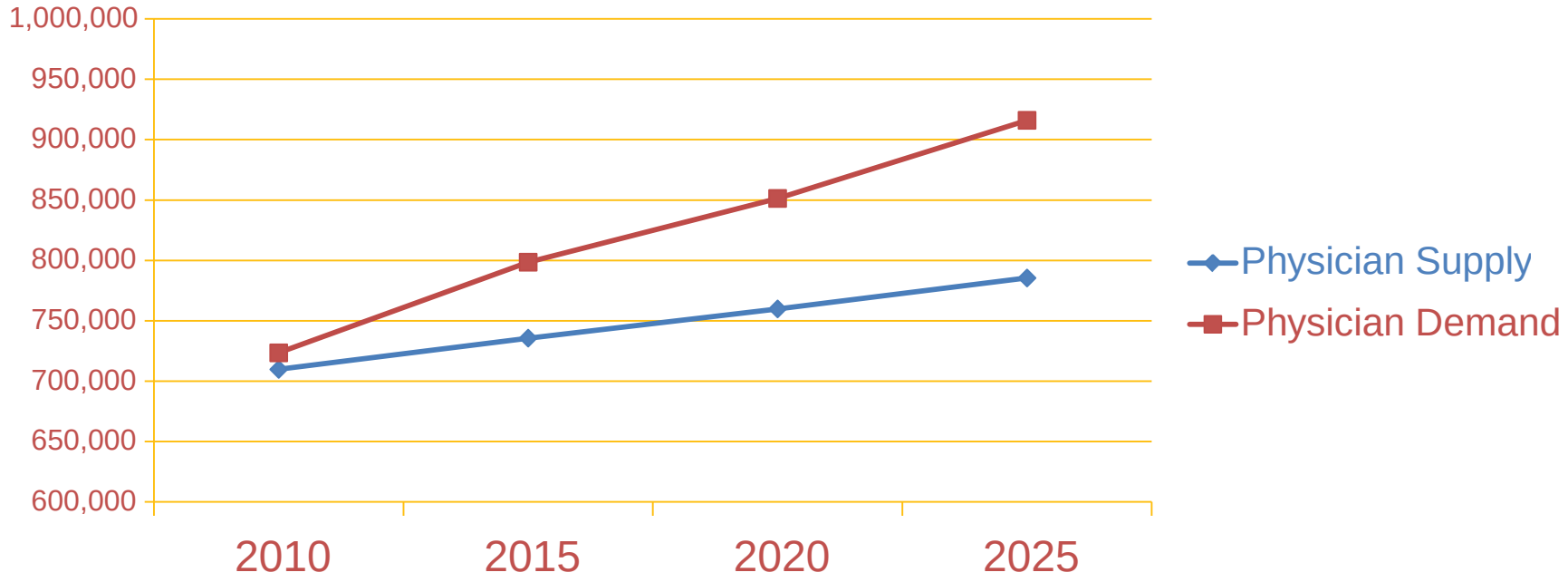
Supply of Psychiatrists has been flat for 20+ years

Current Psychiatrists are Aging Out Fast

Percent of MD's by Specialty over age 55

- Off all sub-specialties (35), Psychiatry is

Projected Supply and Demand of All Physicians 2010 - 2025



Source: AAMC Center for Workforce Studies, June 2010 Analysis

So, what to do…

- There is NO one magic bullet
- More and larger “help wanted” signs won’t work
- Warm bodies with prescription pads won’t work
- Locums Tenens isn’t “the solution”
- Tele-psychiatry isn’t “the solution”

Collaboration Models

- Clearly must change the way we do business
- Primary Care Physicians with Consulting Psychiatrist
- Advanced Practice Nurse Practitioners as LIPs with Collaborating Psychiatrists (practice agreements or prescriptive agreements)
- Psychologists with Supervising Psychiatrists
- Physician Assistants as psychiatrists' extenders

Potential Options and Concerns

1.

Benefits of Co -Location and Integration

- Patients prefer it
- Percent complying with a referral rises from 15-20% to 40-60%
- Builds personal relationships – the foundation of any enduring arrangement
- Allows more accurate understanding of each other's incentives, methods and constraints
- Opportunities for informal consultation
- Single clinical record reduces errors
- Facilitates converting BH clinicians into consultants to PCPs