

Choice and Continuity of Care as Significant Issues for Equality in Mental Health Care

Miriam Ruttenberg, Esq.*

Introduction

Achieving equality for mental health care is much more complicated than parity and essential health benefits.¹ The Affordable Care Act (ACA), while a step in the direction of allowing more access to healthcare for millions of people, is not a complete solution to the problem of health care delivery and quality.² This paper focuses on two concerns of people with lived experience of psychiatric illness, also referred to as mental health consumers.³ The first concern is choice of provider and choice of treatment.

* Miriam Ruttenberg is a Senior Attorney at Mental Health Legal Advisors Committee (MHLAC), a state agency within the Supreme Judicial Court. Ms. Ruttenberg recently participated as a panelist at the *Journal of Health & Biomedical Law's* annual symposium in the Spring of 2014 entitled *Mental Health: The Next Frontier in Healthcare Equality*.

¹ The Affordable Care Act, 42 U.S.C. § 18001 (2010). SAMSA BETA, Mental Health Parity and Addiction Equity, <http://beta.samhsa.gov/health-reform/parity> (last visited May 14, 2014). There are a number of exclusions from parity coverage, such as small employers, etc. *Id.*

² “Among the uninsured, an estimated 13.4 million people with behavioral health conditions will be newly eligible for coverage under either Medicaid or state insurance exchange plans.” *The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States*, National Association of State Mental Health Program Directors, January 2013; *Mental Health and the Uninsured*, NATIONAL ALLIANCE ON MENTAL ILLNESS (March 2013) available at http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Issue_Spotlights/Health_Care_Reform/ACA-FactSheet9-MedicaidandMH.pdf. The White House says 7 million have enrolled through private exchanges as of April 1, 2014. Mark Landler, *Enrollment Exceeds Obama's Target for Healthcare Act*, THE NEW YORK TIMES, April 17, 2014. One author estimates that 62 million will benefit from expansions of coverage/parity (which is different than numbers of those who are newly eligible). See Jasmine E. Harris, Symposium: Gender Matters: Women, Social Policy, and the 2012 Election, “Cultural Collisions and the Limits of the Affordable Care Act,” 22 AM. U. J. GENDER SOC. POL'Y & L. 387, 396 (2014).

³ Some people use the term “people with lived experience”, some use “peer”, some use “survivor”, and some use “consumer.” This article uses the term people with lived experience as well as consumer because in the context of the health care reform subjects examined in this paper, persons with lived experience are situated as consumers of health care.

The second concern is continuity of care, which includes the ability for people with mental health issues to continue to see their providers even if the providers become out-of-network during their course of treatment.⁴ The underlying themes of each of these concerns are the right to dignity, autonomy, and quality care. The author's organization, Mental Health Legal Advisors Committee (MHLAC), approaches representation and advocacy for clients from the perspective of allowing for their greatest possible autonomy.⁵

The clients of Mental Health Legal Advisors Committee are, for the most part, indigent and receiving Supplemental Security Income or Social Security Disability Insurance as their sole or primary income. Additionally, they typically receive health benefits through MassHealth/Medicaid, Medicare or both.⁶ Some clients have private insurance. Their psychiatric diagnoses range from anxiety and depression to schizophrenia and dissociative identity disorder. In order to become a client of MHLAC, an individual's legal issues must be connected with his or her psychiatric issues and may span a range of civil legal issues such as rights when involuntarily hospitalized, private disability insurance disputes with former employers, access to appropriate state services, and custody and parenting time with their minor children.⁷

I. Choice of Provider and Choice of Treatment Modality

Choice is vital to recovery for persons with behavioral health issues. As new forms of health care delivery and payment are implemented, it is imperative that

⁴ See Heather Howard, *State Efforts to Promote Continuity of Coverage and Care Under the Affordable Care Act*, 38 J. OF HEALTH POLITICS, POLICY, AND L. 1176 (2013). Massachusetts, along with other states, has worked hard to ensure that continuity of all care is maintained with the implementation of the ACA. *Id.* at 1177.

⁵ See *About Us*, MENTAL HEALTH LEGAL ADVISORS COMMITTEE, <http://www.mhlac.org/AboutUs.htm> (last visited May 12, 2014).

⁶ The ACA has prompted many changes in MassHealth. *Massachusetts Healthcare Programs*, <http://www.massresources.org/health-care-2014.html> (last visited May 19, 2014). For example, the ACA greatly expands who may be covered by MassHealth based on income, occupation, college status, preexisting conditions, and citizenship. *Id.*; *Information for MassHealth Members and Applicants About the Affordable Care Act (ACA) and MassHealth*, MASS. EXEC. OFFICE HEALTH & HUMAN SERV., <http://www.mass.gov/cohhs/provider/insurance/masshealth/aca/information-for-masshealth-members-applicants-and-aca.html> (last visited May 19, 2014).

⁷ Over the years of representing and counseling clients in family law, guardianship, and other matters, it has become clear to this author that regardless of the particular legal concern about which the client contacts MHLAC, having adequate health insurance coverage and genuine access to appropriate providers is critical to the overall wellness that undoubtedly affects the legal matter.

consumer choice be protected in order to optimize the opportunities for recovery. The importance of patient choice is well recognized by an emerging field of social scientists, epidemiologists, and clinicians.⁸

The concept of choice in health care, and specifically mental health care, can be conceived as both an outcome measure and as part of the patient experience.⁹ As advocates for persons with mental illness, we are concerned with patient experience of health care. A recent study assessed consumers' perception of quality of care and found that often consumers' needs are not met in the areas of choice, respect, and autonomy.¹⁰ The authors noted "choice has been defined as the situation in which providers can be chosen freely, communication as information about treatment and procedures in a comprehensible manner, and attention as possibility of talking to a professional at short notice."¹¹

Under health care reform, we are moving toward a model of Accountable Care Organizations (hereinafter "ACOs"), which are limited networks of providers—the limited networks are what make coverage affordable for insurers.¹² However, limited networks often mean longer wait times to see providers, leaving the consumer to choose between a long wait without treatment or out-of-network care with a higher co-pay.¹³ For those who do not have chronic health conditions and only require routine check-

⁸ See, e.g., ADRIAN EDWARDS & GLYN ELWYN, *SHARED DECISION MAKING IN HEALTH CARE: ACHIEVING EVIDENCE BASED PATIENT CHOICE* (2nd ed. 2009). See also Francesc Borrell-Carrio, Anthony Suchman, Ronald Epstein, *The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry*, 2 ANNALS FAMILY MED. 576 (2004), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466742/pdf/0020576.pdf>.

⁹ See Cathal Doyle, et. al., *A systematic review of evidence on the links between patient experience and clinical safety and effectiveness*, BMJ OPEN (Jan. 3, 2013), available at <http://bmjopen.bmj.com/content/3/1/e001570.full>. "Patient experience includes "the ability of clinicians to empathise, respect the preferences of patients, include them in decision-making and provide information to enable self-care. It also refers to patients' expectations that professionals will put their interest above other considerations and be honest and transparent when something goes wrong." *Id.* See also Angelo Barbato, et al., *Quality Assessment of Mental Health Care by People with Severe Mental Disorders: A Participatory Research Project*, COMMUNITY MENTAL HEALTH JOURNAL (2014).

¹⁰ Barbato, *supra* note 9.

¹¹ *Id.* at 407.

¹² *What is an Accountable Care Organization (ACO)?*, ACCOUNTABLE CARE FACTS, <http://www.accountablecarefacts.org/topten/what-is-an-accountable-care-organization-aco-1> (last visited Apr. 30, 2014).

¹³ See Chad Turhune, *Insurers Limiting Doctors, Hospitals in Health Insurance Market*, LOS ANGELES TIMES (Sept. 14, 2013), <http://articles.latimes.com/2013/sep/14/business/la-fi-insure-doctor-networks-20130915> (reporting insurers hold down costs by limiting options to care).

ups and related care,¹⁴ a limited network of health providers working with their primary care physician may be sufficient.¹⁵ For individuals with significant mental health conditions, who may seek a range of treatments including medications, talk therapy, and other community wellness and wrap around supports, limited care networks fall short.¹⁶ Many mental healthcare providers do not accept insurance, which means that having insurance coverage does not necessarily increase access for those who cannot afford to pay out-of-pocket for therapy.¹⁷

Having a true choice of clinician or provider is vital for consumers of mental health services. Specifically, this means choice of a provider who is physically accessible as well as covered by insurance. Consumers of mental health services must be able to go outside their ACO in the event they wish to see a provider not covered by their ACO. Consumers also should be able to change ACOs altogether, without undue delay, in order to feel comfortable with their network of providers and overall care. Additionally, peer services and supports should be a covered benefit in the ACOs.¹⁸ Peers should be

¹⁴ It bears noting that no one knows whether or when he may develop a chronic condition that would require more complex medical care.

¹⁵ See Jay Hancock, "Narrow Networks" Trigger Push-Back from State Officials, KAISER HEALTH NEWS (Nov. 25, 2013), <http://www.kaiserhealthnews.org/stories/2013/november/25/states-balk-at-narrow-networks.aspx> (reporting state government concerns over patients' access to providers, particularly very ill patients).

¹⁶ See Richard Martini et al., *ACOs & CAPS: Preparing for the Impact of Healthcare Reform On Child and Adolescent Psychiatry Practice*, AM. ACAD. CHILD & ADOLESCENT PSYCH., 7 (Mar. 2013), available at https://www.aacap.org/App_Themes/AACAP/docs/Advocacy/policy_resources/preparing_for_healthcare_reform_201303.pdf (discussing impact of ACOs on provision of mental health services).

¹⁷ See Sarah Varney, *Health Law Brings Changes in How Therapists Do Business*, KAISER HEALTH NEWS (Oct. 24, 2013), <http://www.kaiserhealthnews.org/Stories/2013/October/24/Health-Law-Changes-Therapy-Business.aspx> (reporting on post Affordable Care Act changes to mental health professionals business model).

¹⁸ See Paul Giofreddo, *Peer Support Programs Provide a Golden Opportunity for Funders to Affect Delivery of Behavioral Health Services*, HEALTH AFFAIRS (Oct. 30, 2013), <http://healthaffairs.org/blog/2013/10/30/peer-support-programs-offer-a-golden-opportunity-for-funders-to-affect-delivery-of-behavioral-health-services/?cat=grantwatch> (describing studies' effectiveness findings regarding peer support). Utilizing past consumers of mental health services as peer support produces no worse results than traditional mental health services. *Id.* While peer support cannot replace the care provided by trained clinically licensed mental health care providers, peer supports can be an effective aspect of an integrated care team, partly because of the increased face to face time at a lower cost. *Id.* See also Christine Vestal, *'Peers' Seen Easing Mental Health Worker Shortage*, KAISER HEALTH NEWS (Sept. 11, 2013), <http://www.kaiserhealthnews.org/stories/2013/september/11/peer-mental-health-workers.aspx> (describing role of non-clinically trained peers assisting in mental health treatment of others); *Mental Health Systems*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Mental->

paid a fair wage and be part of the care team.¹⁹ Peers also should be available to help consumers with decision-making in their treatment plans, if desired.²⁰

The key to quality and effective health care delivery is the relationship between the provider and the consumer receiving services. Research demonstrates that therapeutic alliance is a strong predictor of positive outcomes.²¹ Consumers' positive experience of providers' services is closely linked to participating in recommended treatment and to positive outcomes.²²

A 2013 Health Policy Brief examined the issue of patient engagement and concluded that "people actively involved in their health and health care tend to have better outcomes—and, some evidence suggests, lower costs."²³ This concept of "shared decision making" is when patients and providers collaborate and "consider the patient's condition, treatment options, the medical evidence behind the treatment options, the benefits and risks of treatment, and patients' preferences, and then arrive at and execute a treatment plan."²⁴ Patient-clinician agreement over treatment goals has been found to be significantly associated with patient treatment adherence.²⁵

Choice of treatment modality also improves health care delivery and outcomes.

Health-Services-.html (last visited May 19, 2014) (noting peer support as a covered category of Medicaid reimbursement).

¹⁹ See TRANSCOM SUBCOMMITTEE, PEERS AS VALUED WORKERS: A MASSACHUSETTS ROADMAP FOR SUCCESSFULLY INTEGRATING CERTIFIED PEER SPECIALISTS AND PEER SUPPORT WORKERS IN THE PUBLIC MENTAL HEALTH SYSTEM 5, 9-10 (2012), available at http://transformation-center-beta.org/wp-content/uploads/2012/02/Roadmap_long-version_final-2.20.pdf (advocating reimbursement of certified peer health specialists commensurate with similar team members).

²⁰ *Id.* at 4.

²¹ See Laura Thompson and Rose McCabe, *The Effect of Clinician-Patient Alliance and Communication on Treatment Adherence in Mental Health Care: a Systematic Review*, 87 BMC PSYCHIATRY at *2, (July 24, 2012), available at <http://www.biomedcentral.com/content/pdf/1471-244X-12-87.pdf> (discussing and analyzing studies on therapeutic approaches in treating mental health patients).

²² Doyle, *supra* note 9.

²³ Julia James, *Health Policy Brief: Patient Engagement*, HEALTH AFFAIRS 1, 1 (February 14, 2013), available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_86.pdf.

²⁴ *Id.* at 2.

²⁵ Thompson, *supra* note 21, at 6. The authors further note that "literature implies providers should engage patients collaboratively in the consultation in order to establish agreement surrounding the tasks of treatment, an important aspect of alliance." *Id.* at 11. The authors concluded that, "whilst time constraints on psychiatric encounters pose a challenge to clinicians in developing bonds with patients, more effective collaboration on practical aspects of treatment may be one way of compensating for this." *Id.*

Some of the important components of this choice include empowerment, engagement with services, and remaining in treatment, or treatment compliance.²⁶ As with choice of provider, choice of treatment is linked with an increased prospect of remaining in treatment and recovery.²⁷ Individuals who received their preferred treatment were half as likely to drop out of treatment and had a higher probability of showing improvement towards recovery than were those who did not receive their preferred treatment.²⁸

People with lived experience have a range of choices for both provider and treatment modality. Within the traditional medical model treatment options include the psychiatrist, therapist, social worker, medication and wellness programs, such as smoking cessation and weight loss.²⁹ Importantly, within the recovery model are also choices such as peer supports,³⁰ alternative and complementary approaches such as Emotional CPR,³¹ and recovery learning communities.³² A recent study examined persons with schizophrenia and their participation in decisions regarding anti-psychotic drugs.³³ The results of the study showed that forty-two percent of the study participants

²⁶ Robert Chaplin, *How Can Clinicians Help Patients to Take Their Psychotropic Medication?* 13 J. CONTINUING PROF'L DEV. 347 (2007), available at <http://apt.rcpsych.org/content/13/5/347.full.pdf+html>.

²⁷ J. Swift and J. Callahan, *The Impact of Client Treatment Preferences on Outcome: A Meta-Analysis*, 65 J. CLINICAL PSYCH. 368, 377 (2009).

²⁸ *Id.*

²⁹ M. Swarbrick, *Wellness-Oriented Peer Approaches: A Key Ingredient for Integrated Care*, 64 PSYCHIATRIC SERVICES 723, 723 (2013).

³⁰ See *Peer Support Resources*, NATIONAL ALLIANCE ON MENTAL ILLNESS, <http://www.namimass.org/programs/peer-support-resources> (last visited May 3, 2014); *Peer Facilitator Meetings*, THE TRANSFORMATION CENTER, <http://transformation-center.org/home/training/peer-facilitators-project/> (last visited May 3, 2014).

³¹ See EMOTIONAL CPR, <http://www.emotional-cpr.org/> (last visited May 3, 2014).

³² See WESTERN MASS RECOVERY LEARNING COMMUNITY, <http://www.westernmassrlc.org/> (last visited May 3, 2014); SOUTHEAST RECOVERING LEARNING COMMUNITY, <http://www.southeastrlc.org/> (last visited May 3, 2014); CENTRAL MASSACHUSETTS RECOVERY LEARNING COMMUNITY, <http://www.centralmassrlc.org/> (last visited May 3, 2014); METRO BOSTON RECOVERY LEARNING COMMUNITY, <http://www.metrobostonrlc.org/> (last visited May 3, 2014).

³³ Johannes Hamann et al., *Patient Participation in Antipsychotic Drug Choice Decisions*, 178 PSYCHIATRY RES. 63, 63-67 (2010). Noting the scarcity of studies on participation preferences of persons with schizophrenia and the meeting of such preferences by psychiatrists, the study aimed to:

- a) assess patient responses to three descriptions of physician–patient decision-making styles and to identify factors that determine increased participation preferences; b) assess how physicians believe drug decisions were shared/not shared with patients and which factors determined a more participatory

wanted to participate in medical treatment decisions, and forty-six percent wanted more detailed information from their doctor.³⁴

Shared decision making for consumers with lived experience should be given the same consideration as for those patients with physical illnesses or conditions.³⁵ Studies often question the degree to which a person with severe psychiatric illness might be able to participate in shared decision making.³⁶ It is crucial that providers approach the concept of shared decision-making openly.³⁷ In particular, shared decision making should be approached with an understanding that while someone in psychiatric crisis may have difficulty in the moment with specific treatment decisions, in general, persons with lived experience should be accorded the same level of patient engagement and shared decision making as other patients.³⁸ From a purely civil rights perspective, it is

behavior; and c) assess the matching of the desire of patients for participation to their actual involvement in drug decisions.

Id. at 63. To carry out the study, patients with schizophrenia between 18 and 80 years of age who were hospitalized and experienced at least one relapse were surveyed. *Id.* at 63-64.

³⁴ *Id.* at 64. Present decision-making patterns shed light on these wants: in only 52% of the cases was the choice of drug a shared decision between physician and schizophrenic patient. *Id.* The study authors recommend that “psychiatrists should be aware of the potential negative consequences of not involving patients (e.g., non-compliance) and also of the potential prospects of revising decisions together with a patient after he/she has recovered from acute illness and regained decisional capacity.” The study authors concluded that an “as much participation as soon as possible” approach is worthwhile. *Id.* at 67.

³⁵ See generally L. Perestelo-Perez et al., *Patient Involvement and Shared Decision-Making in Mental Health Care*, 6 CURR. CLIN'L PHARMA. 83 (2011) (noting prevalence of shared decision-making in physical health settings and encouraging the same in mental health context).

³⁶ Hamann, *supra* note 33, at 67. The authors admit that it is not always easy for physicians to negotiate treatment with persons with schizophrenia who prefer treatment options such as hypnotherapy or herbal remedies, or that lack decisional capacity, and that such barriers stand in the way of patient participation in psychiatry. *Id.*

³⁷ *Id.* Although the authors acknowledge the barriers to patient participation, they argue that “simply ignoring the desire of those patients for participation might even worsen their satisfaction with care and attitudes toward treatment.” *Id.*

³⁸ See James, *supra* note 23; Hamann, *supra* note 33, at 67. Patients in any context and suffering from any condition, physical or mental, may have difficulty choosing among various making treatment options on the spot. *Id.* See also James, *supra* note 23, at 2. For instance, while one patient with knee pain may choose to have knee replacement surgery, another worried about the risks and the success of surgery may choose to manage the pain with medication and weight loss. *Id.* Such an example illustrates that “there are multiple, reasonable treatment options, each with their own risks and benefits, and the ‘correct’ path forward should be guided by a patient’s unique needs and circumstances.” *Id.* See also Hamann, *supra* note 33, at 67. Proponents of extending this individualized, shared decision making approach to the mental health care context argue that “[i]mplementing . . . provider–patient communication might help to engage these

important to remember that people who do not have psychiatric challenges and make poor health decisions (e.g. smoking after cancer, neglecting to take their heart or diabetes medications) are not deprived of their civil liberties because of their decisions regarding how they manage their health.³⁹

In terms of legal advocacy for persons with lived experience and respect for their choices about their own treatment, the following are two examples of how advocates at MHLAC have assisted their clients.

A. Choice of Treatment Modality

MHLAC represented a young father with diagnosis of bipolar disorder who chose not to take traditional medication. In his case, Lithium was the drug of choice for his treating doctors, and it was also a drug the client strongly objected to. He had concerns about the way the drug made him feel, as well as long-term negative effects, such as thyroid disruption. He felt strongly that he could manage his psychiatric symptoms with alternative treatments. The legal case was custody and parenting time with his daughter. In particular, the child's mother objected to unsupervised visits by the father, unless he was on Lithium to manage his bipolar disorder. MHLAC litigated the case in probate court and the judge agreed that the father could have unsupervised time with his daughter, even if he was not taking traditionally recommended medication, so long as the father agreed to alternative mechanisms for confirming his mental health stability prior to unsupervised contact. The father has continued to see his daughter without supervision and without medication, and has managed his symptoms by continuing with his chosen alternative modalities.

patients in the clinical decision process and improve their satisfaction with their care . . . [and] [a]n increased involvement might also help in addressing the needs of these patients and in including them in compliance improving measures." *Id.*

³⁹ See Thea Amidov, *Uncivil Commitment: Mental Illness May Deprive You of Civil Rights*, PSYCHCENTRAL.COM, <http://psychcentral.com/blog/archives/2013/03/04/uncivil-commitment-mental-illness-may-deprive-you-of-civil-rights/> (last visited May 2, 2014). "People with psychiatric disabilities are routinely deprived of their rights in a way no other disability group [or non-disabled persons] has been." *From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves*, NAT'L COUNCIL ON DISABILITY 1, 51 (2000), <http://www.ncd.gov/publications/2000/Jan202000>. This is because the mental health system has been designed and implemented without the participation of psychiatric patients. *Id.* Thus, these patients are both forced to accept services they do not want and are denied access to services they desire. *Id.*

B. Choice of provider and continuity of care

MHLAC also assisted an older woman with hard-to-manage diabetes and psychiatric issues who had a strong alliance with her diabetes care manager. This care manager was very familiar with the client's psychiatric issues and how they intersected with her diabetes issues. Initially the client lived in a Department of Mental Health (hereinafter "DMH") group home, which was located in close proximity to her diabetes care manager. However, DMH later transferred her to another group home farther away, making it extremely difficult to see her diabetes care manager. MHLAC advocates worked with the client and DMH, as well as MassHealth, to ensure that the client could get transportation services from her new location in order to continue with her preferred provider.

II. Continuity of Care

"Continuity of care is rooted in a long-term patient-physician partnership in which the physician knows the patient's history from experience and can integrate new information and decisions from a whole-patient perspective efficiently without extensive investigation or record review."⁴⁰ Historically continuity of care has been valued as a cost-effective approach given that the background knowledge of the patient is preserved. Ensuring continuity of care has often been an issue as a result of HMOs and network shifting because of insurer or provider changes.⁴¹

One study found "consistent, positive relationships between continuity of care and quality of life, community functioning, and service satisfaction among persons with severe mental illness."⁴² In persons with both substance abuse and mental health disorders studies have shown the important benefits of continuity of care for consumers

⁴⁰ *Continuity of Care, Definition of*, Am. Acad. Family Physicians, <http://www.aafp.org/about/policies/all/definition-care.html> (last visited May 2, 2014).

⁴¹ Ashley C. Short et al., *Provider Network Instability: Implications for Choice, Costs and Continuity of Care*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, <http://www.hschange.org/CONTENT/325/> (last visited May 2, 2014) (discussing sources of instability in the system which disrupt continuity of care).

⁴² See generally Carol Adair, et al., *Continuity of Care and Health Outcomes Among Persons With Severe Mental Illness*, 56 *Psychiatric Services* 1061, 1068 (2005), available at <http://ps.psychiatryonline.org/data/Journals/PSS/3651/1061.pdf>. The authors further concluded that "[a]ssociations between continuity and quality of life held up in multivariate models. Although further research is clearly needed before the causal web of associated relationships is fully understood, these findings suggest that efforts at improving continuity in and among mental health services may be fruitful." *Id.* at 1068.

engaged in long-term recovery programs.⁴³ Under the newer model of ACOs, the cost-effectiveness of a patient continuing with his long-time care provider is undermined by the belief that controlling costs within a limited network is preferred over administrative inconveniences that may arise with an out-of-network provider involved in the patient's care team.⁴⁴

Of greatest concern for persons with chronic and severe mental health issues, particularly those connected to trauma histories, is having to change providers after having developed a therapeutic alliance.⁴⁵ While the ACO model would provide continuity of care for a person who is starting fresh with no prior medical care or therapeutic alliances that needed to be preserved, it is imperative that persons with psychiatric histories who wish to continue with their current provider be able to do so as they are shifted into an ACO.⁴⁶ One way continuity of care can be accomplished is through a single case agreement. Single case agreements are contracts between the insurer and the out-of-network provider that allow the consumer to see his or her out-of-network provider, usually at a negotiated in-network rate.⁴⁷ Under these agreements the provider can continue to provide treatment and be reimbursed by the insurer.⁴⁸ Sometimes, however, even if a provider is willing to enter into a single case agreement, the agreement is not possible because either the insurer or the provider group to which

⁴³ See *id.* at 1066 (discussing the need for continuity of care in substance abuse treatment programs). See also André Wierdsma et al., *Reconstructing Continuity of Care in Mental Health Services: A Multilevel Conceptual Framework*, 14 J. Health Serv. Research and Policy 52, 52-57 (2014), available at <http://hsr.sagepub.com/content/14/1/52> (stating that continuity of mental health care is a key issue).

⁴⁴ See Erin Shigekawa and Marianne Udow-Phillips, *Emerging Health Insurance Products in an Era of Health Reform*, CENTER FOR HEALTHCARE RESEARCH & TRANSFORMATION, 1,7 (2013), available at <http://www.chrt.org/assets/price-of-care/CHRT-Issue-Brief-November-2013.pdf> (discussing limited network plans and impact on costs).

⁴⁵ Deborah L. Cabaniss, M.D., *The Therapeutic Alliance: The Essential Ingredient for Psychotherapy*, HUFF POST HEALTHY LIVING (May 31, 2012), http://www.huffingtonpost.com/deborah-l-cabaniss-md/therapeutic-alliance_b_1554007.html.

⁴⁶ See Heather Howard & Chad Shearer, *Report on Health Reform Implementation, State Efforts to Promote Continuity of Care under the Affordable Care Act*, 38 J. HEALTH POLITICS, POLICY & L. 1173, 1174 (2013) "Shifting between different coverage options—Medicaid and subsidized exchange coverage—risks disruptions in coverage and continuity of care." *Id.*

⁴⁷ Maria K. Todd, *THE MANAGED CARE CONTRACTING HANDBOOK: PLANNING & NEGOTIATING THE MANAGED CARE RELATIONSHIP*, 77 (2009). Continuous discount agreements are another option that providers have to provide discounted services on more than one occasion. *Id.* This saves providers and patients from having to renegotiate discount rates each time the patient is seen by the provider, whereas with single case agreements, each time the patient is seen, the patient must renegotiate the discount rate. *Id.*

⁴⁸ See *id.*

the therapist belongs will not participate.⁴⁹ Insurers are often unreceptive to these case agreements and will require the provider to spend a significant amount of non-reimbursable time justifying why their patient needs to continue seeing them rather than an in-network provider.⁵⁰

In Massachusetts, under current law individuals receiving services have little recourse when a provider becomes out-of-network.⁵¹ However, legislation was filed that would have ensured continuity of care for individuals engaged in continuing course of mental health treatment.⁵² The testimony in support of the bill highlighted a number of important issues. The reasons that consumers are losing their in-network providers may be loss of employment and its attendant health coverage, but in the changing landscape of health care reform, providers often become out-of-network due to changes in insurance contracts or networks.⁵³ The Massachusetts Psychological Association noted that:

Treatment for behavioral health disorders is not pleasant and it is not easy to build sufficient trust in a provider to reveal things one is distressed and embarrassed about. These are often necessary components of the treatment process . . . so once accomplished it is counterproductive to expect that the consumer will need to go through the process again in mid-stream with a new provider.⁵⁴

Permitting patients to continue with their particular caregivers is essential, especially for those with significant and persistent mental health challenges.⁵⁵ For

⁴⁹ See e.g. *Single Case Agreements for Behavioral Health Services*, BALANCE POINT, <http://balancepointnc.com/single-case-agreements-for-behavioral-health-services/> (last viewed May 3, 2014).

⁵⁰ See *id.* Insurance companies may require, among other things the provider to submit to an interview with a licensed care manager, provide information about the patient's diagnosis, symptoms, functional impairments, as well as measurable and evidence-based treatment goals. *Id.* Providers also need to explain the rationale for why the patient's treatment needs cannot be met by an in-network provider. *Id.*

⁵¹ See MASS. GEN. L. ch. 176O, §15 (2013).

⁵² H.B. 835, 2013 Leg., 188th Sess. (Mass. 2013) (sent to "study" on April 15, 2014—it is commonly understood that this means there will be no further action on the bill during the legislative session).

⁵³ Written testimony of Elena Eisman, Ed.D, ABPP, Executive Director Massachusetts Psychological Association, October 16, 2013.

⁵⁴ *Id.*

⁵⁵ See *id.* "Research shows that 30% of the efficacy of behavioral health treatment is related to the relationship between the provider and the consumer of services. For this reason, both the

instance, when a clinician becomes out-of-network, clients face the choice of terminating care, beginning again with new provider, or paying higher (often prohibitive) out of pocket costs to see the original provider on out-of-network basis.⁵⁶ In their written testimony to the Massachusetts Joint Commission on Financial Services, MHLAC and Health Care For All, a Massachusetts organization committed to ensuring health care accessibility, stated:

These choices are especially difficult for low and moderate-income persons with trauma histories. Should an individual choose a new provider, they must retell their painful histories and risk decompensation, resulting in even more treatment.⁵⁷

Unsurprisingly, testimony opposed to the bill focused on supposed increased costs.⁵⁸ However, the language of the bill provides that insurers need pay no more than the rates paid to in-network providers.⁵⁹ The opposition also ignored the real costs that come with additional treatment for a person who must start over in telling her story and forming an alliance with her therapist, at the risk of setbacks and more intensive psychiatric care.⁶⁰

III. Medicaid-Medicare (Dual) Eligible: Choice and Continuity Issues

As part of federal health care reform, states must create “dual eligible” programs—Integrated Care Organizations (ICOs)—that serve populations who receive both Medicaid and Medicare coverage.⁶¹ In Massachusetts, this program is called One

Institute of Medicine and the American Psychological Association include these factors in their definitions of treatment that is evidence based.” *Id.*

⁵⁶ See Sarah Rosenthal and Derek D. Petersen, *Insurance Guide for Families Seeking Mental Health Services*, MASS. SCHOOL OF PROF'L PSYCHOLOGY INTERFACE REFERRAL SERV., <http://msppinterface.org/guides/insurance-guide> (last visited April 20, 2014).

⁵⁷ Mental Health Legal Advisors Committee and Health Care for All, written testimony to the Massachusetts Joint Committee on Financial Services, October 16, 2013.

⁵⁸ See Massachusetts Association of Health Plans (MAHP), written testimony to the Massachusetts Joint Committee on Financial Services, October 16, 2013. Only one organization submitted testimony in opposition to the bill. *Id.*

⁵⁹ H.B. 835, 2013 Leg., 188th Sess. (Mass. 2013) (providing that “[t]he carrier shall reimburse the licensed mental health care professional the usual network per-unit reimbursement rate”).

⁶⁰ Hearing before the Joint Committee on Financial Services, 188th Gen. Court (Oct. 16, 2013) (opposing testimony written by Massachusetts Association of Health Plans).

⁶¹ See *About the Medicare-Medicaid Coordination Office*, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html> (last visited May 1, 2014).

Care, and is managed through MassHealth.⁶² The One Care program became operational in October 2013.⁶³ While for many consumers this model is a great improvement over their formerly fragmented care and coverage, for others, particularly persons with psychiatric issues, the new ICOs may be problematic in terms of choice of provider and continuity of care.⁶⁴ This is especially true for people who have existing relationships with their therapists or other behavioral health providers. Medicaid requires a 90-day period of transition for continuity of care, however some states (not including Massachusetts) are opting to provide greater periods of continuity of care in recognition of the importance for the consumer.⁶⁵

In examining this issue, the National Senior Citizens Law Center reviewed the Memorandums of Understanding between the Medicare-Medicaid Coordination Office and five states—Massachusetts, Ohio, Illinois, California and Virginia. Of those, Massachusetts has the shortest transition period—90 days for all services.⁶⁶ This is a relatively short period of time for adequate transition of many services and providers—particularly in the behavioral health context. The NSCLC recommends a 12 month period for all services, and in addition, requiring single case agreements beyond that period when appropriate.⁶⁷

IV. Conclusion

To ensure successful evolution of health care delivery, the concerns of

⁶² See *One Care: MassHealth plus Medicare*, MASS. EXEC. OFFICE HEALTH & HUMAN SERV., <http://www.mass.gov/eohhs/consumer/insurance/one-care/> (last visited May 2, 2014).

⁶³ *Id.* The official website of the Executive Office of Health and Human Services (EOHHS) states, “[s]tarting in October 2013, MassHealth and Medicare will join together with health plans in Massachusetts to offer One Care . . . a new and easier option for people with disabilities to get the full set of services provided by both MassHealth and Medicare.” *Id.*

⁶⁴ See, e.g., Christine Vestal, *States Meld Medicare and Medicaid*, USA TODAY (Feb. 21, 2014, 11:41AM), <http://www.usatoday.com/story/news/nation/2014/02/12/stateline-medicare-medicaid-healthcare/5419453/> (quoting Boston resident Dennis Heaphy). Heaphy has benefited from the implementation of Massachusetts’ One Care program. *Id.* For example, Heaphy quickly and easily received a larger, more accessible bed, which makes it easier for him to receive care. *Id.* Before One Care, neither Medicare nor Medicaid would have allowed for the purchase of the bed. *Id.*

⁶⁵ See generally *Continuity of Care in the Dual Eligible Demonstrations*, NATIONAL SENIOR CITIZENS LAW CENTER 4, 6 (May 2013), available at <http://www.nsclc.org/wp-content/uploads/2013/05/Care-Continuity-Final-052913.pdf> (analyzing five states’ financial alignment models for care continuity).

⁶⁶ *Id.* at 6.

⁶⁷ *Id.*

consumers with lived experience must be considered in policy development and application of new federal requirements under the Affordable Care Act. Specifically, respecting and effectuating choice of treatment modality, choice of provider and continuity of care are critical to dignity and recovery. People with lived experience of psychiatric issues are among the most vulnerable in the health care system. The ACA and its mandates are meant to encourage integrated care so that people with behavioral health issues are not left behind, but if the systems are designed without considered attention to consumer choice and continuity of care the question of whether people with psychiatric care needs will fully benefit under health care reform will remain.