Health Reform and Politics 101 for Psychiatric Nurse Therapists

The health care bills recently passed by both houses of the U.S. Congress signal the first significant overhaul of health care by the federal government since the advent of Medicare in the 1960s. The Patient Protection and Affordable Care Act was passed by the House of Representatives in fall 2009, and the Senate version was passed on Christmas Eve 2009, a time when so many around the world are looking for some measure of peace and comfort. What can be more appropriate to this outlook than an expectation that affordable health care will be available to all when needed and that health care would include essential mental health assessment and treatment?

In whatever form the health care bill assumes when it survives the process of full congressional approval, it will pose significant challenges for psychiatric-mental health providers. I am one of those providers, a clinical nurse specialist psychotherapist whose practice is based in a nurse-managed primary health care clinic. This clinic provides an integrated model of primary health care, especially to those who are poor and uninsured, and a large segment of this patient population initially arrives with undiagnosed or untreated mental illness and behavioral disorders.

Integrated health care requires a partnership between primary health care providers and psychiatric-mental health providers and the integration of basic mental health screenings and assessments as part of intake procedures. This is of prime importance because when mental health care is isolated, chronic medical conditions, as well as serious mental health needs and treatable mental illness, go undetected longer. This results in higher medical costs, greater chronicity of diseases, as well as poorer prognoses and response to treatment. As the policy director of the Bazelon Center for Mental Health Law said in a 2004 report, “The wall between physical and mental health care perpetuates a public health crisis” (Burley, 2004, para. 3). However, for this model to be widely adopted, mental health treatment must be billable at an equal rate to physical health care services. And qualified advanced practice nurses (APNs) must be recognized by all state insurance/health home panels as reimbursable primary mental health care providers who provide patient care, lead teams, and direct the “health home” described in the Senate’s health care bill.

The policy and practice issues associated with providing integrated physical and mental health services in primary health care settings reflect the issues of insurance coverage, reimbursement for provider services, and prescription costs that fueled the health care reform movement. They call for recognition by this country at long last that health care is a basic right, not a privilege for those who can afford it. This is especially true for the treatment of catastrophic illnesses that leave affected families in the United States shell shocked and bankrupt, regardless of “good health habits.” The United Nations’ Universal Declaration of Human Rights, signed by the United States in 1948, includes the right to medical care “adequate to the preservation of their own and their family’s well-being” (Article 25). This declaration has been used in more than 150 cases in U.S. courts.
as of 2003 and has become part of the common law of the United States, as well as of the world (Right to Health Care, n.d.). As I consider these issues and how Congress will mold these bills into one health care bill that supports this human right, my chief concerns remain:

- The most common reason uninsured patients provide for not taking their medicines as prescribed is that they cannot afford to pay for their medicine. Although prescription assistance programs exist, there is no guarantee that any of them provide patients with an ongoing supply of prescribed medications. Prescription drug coverage should be fully integrated into any health plan, but the health care bills do not close the Medicare “doughnut holes” (created when older adults must pay full price for their medicines until their yearly co-pay is reached, and the co-pay can reach thousands of dollars), and they both depend on drug companies voluntarily lowering their prices to lower costs. I do not see much improvement from the status quo here.

- Psychiatric-mental health APNs are sorely needed in community-based health care settings, but there are not enough of us. In many states, independent practice by an APN as a psychotherapist in primary care is not recognized by the state’s Medicare system.

I was reminded of this last year when I received an e-mail from my state’s chief of the Bureau of Comprehensive Health Services, after I had inquired about fee for services. The message indicated that no psychotherapy can be provided other than by a physician. If the reimbursement system does not recognize psychiatric APNs as providers of psychotherapy, then psychiatric APNs cannot afford to open private practices, clinics cannot afford to contract with them for services, and the shortage of mental health care providers continues unchecked.

- The two bills are each more than 1,600 pages long. They both contain language that recognizes APNs as primary care providers and as important members of a health care team. However, the language is general enough that it can be ignored by insurance panels everywhere, including the statewide insurance/health home panels that make the decisions about what is billable and who or what health care profession will be reimbursed for direct patient services, where, and when. Both bills contain provisions that strengthen the powers of these panels to determine reimbursements for psychiatric services by APNs. If left unchecked, their raison d’être can be to keep certain providers out and to keep the state’s portion of federal health care monies in.

- Both bills appropriate grants to fund nurse-managed clinics, but many of these clinics close after the 3- or 5-year grant funding period is over because they cannot obtain sufficient third-party reimbursement to cover operating expenses. As a provider at one of these clinics funded by a Health Resources and Services Administration grant, I would much rather the government keep its grant funding and instead link the state appropriations from the bill to a requirement that all remaining barriers to practice for qualified APNs be removed. For many of us, these barriers include required (paid) written consultation contracts with physicians, reimbursement for physician-only services or physician-supervised services only, and a requirement that only physicians can lead a health or medical home. To accomplish this, the state legislatures would have to move quickly to change the scope of practice language in some states.

It seems that lately every nursing journal contains reports of nursing leadership finally being “at the table,” as they testify at a congressional meeting or attend a sponsored dinner or speak at a health care summit. But it is much too soon to be complacent or to congratulate our profession for being recognized for the work we do. Instead, the health care bill when passed will be just the beginning of a long process by all of us of demanding accountability and transparency by our duly elected federal and state representatives as they fine-tune this legislation. We still have quite a way to go before we arrive at this journey’s end—when psychiatric APNs are not just recognized as primary mental health providers but equitably reimbursed as such.

REFERENCES


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