EXPANDING ACCESS TO BEHAVIORAL HEALTH CARE FOR PEOPLE LIVING WITH HIV/AIDS

NATIONAL CENTER FOR
INNOVATION IN HIV CARE

This brief describes recent changes that may increase behavioral health access.

BACKGROUND

People living with HIV (PLWH) face chronic and pervasive stigma and discrimination. This results in stress that contributes to disproportionate prevalence of behavioral health problems, including depression, anxiety, psychological trauma, and substance use.[1-3] PLWH who suffer from behavioral health problems often face the dual stigma of HIV and having co-occurring psychiatric diagnoses. PLWH have unique needs for integration of culturally-tailored behavioral health services into primary care, which can, in turn, improve engagement in HIV care, and lead to an increase in antiretroviral medication adherence.[4,5]

PLWH encounter numerous barriers to behavioral health treatment. Medical mistrust, discrimination within the health care system, poor integration of behavioral health and primary care services, as well as inadequate insurance or lack of insurance coverage for behavioral health treatment have historically contributed to behavioral health care disparities among PLWH.[1-5]

The purpose of this brief is to describe recent changes in federal health policy that may increase behavioral health treatment access for PLWH. This brief will assist the staff of AIDS service organizations, community-based organizations, and HIV-focused health service organizations to optimize behavioral health treatment access for the vulnerable populations served.

STIGMA-RELATED STRESS CAN WORSEN BEHAVIORAL HEALTH AND PHYSICAL HEALTH

PLWH face pervasive and chronic stigma-related stressors pertaining to their HIV status as well as other stigmatized aspects of their identity, such as race, sexual orientation, or gender identity. For example, gay and bisexual men and transgender women, particularly among people of color, are the U.S. populations with the highest incidence and prevalence of HIV.[6-9]

As described by Ilan H. Meyer and Mark L. Hatzenbuehler,[10-12] external stigma-related stressors, such as discrimination, marginalization, and violence, can lead to disruptions in general psychological processes, such as difficulty using coping mechanisms, emotional regulation, social or interpersonal dynamics, and cognitive functioning. External stigma-related discrimination can also result in internal stigma-related stressors, such as expectations of rejection, distress related to identity concealment, and internalized homophobia or transphobia.

These disruptions in general psychological processes and internal stigma-related stressors, in turn, can result in increased behavioral health problems, including poor coping mechanisms, decrease in self-care, and increase in substance use. Eventually, poor self-care may be associated with poor HIV-related health outcomes, in part due to decreased engagement in HIV treatment and preventative services. For example, posttraumatic stress disorder is associated with lower odds of antiretroviral medication adherence among PLWH.[13]

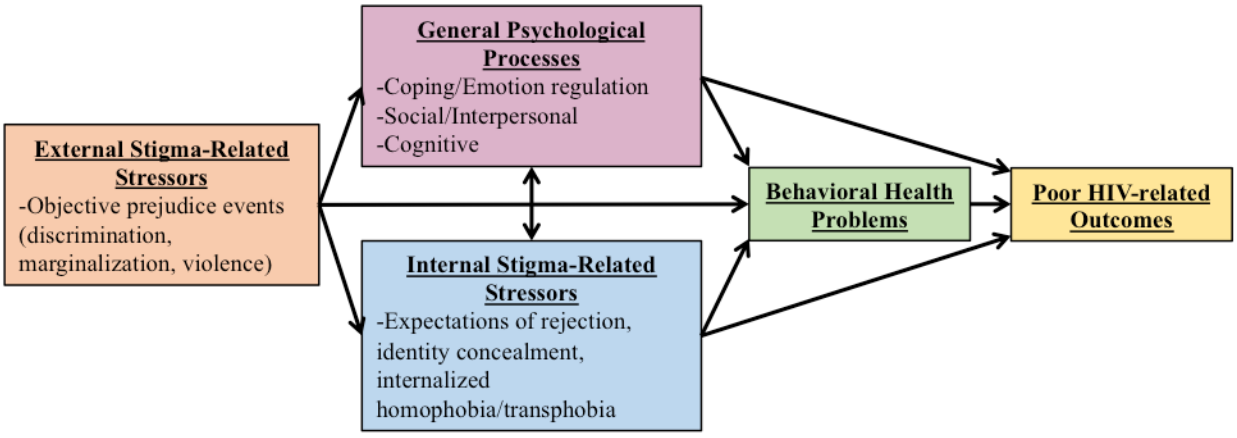

Figure adapted from: Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological bulletin, 135*(5), 707.

EXPANDING ACCESS TO BEHAVIORAL HEALTH TREATMENT

Recent changes in health policy were designed to extend access to coverage and care through expansion of Medicaid to those earning up to 138% of the federal poverty level (FPL).[14] Thirty-one states and the District of Columbia have embraced this expansion,[15] with some states expanding Medicaid coverage to some categories of individuals (pregnant women, infants, people living with HIV, women with cervical and breast cancer) with incomes higher than 138% of the FPL.[16,17] This socioeconomic bracket disproportionately includes PLWH and those with psychiatric disorders, who are more likely to have low incomes or be unemployed.[18] Thus, Medicaid expansion is especially relevant to PLWH suffering from behavioral health problems.

Medicaid also offers a broader range of services for people with chronic disabilities than that which is available with most private insurance policies, including additional case management, psychosocial rehabilitative services, and crisis intervention options.[19] Indeed, Medicaid is the largest payor of behavioral health treatment and rehabilitation programs in the United States, covering 30% of behavioral health costs nationwide.

Recent changes in health care coverage also required that behavioral health care services are fully covered, with no copays, as one of the ten Essential Health Benefits.[20]

In addition, currently all qualified health plans (QHPs) sold on an exchange and all plans sold in the individual market must comply with the Mental Health Parity and Addiction Equity Act of 2008; thus, behavioral health care treatments must be covered at parity with medical and surgical benefits.[21]

Behavioral health services are fully covered as an Essential Health Benefit.

Coverage now includes provisions to support development of patient-centered medical homes (PCMHs), in which care teams oversee coordination and continuation of care to meet a broad array of patient's long-term needs; linking preventative, acute, and chronic care; and integrating basic medical and behavioral health services.[18] PCMHs aim to improve delivery of services and outcomes related to chronic diseases, including HIV.

Behavioral health integration is particularly critical in the context of shortages in availability of freestanding behavioral health care services for PLWH. Integration of behavioral health and primary care is driven by the triple aim of health care reform, to improve the experience of care, improve the health of populations, and reduce per capita costs of health care.[22]

The PCMH model requires that health care providers caring for Medicaid beneficiaries utilize population health management approaches to ensure that care is quality-driven, cost-effective, culturally appropriate, person-centered, and evidence-based. Population health management promotes development of capacity to utilize data to identify patients in need of specific evidence-based treatments, and to tailor care to those most in need of particular services at a given point in time.[23] Population health management metrics are often written into performance-based contracts. For example, these metrics could include the percentage of the patient population with HIV and major depressive disorder that has been prescribed an antidepressant medication and has had their HIV viral load checked in the last year. Behavioral health case managers, substance use counselors, peer specialists, community health workers, and health navigators are increasingly being trained for integral roles in population health management models for patients with co-occurring conditions who are high utilizers of care, such as PLWH who have co-occurring psychiatric diagnoses.

Tailored evidence-based behavioral interventions in combination with biomedical HIV treatments, often referred to as "bio-behavioral" HIV care, are associated with improved health outcomes for PLWH.[24,25] These interventions, supported by recent health policy changes focused on behavioral health integration, can result in improved linkage to and retention in HIV-focused primary care, including greater antiretroviral medication adherence.

Moreover, the recently established Medicaid "health home" option advances integration of physical and behavioral health care for Medicaid beneficiaries with the highest need and highest cost due to severe mental illness.[18] Based on this, health homes are eligible for a 90% federal match incentive during the first two years of their operation.

Some recent federal policy provisions may also serve to decrease discrimination in health care against PLWH who are members of stigmatized subpopulations. A 2012 federal regulation prohibits sexual orientation and gender identity discrimination by QHPs traded on state health insurance marketplaces. This regulation also bans "marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs," which could potentially

help protect PLWH.[26] In addition, a federal regulation implementing Section 1557 may similarly help reduce discrimination in health care coverage toward PLWH who belong to some vulnerable communities.[27]

In addition, as of January 2014, individuals can no longer be denied insurance due to pre-existing conditions,[18] including HIV, psychiatric diagnoses, or transgender medical history. Under recent federal health policy changes, new private plans are also required to cover preventative services without cost sharing. Mandated preventative services include screening for depression, screening and behavioral counseling for alcohol use disorders, and screening and cessation services for tobacco use disorders,[21] all of which bear particular relevance to PLWH who have disproportionate prevalence of depression, alcohol use disorders, and tobacco use.

An understanding of recent behavioral health treatment access expansion at the federal level will help guide professionals serving PLWH to engage more effectively with health insurance plans when pursuing authorization of behavioral health treatment coverage for their clients.

Individuals can no longer be denied insurance due to pre-existing conditions, including HIV, psychiatric diagnoses, or transgender medical history.

CONCLUSIONS

Recent U.S. health policy provisions grant expanded access to much-needed behavioral health treatment services for PLWH. Opportunities exist to increase access to care through provisions that address discrimination, delineate essential health benefits, integrate behavioral health care, prohibit denial based on pre-existing conditions, and emphasize preventative care.

Staff at AIDS service organizations, community-based organizations, and HIV-focused health service organizations should be aware of recent policy changes that facilitate access to expanded behavioral health treatment, in order to assist PLWH in receiving the behavioral health care they need to thrive.

REFERENCES

1. Rueda S, Mitra S, Chen S, et al. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analysis. BMJ Open. 2016. 6(7):011453.

2. Chambers LA, Rueda S, Baker DN, et al. Stigma, HIV, and health: a qualitative synthesis. BMC Public Health. 2015. 15(1):848.

3. Schadé A, van Grootheest, G, Smit JH. HIV-infected mental health patients: characteristics and comparison with HIV-infected patients from the general population and non-infected and mental health patients. BMC Psychiatry. 2013. 13(1):1.

4. Proeschold-Bell RJ, Reif S, Taylor B, et al. Substance use outcomes of an integrated HIV-substance use treatment model implemented by social workers and HIV medical providers. Health & Social Work. 2016. 41(1):e1-e10.

5. Safren SA, Bedoya CA, O'Cleirigh C, et al. Cognitive behavioural therapy for adherence and depression in patients with HIV: a three-arm randomized controlled trail. The Lancet HIV. 2016. 3(11):e529-e538.

6. Reisner SL, Poteat T, Keatley J, et al. Global health burden and needs of transgender persons: a review. The Lancet. 2016. 388(10042):412-436.

7. Habarta N, Wang G, Mulatu MS, et al. HIV testing by transgender status at Centers for Disease Control and Prevention-funded sites in the United States, Puerto Rico, and US Virgin Islands, 2009-2011. American Journal of Public Health. 2015. 105(9):1917-1925.

8. CDC. Diagnoses of HIV infection in the United States and dependent areas, 2014. HIV Surveillance Report. 2014. 26. Available from: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf.

9. Wejnert C, Le B, Rose CE, et al. HIV infection and awareness among men who have sex with men – 20 cities, United States, 2008 and 2011. PloS One. 2013. 8(10):e76878.

10. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychological Bulletin. 2003. 129(5):674.

11. Hatzenbuehler ML. How does sexual minority stigma "get under the skin"? A psychological mediation framework. Psychological Bulletin. 2009. 135(5):707.

12. Hatzenbuehler ML, Nolen-Hoeksema S, Erickson SJ. Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: results from a prospective study of bereaved gay men. Health Psychology. 2008. 27(4):455.

13. Keuroghlian AS, Kamen CS, Neri E, et al. Trauma, dissociation, and antiretroviral adherence among persons living with HIV/AIDS. Journal of Psychiatric Research. 2011. 45(7):942-948.

14. Jacobs LR, Skobpol T. Health care reform and American politics: what everyone needs to know. New York: Oxford University Press; 2010.

15. The Kaiser Commission on Medicaid and the Uninsured. Current status of state Medicaid expansion decisions. 2016. Available from: http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/.

16. Seifert R, Anthony S. The basics of MassHealth. 2011. Available at: http://www.umassmed.edu/uploadedFiles/CWM_CHLE/Included_Content/Right_Column_Content/MassHealth%20Basics%202011-FINAL.pdf. Accessed November 8, 2012.

17. Raymond A. The 2006 Massachusetts Health Care Reform Law: progress and challenges after one year of implementation. 2007. Available at: http://masshealthpolicyforum.brandeis.edu/publications/pdfs/31-May07/MassHealthCareReformProgess%20Report.pdf. Accessed November 10, 2012.

18. Mechanic D, Olfson M. The relevance of the Affordable Care Act for improving mental health care. Annual Review of Clinical Psychology. 2016. 12:515-542.

19. Mechanic D. More people that ever before are receiving behavioral health care in the United States, but gaps and challenges remain. Health Aff. 2014. 33:1416-24.

20. Beronio K, Po R, Skopec L, et al. Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans. ASPE Issue Brief. 2013. Available from: http://www.aspe.hhs.gov/health/reports/2013/ mental/rb_mental.cfm

21. Beronio K, Glied S, Frank R. How the Affordable Care Act and Mental Health Parity and Addiction Equity Act great expand coverage of behavioral health care. J. Behav. Health Serv. Res. 2014. 41:410-28.

22. Levey SMB, Miller BF. Behavioral health integration: an essential element of population-based healthcare redesign. Translational Behavioral Medicine. 2012. 2(3): 364-371.

23. SAMHSA-HRSA Center for Integrated Health Solutions. Population management in community mental health center-based health homes. 2014. Available from: http://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf.

24. Blashill AJ, Ehlinger PP, Mayer K, et al. Optimizing adherence to preexposure and postexposure prophylaxis: the need for an integrated biobehavioral approach. Clinical Infectious Diseases. 2015. 60(3):S187-90.

25. Collins LM, Kugler KC, Gwadz MV. Optimization of multicomponent behavioral and biobehavioral interventions for the prevention and treatment of HIV/AIDS. AIDS and Behavior. 2016. 20(1):197-214.

26. Rosenbaum S. Essential health benefits update: proposed regulations implementing the ACA; and application of the proposed EHB regulations to Medicaid benchmark plans. Health Reform GPS. George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation. November 29, 2012. Available at: http://healthreformgps.org/resources/essential-health-benefits-update-proposed-regulations-implementing-the-aca-and-application-of-the-proposed-ehb-regulations-to-medicaid-benchmark-plans/.

27. Wang T, Cahill S. ACA rule should improve access to health care for transgender people. The Hill. 2016. Available from: http://thehill.com/blogs/pundits-blog/civil-rights/297568-aca-rule-should-improve-access-to-health-care-for-transgender.

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