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Negotiating for Improved Reimbursement for Dialectical Behavior Therapy: A Successful Project

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Dialectical Behavior Therapy (DBT) is an evidence-based treatment for borderline personality disorder that has been widely disseminated to many outpatient treatment settings. Many practitioners depend on third-party payers to fund treatment delivery. DBT requires additional clinical services not often included in outpatient therapy, including a weekly skills group led by 2 clinicians, and the requirement for clinicians to attend weekly consultation team and provide intersession contact for coaching. Standard outpatient insurance rates for individual and group sessions do not provide adequate reimbursement for the additional services of DBT. This paper describes how 2 DBT team leaders collaborated to obtain improved reimbursement for their programs. The 2 teams met with insurers, educated them about DBT, and showed outcomes from their programs to achieve large increases in reimbursement rates. The paper includes client outcome data from both programs.

The provision of behavioral health treatments that are not based on scientific evidence is surprisingly common in the United States, where outcomes lag behind those of other developed nations (Cookson, 2009; McGlynn et al., 2003; Wang, 2009; Wang et al., 2006;). For some years, insurers have expressed concerns about providing reimbursement for treatments that have not been proven effective (Garber, 2001). Utilization of evidence-based treatments (EBTs) in behavioral health has been determined to be important in containing the escalating costs of health care (Luke, 2011). To promote use of EBTs toward the goal of reducing costs, Congress has established the Patient-Centered Outcomes Research Institute (PCORI) as part of the Patient Protection and Affordable Care Act. The mandate of the PCORI is to conduct and review effectiveness research and to influence public and private health care delivery (Clancy & Collins, 2010).

Even though the importance of EBTs is increasingly being recognized, the implementation and delivery of EBTs to clients in community mental health centers and small private clinics continues to be fraught with barriers (Drake et al., 2001; Herschell, Kogan, Celedonia, Gavin, & Stein, 2009; Mancini et al., 2009), including low reimbursement rates, denied reimbursement, and limited number of sessions (Keefe, Hall, & Corvo, 2002). The 2008 Mental Health Parity Act, intended to reduce barriers to mental health services, specifically states that "standards for provider admission to participate in a network, including reimbursement rates" must be comparable to medical/surgical services (United States Department of Labor, 2011, p. 2). According to the American Psychological Association, state and national psychological associations are challenging recent dramatic cuts in reimbursement rates, such as the 42% cut by Humana in Illinois of reimbursement of procedure code 90806, the designation for 50 to 60 minutes of outpatient therapy, to $58, by saying these cuts violate parity law and will limit the availability of mental health services (APA Practice Central, 2011). Similar dramatic cuts in reimbursement rates for behavioral health services in Ohio, Kansas, and California have also affected service delivery (Ragusea, 2012; Wolfe, 2012). Cuts in reimbursement rates seem likely to result in further decreases in access to EBTs in the community by discouraging clinicians offering specialized treatment from accepting insurance reimbursement.

Clinicians providing EBTs may have additional reimbursement problems not faced by those providing 50 minutes of nonspecific psychotherapy. For example, several aspects considered integral to Dialectical Behavior Therapy (DBT), including phone coaching and weekly

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case consultation between individual therapists and skills group leaders, may not be reimbursed by insurers. Furthermore, DBT requires two trained clinicians to lead skills groups, which are typically limited to 10 or fewer participants.

DBT is an evidence-based treatment for borderline personality disorder (BPD), developed by Marsha Linehan and colleagues at the University of Washington and described in the treatment and skills training manuals (1993a, 1993b). Randomized controlled trials supporting the efficacy and effectiveness of DBT have been conducted by Dr. Linehan at the University of Washington (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999; Linehan et al., 2002; Linehan et al., 2006; Linehan, McDavid, Brown, Sayrs, & Gallop, 2008) and at other sites in North America (Koons et al., 2001; Lynch, Morse, Mendelson, & Robins, 2003; Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan, 2001) and in Europe (Bohus et al., 2004; Van den Bosch et al., 2005; Verheul et al., 2003).

In the state where the authors practice, most behavioral health services are delivered by private agencies, both nonprofit and for-profit. There are few community mental health clinics throughout the state and only one state hospital. The standard reimbursement rate for procedure code 90806 (individual therapy 45 to 60 minutes) averages approximately $65 for a master's-level clinician and approximately $80 for a doctorate-level clinician, rates that have not increased in 14 years. Reimbursement by the state Medicaid provider for procedure code 90853 (group psychotherapy) is $24.25, an increase of $3.25 in the past 6 years. One of the two major private insurers currently reimburses at $21.31, an increase of 24 cents in 10 years. This rate applies regardless of the length of the group or the number of therapists leading the group.

The state contracts with private insurers to manage delivery of Medicaid benefits and close to 25% of insured persons are covered by Medicaid (Jennings, 2012, para. 2). Twenty-eight percent of the people in the state are uninsured (New Mexico Selected Health Statistics, 2009). For those who do have behavioral health coverage, many have plans with high yearly deductibles, high co-pays, and limits on the number of sessions per year.

Rationale

Because they deemed the rate of reimbursement for DBT inadequate to pay for all the services required to deliver the treatment to fidelity, two DBT teams in nearby cities joined together in 2007 to approach their state's major health care insurers and educate them about the nature and effectiveness of DBT. Team A is an association of independent private practitioners formed in 1999 and consisting of two social workers, three licensed professional counselors, and a clinical psychologist. Team A runs two adult groups and follows about 50 clients in stages one through three of DBT. Team B was founded in 2000. Team B is an agency owned by two partners who hire therapists for their team. This team includes four social workers and two licensed professional counselors. Team B runs four adult groups and follows approximately 60 clients in all three DBT stages.

Seven years prior to the project described in this paper, the two teams had asked for and received a raise in reimbursement for DBT skills group, procedure code 90853, to $50. While this amount was still deemed low, the readiness of insurers to pay more demonstrated that they recognized that DBT skills group was different from standard group psychotherapy and warranted higher reimbursement.

The negotiations for this project had four objectives: (a) to develop relationships with third-party payers to determine their interest in supporting EBTs, especially DBT; (b) to educate them about DBT's treatment structure and potential to improve mental health outcomes at reduced cost over treatment as usual; (c) to provide evidence about the effectiveness of their specific programs on key outcome variables; and (d) to achieve higher rates of reimbursement for therapists providing DBT to fidelity.

Method

Participants

Participants for the project came from the two DBT teams. Persons who were accepted into the DBT programs and consented to the testing protocol were included. Both practices receive referrals specifically for DBT, often from the local hospitals and from the third-party payers. The practices also treat many self-referred clients. Many of these clients have been diagnosed with BPD and most have suicidal and/or self-harm behaviors. Clients thus referred are then reassessed using structured and semistructured interviews based on the SCID 1 and SCID 2 (First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 2002) for appropriateness for DBT. In some cases the teams request outside psychological evaluations prior to admitting them to the DBT program, but usually they rely on their own diagnostic interviews. Some of these clients meet criteria for BPD and some do not.

In some instances individuals referred for DBT present with problems that can be more efficiently treated with other empirically supported treatments. In these cases the clients are either treated by individual team members trained in those treatments or are referred to other appropriate professionals outside the teams. The practices do sometimes offer DBT to individuals who may not meet full criteria for BPD but who have been refractory to other empirically supported treatment. Typically, these persons have significant skills deficits and problems with emotion regulation that contribute to poor overall quality of life. In

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