Trends in Behavioral Health

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Disclaimer

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My Background

- Medical Director for National Council for Behavioral Health
- Practicing Psychiatrist in a Community Health Center
- Distinguished Professor, Missouri Institute of Mental Health, University of Missouri St. Louis
- Previously
  - Medicaid Director for Missouri
  - Medical Director Missouri Department of Mental Health
2000 Up to 2008

- Bed capacity fairly stable
- Reduce discrimination
- Increased medication usage
- Increased MH prescribing by PCPs
- Emergence of EBP
- Integration of BH and medical care

“Better But Not Well”
Richard Frank, PhD

- Improvements in Care to MI due to:
  - Disabled income and housing supports
  - Newer medications easier to prescribe correctly
  - Many more persons with SMI treated by PCPs with medication
Overall

- Treatments get continually better
- Community focus and locus increases
- Financing and administration has become ridiculously complex

CATEGORIES OF PEOPLE IN THE U.S. HEALTH INSURANCE SYSTEM

- The Young
- Working-age people
- People age 65 and over

For the super rich, “Disneyland” the sky-is-the-limit policies without rationing of any sort (Boutique medicine)

Near poor children may be temporarily covered by Medicaid and S-Chip, although 4 million are still uninsured.

Persons over age 65, who are covered by the federal Medicare program, but not for long-term care. Often the elderly have private supplemental MediGap insurance.

The millions of uninsured tend to be near poor.

The employed and their families who are typically covered through their jobs, although many small employers do not provide coverage.

The federal-state Medicaid program for certain of the poor, the blind and the disabled

The very poor elderly are also covered by Medicaid

The young

The working-age people

The people age 65 and over

The federal-state Medicaid program for certain of the poor, the blind and the disabled

The millions of uninsured tend to be near poor

The employed and their families who are typically covered through their jobs, although many small employers do not provide coverage.

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The very poor elderly are also covered by Medicaid
Alexis Pozen
David M. Cutler

Medical Spending Differences in the United States and Canada:
The Role of Prices, Procedures, and Administrative Expenses

The United States far outspends Canada on health care, but the sources of additional spending are unclear. We evaluated the importance of incomes, administration, and medical interventions in this difference. Pooling various sources, we calculated medical personnel incomes, administrative expenses, and procedure volume and intensity for the United States and Canada. We found that Canada spent $1,589 per capita less on physicians and hospitals in 2002. Administration accounted for the largest share of this difference (39%), followed by incomes (31%), and more intensive provision of medical services (14%). Whether this additional spending is wasteful or warranted is unknown.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3024588/

2008 through 2010
Suddenly A New Environment

• 2008 – MH and SA Parity Act
• 2009 – Economic Crisis
• 2009 – HIT Act
• 2010 – Health Care Reform
More Americans Gaining Coverage (that includes Parity)

Yet, lack of access, disparities persist...

- Mental illness is the leading source of disease burden in the US
- Addiction has become a public health crisis
- Suicide rates are climbing
- Continued high levels of unmet need for care
- Little access to care even among working people with health coverage
- Lack of access to care has a critical impact on special populations: children, people of color, justice-involved
State Delivery System Reform Initiatives
FY 2015 and FY2016

In Place in FY 2014:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH</td>
<td>26</td>
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<tr>
<td>ACA Health Homes</td>
<td>16</td>
</tr>
<tr>
<td>ACO Initiative</td>
<td>6</td>
</tr>
<tr>
<td>Dual Eligible Initiative</td>
<td>13</td>
</tr>
<tr>
<td>Episode of Care</td>
<td>2</td>
</tr>
<tr>
<td>DSRIP</td>
<td>6</td>
</tr>
<tr>
<td>Any Delivery System Initiatives</td>
<td>35</td>
</tr>
</tbody>
</table>

NOTE: Expansions of existing initiatives include rollouts of existing initiatives to new areas or groups and significant increases in enrollment or providers.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.

CCBHC States

- Minnesota
- Missouri
- New Jersey
- Nevada
- New York
- Oklahoma
- Oregon
- Pennsylvania
Delivery System Redesign

- Data Driven Care
  - Care Management
  - Care Coordination
- Population Management
- Integration of Behavioral Healthcare and General Healthcare
- Increase Use of Preventive care
- Increase Access to Primary care
- Health Information Technology Interoperability STDS

Payment Reforms

- Bundled Payments
- Global Payments
- Pay for Performance
- Accountable Care Organizations (ACOs)
- Reduces Hospital Payments
- Increases Primary Care and Preventive care Payments
Where are we today?
The Good News

• There is growing awareness of our issues
  • Understanding that behavioral health is essential to whole health
  • Sustained media attention, growing numbers of people talking openly about their or their loved one's experience

• More Americans have coverage than ever before
  • Coverage includes parity for most Americans
  • Full parity implementation has proven difficult, many consumers still lack access to key services

Good News: Growing recognition that…

• Behavioral health is essential to whole health
  • Higher costs, poorer overall outcomes associated with co-occurring BH and physical health conditions

• Treatment works
• Recovery and a fully functioning life in the community are possible
Public Attention to Mental Health and Addiction is Growing

"Elsewhere, groups or networks have formed to spread the knowledge...They include the National Council on Behavioral Health’s Trauma-Informed Care Learning Community..."

Fact: Addictions – Public Health Crisis

Addictions as chronic diseases ... medications ... inpatient ... residential and outpatient treatments ... and recovery supports including housing
Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case1 and Angus Deaton1

Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544

Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

This paper documents a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the United States between 1999 and 2013. This change reversed decades of progress in mortality and was unique to the United States; no other rich country saw a similar turnaround. The middle mortality reversal was confined to white non-Hispanics, black non-Hispanics and Hispanics at midlife, and those aged 65 and above in every racial and ethnic group, continued to see mortality rates fall. This increase for whites was largely accounted for by increasing death rates from drug and alcohol poisonings, suicide, and chronic liver diseases and cirrhosis. Although all the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). The comparison is similar for other Organisation for Economic Co-operation and Development countries.

Fig. 1 shows a cessation and reversal of the decline in midlife mortality for US white non-Hispanics after 1998. From 1978 to 1998, the mortality rate for US whites aged 45–54 fell by 2% per year on average, which matched the average rate of decline in the six countries shown, and the average over all other industrialized countries. After 1998, other rich countries’ mortality rates continued to decline by 9% a year. In contrast, US white non-Hispanic mortality now by

http://www.pnas.org/content/112/49/15078.full

Mortality by Cause, White non-Hispanics

Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

“Deaths of Despair” Among Middle-Class Whites

Life Expectancy


Comparison of Metabolic Syndrome Prevalence in Fasting CATIE Subjects and Matched NHANES III Subjects

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Males CATIE</th>
<th>Males NHANES</th>
<th>p</th>
<th>Females CATIE</th>
<th>Females NHANES</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metabolic Syndrome Prevalence</td>
<td>36.0%</td>
<td>19.7%</td>
<td>.0001</td>
<td>51.6%</td>
<td>25.1%</td>
<td>.0001</td>
</tr>
<tr>
<td>Waist Circumference Criterion</td>
<td>35.5%</td>
<td>24.8%</td>
<td>.0001</td>
<td>76.3%</td>
<td>57.0%</td>
<td>.0001</td>
</tr>
<tr>
<td>Triglyceride Criterion</td>
<td>50.7%</td>
<td>32.1%</td>
<td>.0001</td>
<td>42.3%</td>
<td>19.6%</td>
<td>.0001</td>
</tr>
<tr>
<td>HDL Criterion</td>
<td>48.9%</td>
<td>31.9%</td>
<td>.0001</td>
<td>63.3%</td>
<td>36.3%</td>
<td>.0001</td>
</tr>
<tr>
<td>BP Criterion</td>
<td>47.2%</td>
<td>31.1%</td>
<td>.0001</td>
<td>46.9%</td>
<td>26.8%</td>
<td>.0001</td>
</tr>
<tr>
<td>Glucose Criterion</td>
<td>14.1%</td>
<td>14.2%</td>
<td>.9635</td>
<td>21.7%</td>
<td>11.2%</td>
<td>.0075</td>
</tr>
</tbody>
</table>

Meyer et al., Presented at APA annual meeting, May 21-26, 2005.
The CATIE Study

At baseline investigators found that:

- 88.0% of subjects who had dyslipidemia
- 62.4% of subjects who had hypertension
- 30.2% of subjects who had diabetes were NOT receiving treatment

Causes of Excess Mortality

- Smoking
- Obesity
- Inactivity
- Polypharmacy
- Under diagnosis of medical conditions
- Inadequate treatment of medical conditions
Per Member Per Month Costs

MH/SU costs in NY State’s Medicaid Program

MH/SU costs in NY State’s Medicaid Program
Does the Broader Healthcare Industry Need Behavioral Health to Succeed?

Drivers of Increased Demand for Behavioral Health Care

- Insurance reform substantially increases behavioral health coverage for adults
- Insurance reform requires newly covered populations meet the parity requirements of Wellstone Domenici Parity Act
- Reform requires or incentivizes integration of Behavioral Health and general medical care
- Stigma continues to drop releasing pent up demand
- Press coverage and mental health impact
New Drivers of BH Demand

- **Medicaid Access Rule**
  - Went into effect October 2016
  - Requires that MHD monitor and report on Access to 5 essential provider types – one is BH

- **Medicaid Managed Care Rule**
  - Extends Wellstone-Domenici BH Parity to Medicaid Managed Care
  - Requires very detailed parity analysis for every eligibility group/benefit plan – approx. 100 in MO!

- **Medicare MACRA P4P**

Fact: Working people have little access to care

- Escalating deductibles/copays make treatment for mental illness (OCD, anxiety, depression - conditions highly responsive to medication and cognitive interventions) out of reach.
- Equally destructive are stagnant insurance reimbursement rates that make behavioral health cash only businesses.
Medicaid is Largely a BH Funding Program

- Single largest payer for BH services accounting for 26% of all behavioral health spending in 2009
- The 20% of Medicaid beneficiaries with a BH diagnosis account for 48% of all Medicaid expenditures
- Total Average Medicaid Expenditures
  - With BH diagnosis $13,303
  - Without BH diagnosis $3564
- About half of the non-dually eligible, under age 65 (including children) with disability have a behavioral health diagnosis
- Total Medicaid expenditures for this group accounts for two thirds of total Medicaid spending

Percent of Adult Group Covered by Medicaid, 2014

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent Covered by Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>General adult population</td>
<td>12%</td>
</tr>
<tr>
<td>Substance abuse disorder</td>
<td>16%</td>
</tr>
<tr>
<td>Any mental illness</td>
<td>20%</td>
</tr>
<tr>
<td>Serious mental illness</td>
<td>24%</td>
</tr>
</tbody>
</table>

Medicaid is Radically Different from Commercial or Medicare Coverage

• Targets high need populations left out of other insurance programs
• Negligible co-pays and no deductibles
• Coverage available nowhere else
  • Long term services and supports – NH, Personal care, Home health
  • Specialized support programs for specialized populations – SMI, DD, Foster care children, HIV,
  • Transportation to and from treatment
• Innovation

Innovative Medicaid Programs For Behavioral Health Populations

• Community support services and case management
• Crisis services and hotlines
• ACT teams
• Peer services
• ER diversion programs
• Partial hospital
• Residential treatment
• Psychosocial rehabilitation
• CMHC health homes
• Family support
Medicaid Spending Now Averages 26% of Total State Budgets

Total Medicaid spending as % of total state spending, average across all states, and Missouri for 2014.

1985 - 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Spending</th>
<th>Missouri</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>31%</td>
<td></td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: HMA, based on NASBO, State Expenditure Report, 2014 and earlier years.

Total Spending on Medicaid and K–12 Education as % of Total State Spending

Average State Percentages, 2008 – 2014

- Medicaid
  - 2008: 20.5%
  - 2009: 22.0%
  - 2010: 23.7%
  - 2011: 24.4%
  - 2012: 24.4%
  - 2013: 25.8%
  - 2014: 26.0%

- K-12 Education
  - 2008: 19.5%
  - 2009: 19.9%
  - 2010: 20.0%
  - 2011: 20.0%
  - 2012: 19.9%
  - 2013: 19.9%
  - 2014: 19.9%

Source: HMA, based on data in: NASBO, State Expenditure Report, 2014 and Earlier Years.
Big Trends

- Increased coverage
- Increased demand
- Focus of high utilizers
- Increased desire for integration by payers
- Provider consolidation
- Performance based payments
- Shrinking psychiatric workforce

HRSA Projects Ongoing Shortages of Professionals

By 2025...

- If levels of demand remain constant, shortages projected among 5 key behavioral health provider types
- If levels of demand increase, shortages projected among 9 key provider types
  - Including shortages of more than 10,000 FTEs among psychiatrists, psychologists, social workers, SUD counselors, mental health counselors, & school counselors

SAMHSA
Ability to recruit & retain staff limited by low rates

Map shows ratio of Medicaid to Medicare payment rates

Payment reform shifts risk & accountability to providers

Episodic Cost Accountability  Total Cost Accountability
Moving from episodic “sick care” to population health management

In 2010, there were no ACOs…

Today, there are more than 700.

Focus: Measurement Based Care

If you don't measure it, you can't improve it
Data Sources

- Claims – broad but not deep, already aggregated
  - Diagnosis
  - Procedures including Hospital and ER
  - Medications
  - Costs

- EMR Data Extracts – deep but not broad, need aggregating

- Practice Reported – administrative burden
  - Metabolic Values – Ht, Wt, BP, HbA1c, LDL, HDC
  - Satisfaction and community function – MHSIP
  - Staffing and Practice Improvement

- Hospital Stay Authorization – hospital admissions

Data You Need to Manage

- Aggregate reporting – performance benchmarking
- Individual drill down – care coordination
- Disease registry – care management
  - Identify Care Gaps
  - Generate to-do lists for action
- Enrollment registry – deploying data and payments
- Understanding – planning and operations
- Telling your story – presentation like this
Principles

• Use the data you have before collecting more
• Show as much data as you can to as many partners as you can as often as you can
  • Sunshine improves data quality
  • They may use it to make better decisions
  • It’s better to debate data than speculative anecdotes
• When showing data ask partners what they think it means
• Treat all criticisms that results are inaccurate or mis-leading as testable hypotheses

More Principles

• Tell your data people that you want the quick easy data runs first. Getting 80% of your request in 1 week is better than 100% in 6 weeks
• Treat all data runs as initial rough results
• Important questions should use more than one analytic approach
• Several medium data analytic vendors/sources is better than on big one
• Transparent bench marking improves attention and increases involvement
Most Important Principles

• Perfect is the enemy of good
• Use an incremental strategy
• If you try figure out a comprehensive plan first you will never get started
• Apologizing for a failed prompt attempt is better than is better than apologizing for missed opportunity

Delivery System Reforms to Coordinate Care and Control Costs Are in Most States in 2014 - 2015

NOTE: Expansions of existing initiatives include rollouts of existing initiatives to new areas or groups and significant increases in enrollment or providers. Dual Eligible Initiatives include those through and outside CMS financial alignment demonstration.

Prospective Payment History

- **Medicare Payments**
  - *Hospital since 1985 – previously were reimbursed for “Allowable Costs”*
  - *FQHCs since 2013*

- **Medicaid Payments**
  - *FQHCs since 2000 – previously were reimbursed based on annual cost report*

Prospective Payment Systems

- **Single payment for a specific period of time or episode of care for a service bundle at the projected average cost of that service bundle**
- **FQHC Medicare** – A single national rate ($158.85)set by CMS with adjustment for geographic cost and visit intensity (up 34% for initial and annual wellness)
- **FQHC Medicaid** – States specific methodology within CMS guidelines and final method approved by CMS
  - *PPS only: 21 States*
  - *Alternative Payment Method (APM): 12 States*
  - *Both: 12 States*
Advantages of PPS

• **Compared to Fee for Service**
  - Fewer claims to submit or process and pay
  - Less incentive to do more services to generate more revenue
  - Results in less volatile and more predictable payments

• **Compared to Cost Reimbursement**
  - Less incentive to do increase costs to generate more revenue
  - Does not require annual cost report and re-setting rates
  - Does not require interim payments and end of year reconciliation calculation and payment

PPS Opportunities

• **Able to include some costs not currently in FFS**
  - Training
  - EHRs
  - Prevention services
  - None face – to-face time
  - Peer services
  - Employment supports
  - Cost of maintaining crisis system capacity

• **Able to include quality bonus**
MACRA – What is it?

- MACRA, bipartisan legislation, replaces the flawed Sustainable Growth Rate formula by paying clinicians for the value and quality of care they provide.
- The new “Quality Payment Program” has two paths:
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models

MIPS Components

MIPS aims:
- Align 3 current independent programs
- Add 4th component to promote improvement and innovation
- Provide more flexibility and choice of measures
- Retain a fee-for-service payment option

Clinicians exempt from MIPS:
- First year of Part B participation
- Medicare allowed charges ≤ $30K or ≤ 100 patients
- Non-patient facing with ≤ 100 patients
- Advanced APM participants
MIPS Component Weights (when fully transitioned)

Component Scoring

- **Quality:**
  - 60 points groups \( \leq 15 \)
  - 70 points for larger groups

- **Advancing Care Information:**
  - 50 points base score
  - 90 points performance score

- **Improvement Activities:**
  - 40 points (2-4 activities; 1-2 activities for practices \( \leq 15 \) clinicians and rural)

- **Cost:**
  - 10 points per measure
  - Score is average of attributable measures

For 2017:
- Quality = 60%
- ACI = 25%
- IA = 15%
- Cost = 0%

Merit Based Incentive Program
Who will NOT participate?

- Providers in their FIRST year of Medicare Part B participation
- Providers with a low Medicare volume
- Medicare claims \( \leq 10,000 \)
- Provider care for \( \leq 100 \) Medicare patients in one year
- Providers participating in advanced alternative payment models
Quality: What is the requirement?

- Providers will choose 6 measures that are relevant to their practice
  - Must include one outcome measure or high value measure
  - Must include a cross-cutting measure
  OR
- Providers can report a Specialty Measure Set

Important Provider Competencies

Characteristics:
- Outcomes-oriented
- Enabled by technology
- Patient-centered
- Use of data and analytics
- Performance transparency
- Ability to partner across organizations

Care Coordination
- Care Management
- Clinical Integration
What BH Organizations Need to Evolve and Prosper

- A Role no one else wants or can do
- Data, Data, and more Data
- Willingness to Change
- Willingness to Risk
- Integration with the Rest of Health Care
- Training, Training, and more Training

Medicaid Reform Proposals Further Crunch States… and Providers

- Proposals to reduce federal share of Medicaid put pressure on states
- Common cost-cutting actions by states include:
  - Provider pay cuts
  - Coverage rollbacks/limitations
  - Benefit reductions
Repeal/Replace/Repair?

- Off the Table for Now
  - The Market Place
  - Repeal of Medicaid Expansion
- Current Proposal
  - Essential Health Benefits
  - Pre-Existing Conditions/Community Rating

Problem Statement

Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data*

<table>
<thead>
<tr>
<th>Diagnosis 1</th>
<th>Diagnosis 2</th>
<th>Frequency among all beneficiaries</th>
<th>Frequency among most expensive 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>Cardiovascular</td>
<td>24.5%</td>
<td>40.4%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Central Nervous System</td>
<td>18.9%</td>
<td>39.8%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Pulmonary</td>
<td>12.5%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Central Nervous System</td>
<td>13.1%</td>
<td>32.9%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Pulmonary</td>
<td>11.2%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Gastrointestinal</td>
<td>10.2%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>Pulmonary</td>
<td>7.0%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Renal</td>
<td>7.1%</td>
<td>24.6%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Gastrointestinal</td>
<td>5.9%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Gastrointestinal</td>
<td>9.5%</td>
<td>24.0%</td>
</tr>
</tbody>
</table>

The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions Center for Health Care Strategies, Inc., October 2009

- 49% of Medicaid beneficiaries with disabilities have a psychiatric illness.
- 52% of those who have both Medicare and Medicaid have a psychiatric illness.
Not Just Another Fad

“Medicare’s ACOs reduced spending by $466 million in 2015, according to fresh data from CMS.”

On the downside: nearly half of participants didn’t achieve any savings.
Questions?

Contact Information: joep@thenationalcouncil.org