Behavioral Health Primary Care Integration Hearing

Alameda County Board of Supervisors
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Sandra Naylor Goodwin, PhD, MSW
California Institute for Mental Health

Agenda

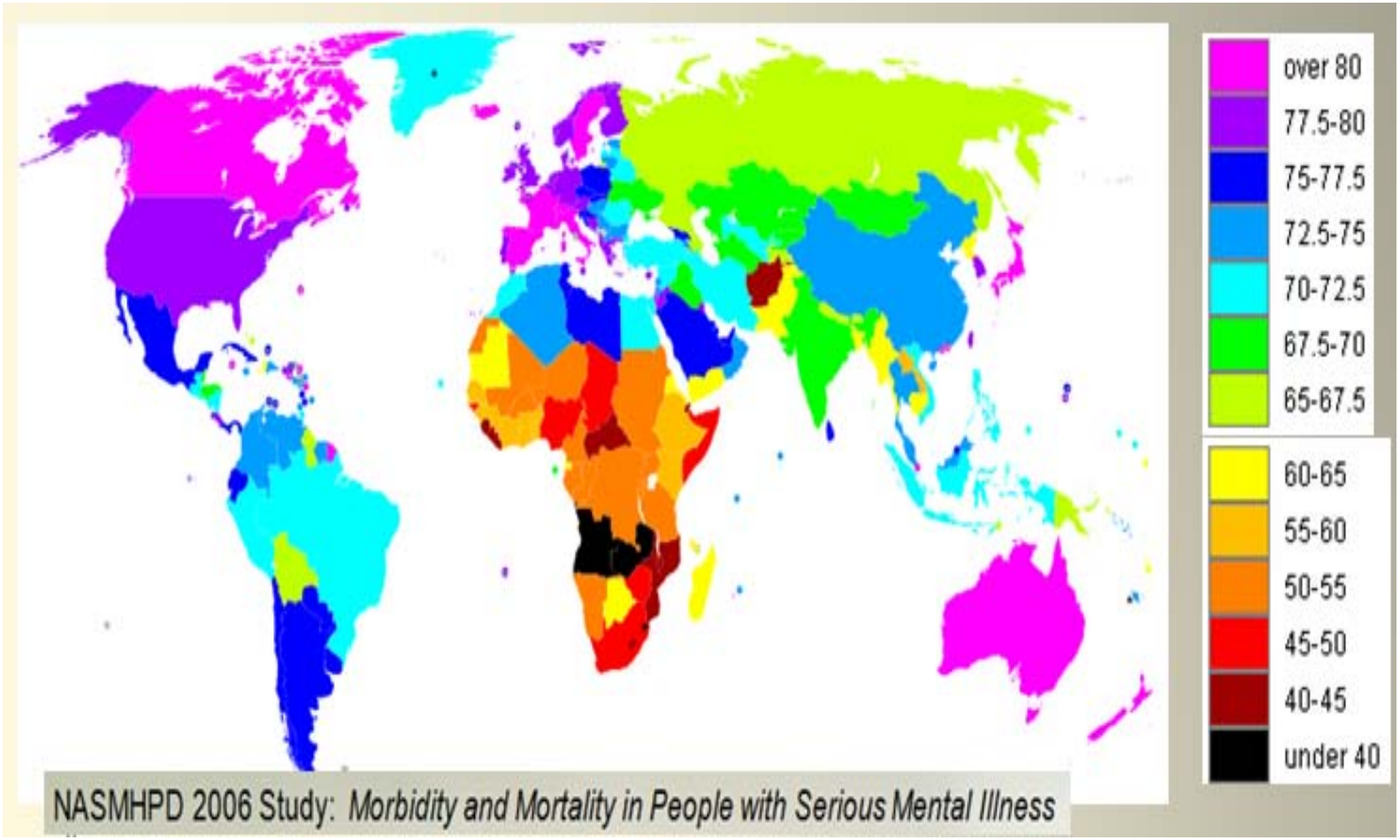
- The Business Case for Bi-Directional Integration
- The Affordable Care Act and Behavioral Health in California

People with Mental Illness Die Younger

- Adults w serious mental illness have a life expectancy about 25 years less than Americans overall.*
  - Primarily from natural causes or preventable diseases, including heart disease, cancer, lung disease or complications from HIV/AIDS
  - Average life span: 53 years old
- Washington state data: add SUD, loose 5 more years – 48 years old

* NASMHPD 2006: Morbidity and Mortality in People w Serious Mental Illness

Putting it in Perspective



Bi-Directional Integration

- Behavioral health integrated into primary care settings and primary care integrated into behavioral health settings
  - Mild and moderate BH risk in primary care health home
  - Serious and severe BH risk in behavioral health home

Mental Health Costs

One of top 10 conditions driving medical costs, ranking 7th in national survey of employers.

Greatest cause of productivity loss among workers.

Depression

Those diagnosed have nearly twice the annual health care costs of those without depression.

Cost burden to employers for workers with depression is estimated at $6,000 per depressed worker per year.

Faces of Medicaid III: *Refining the Portrait of People with Multiple Chronic Conditions*

- New analysis includes pharmacy & 5 years data
- Fewer than 5% of beneficiaries account for more than 50% of overall Medicaid costs
- 75% of Medicaid costs = 3 or more chronic conditions

–October 2009 Center for Healthcare Strategies

Faces of Medicaid III

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

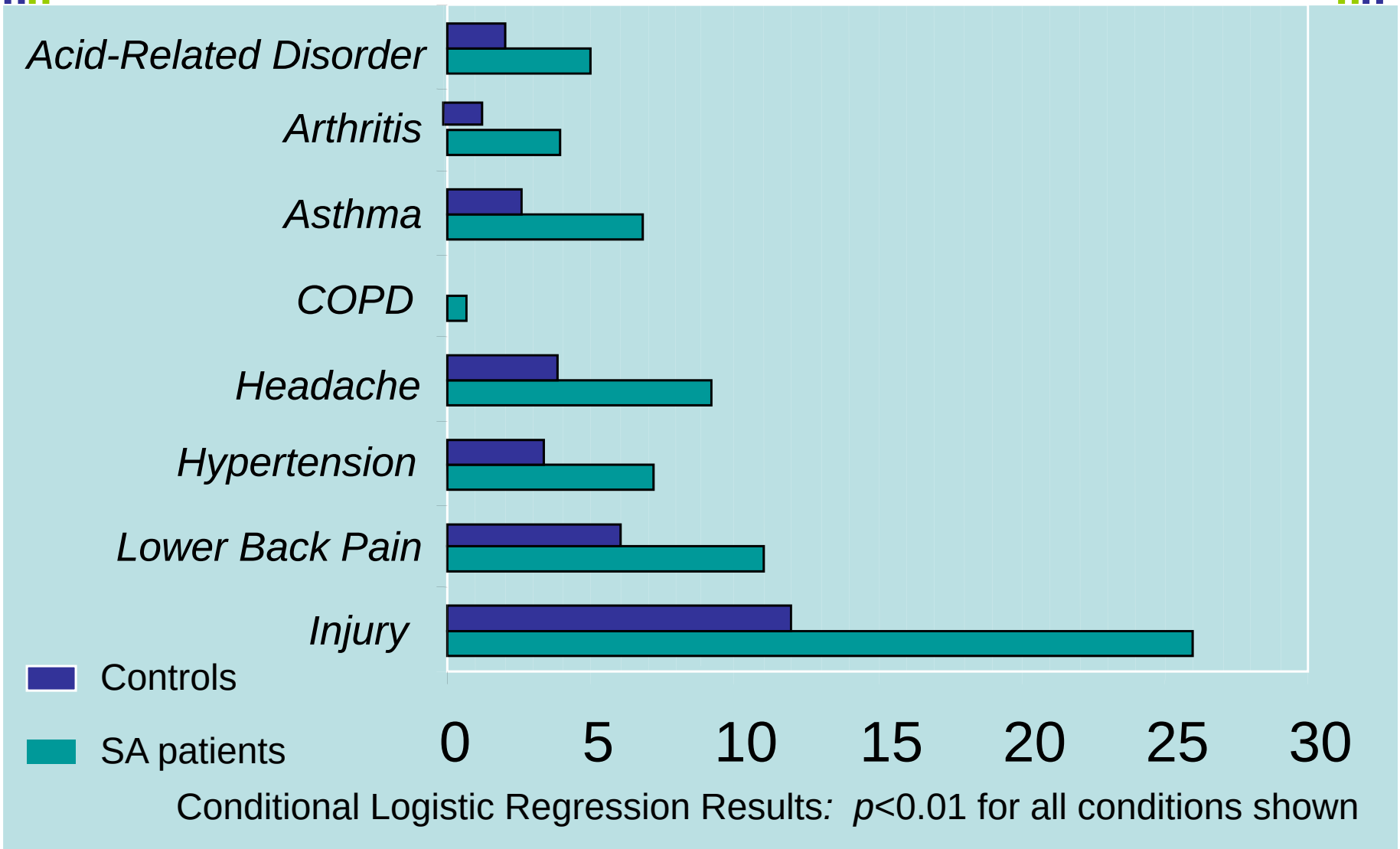
Diagnosis 1	Diagnosis 2	Frequency among all beneficiaries	Frequency among most expensive 5%
Psychiatric	Cardiovascular	24.5%	40.4%
Psychiatric	Central Nervous System	18.9%	39.8%
Cardiovascular	Pulmonary	12.5%	34.3%
Cardiovascular	Central Nervous System	13.1%	32.9%
Psychiatric	Pulmonary	11.2%	28.6%
Cardiovascular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

- 49% of Medicaid beneficiaries with disabilities have a psychiatric illness.
- 52% of those who have both Medicare and Medicaid have a psychiatric illness.

Kaiser Substance Use Study

- Context of a health plan
  - Employers are primary purchasers
- Alcohol and drug problems as primary problems and as risk factors for other health conditions
- Treatment can be effective
- Not treating them causes lack of improvement in other health conditions (and problems in work productivity)
- Not treating them causes more ER and inpatient utilization
- Not treating them causes health problems and cost for family members

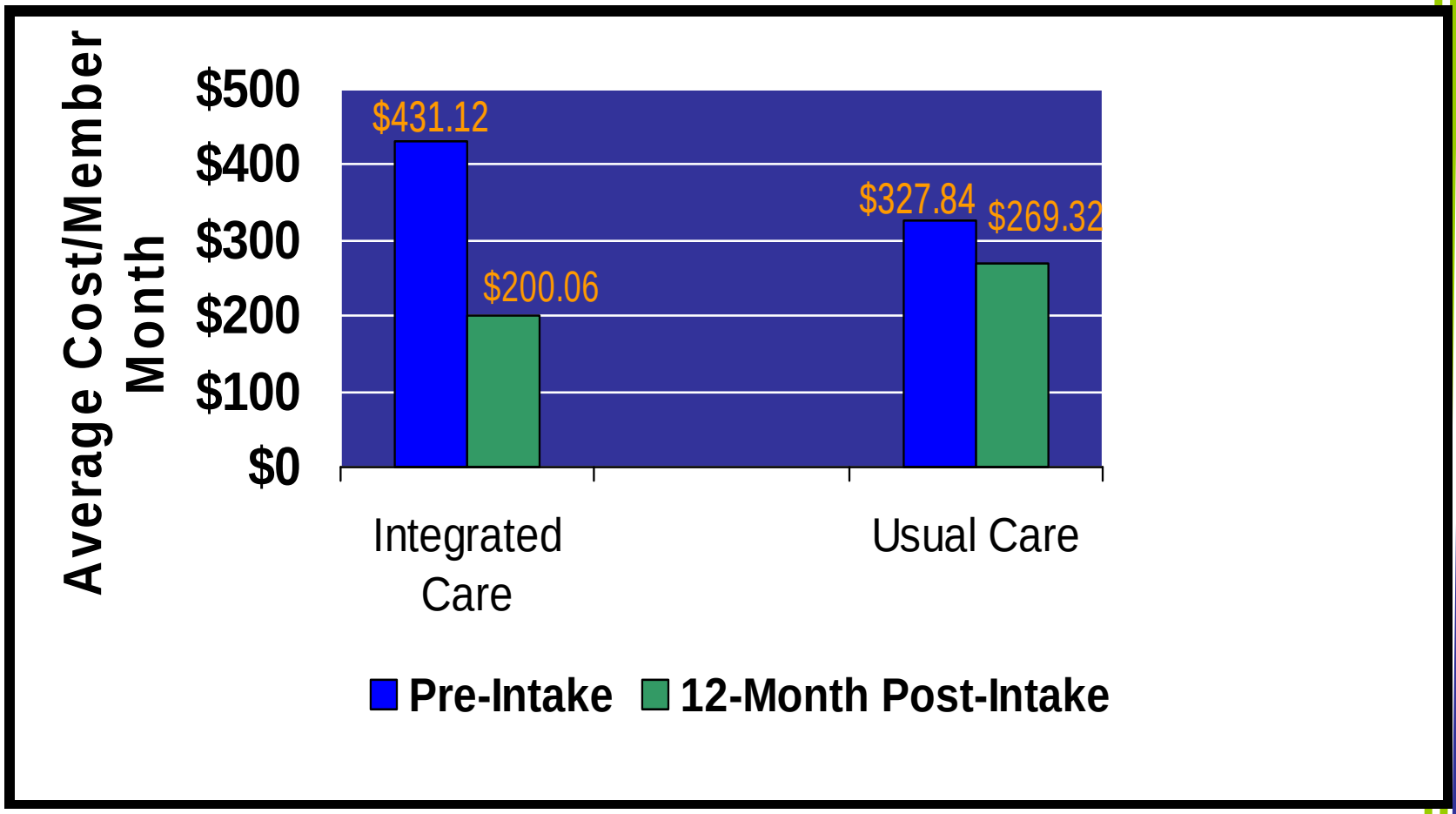
Prevalence in Substance Abuse Patients Vs. Matched Controls



Conditional Logistic Regression Results: $p<0.01$ for all conditions shown

Mertens et al. (2003). *Archives of Internal Medicine* 163: 2511-2517.

Medical Costs after Treatment for Integrated Medical Care for Those with Substance Abuse-Related Medical Conditions



Parthasarathy S, Mertens J, Moore C, Weisner C. Utilization and cost impact of integrating substance abuse treatment and primary care. *Med Care.* Mar 2003;41(3):357-367.

Effect of SUD Conditions on Healthcare Cost of Family Members

- Pre-treatment, families of all SUD patients have higher medical costs than control families
- Adult family members have significantly higher prevalence of 12 medical conditions compared with control group; child family members have significantly higher prevalence of 9 medical conditions
- At 2-5 years post-intake for SUD services, if family member w/SUD condition were abstinent at 1 year, family members had similar average PMPM medical costs as control group
- Family members of SUD patients who were not abstinent at 1 year had a trajectory of increasing medical cost relative to control group

California Medi-Cal Costs

11% of Californians in the fee for service Medi-Cal system have a serious mental illness.

Healthcare spending for these individuals is 3.7 times greater than it is for all Medi-Cal fee-for-service enrollees.

($14,365 per person per year compared with $3,914.)

Making the Case Still More Compelling…

- "if a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders **via an effective integrated medical-behavioral healthcare program**
  - $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members
  - the cost of doing nothing may exceed $300 billion per year in the United States."

    - Chronic conditions and comorbid psychological disorders, Milliman Research Report, July 2008 [Note: this analysis based on commercially insured population]

The Affordable Care Act and California's "Bridge to Health Care Reform"

ACA and Behavioral Health

- ACA Major Theme: Integration
  - Financing and Reimbursement Changes
  - Medicaid Expansion
  - Parity in Essential Benefits (Medicaid and commercial)
  - Infrastructure Supports

California

- Low Income Health Plans
- Seniors and Persons with Disabilities
- Dually Eligible (Medicare & Medi-Cal)
- Parity

California's Bridge to Health Care Reform 1115 Waiver & Demonstrations

- Key Programmatic Elements
  - Expand coverage to more uninsured adults;
  - Support uncompensated care costs;
  - Improve care coordination for vulnerable populations; and
  - Promote public hospital delivery system transformation.
  - Integration of MH/SUD/PC not mentioned

Low Income Health Program

- Low Income Health Program (LIHP) – two components
  - Medicaid Coverage Expansion (MCE)
    - Up to 133% FPL
    - ***Mental Health Minimum Benefit Required***
    - ***Substance Use Disorder Benefit <u>Not Required</u>***
    - FFP not capped
    - May be CPE or capitated
  - Health Care Coverage Initiative (HCCI)
    - 134% to 200% FPL
    - ***MH & SUD Minimum Benefit <u>Not Required</u>***
    - FFP is capped – county will get an allocation
    - Financed through IGT

Managed Care for Seniors and Persons with Disabilities (SPDs)

- Medi-Cal enrollees who are Seniors or Persons with Disabilities (SPDs) into mandatory managed care
  - Goal to provide more coordinated care and contain costs.
- **49% of persons w disabilities**
- **36% of seniors have psychiatric illness**
- Behavioral Health not adequately addressed

Dually Eligible: Medicare/Medi-Cal

- Demonstration Project: Coordinate disparate, costly benefits, improve health
  - All Medicare Part C and D Benefits
  - All Medi-Cal Services currently required in managed care coverage
  - Long-term supports and services
    - Nursing facilities, In-Home Supportive Services (IHSS), and Five home-and community-based waiver services.
  - ***Coordination with mental health and substance use disorder carved-out programs required by CMS***

Dually Eligible: Medicare/Medi-Cal

California Data:

- 1.1 million dual eligibles
- Roughly 14% of Medi-Cal population but are 25% of cost
- 20% enrolled in Medi-Cal managed care
- $7.6 billion in state Medi-Cal costs ($20 billion with Medicare)
- $3.2 billion in LTC costs = 75% of Medi-Cal total LTC spending

Dual Eligibles

- 52% of individuals dually eligible for Medi-Cal and Medicare have a psychiatric disability
- CMS requires CA to address MH/SUD
  - Appendix 2 Framework for Shared Accountability: Coordination and Alignment Strategies for Integrated Delivery of Behavioral Health Services
- Alameda MHS – 3,488 rec'g services

Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equity Act 2008

- General rule – parity applies if a plan offers medical/ surgical and MH/SUD benefits (> 50 employees)
  - Applies to Medicaid Managed Care
  - New rules for Medicaid out sometime “soon”
  - Will apply to Medicaid benchmark plans beginning in 2014
- A plan may not apply any **financial requirement** or **treatment limitation** to MH/SUD benefits in any classification that is **more restrictive** than the **predominant** requirement or limitation for **substantially all** medical/surgical benefits in the same classification

Additional Federal Requirements Addressing Parity

- ***Behavioral Health Services Assessment*** *- By March 1, 2012, State to submit CMS for approval an assessment that shall include information on available mental health and substance use service delivery infrastructure and other information necessary to determine the current state of behavioral service delivery in California.*

- ***Behavioral Health Services Plan*** *- By October 1, 2012, the State will submit to CMS for approval a detailed plan, outlining the steps and infrastructure necessary to meet requirements of a benchmark plan no later than 2014.*

Recommendations

- Provide demonstration to state
- Develop model MOU between health plans and behavioral health
- Address behavioral health needs to improve health, improve bottom line
- Seek additional federal grant & Medicaid funds
  - Co-location; targeted case management; vocational supports, peer services, recovery support
- Collect data on bi-directional integration; health outcomes, cost savings, disparities