Behavioral Health Innovations

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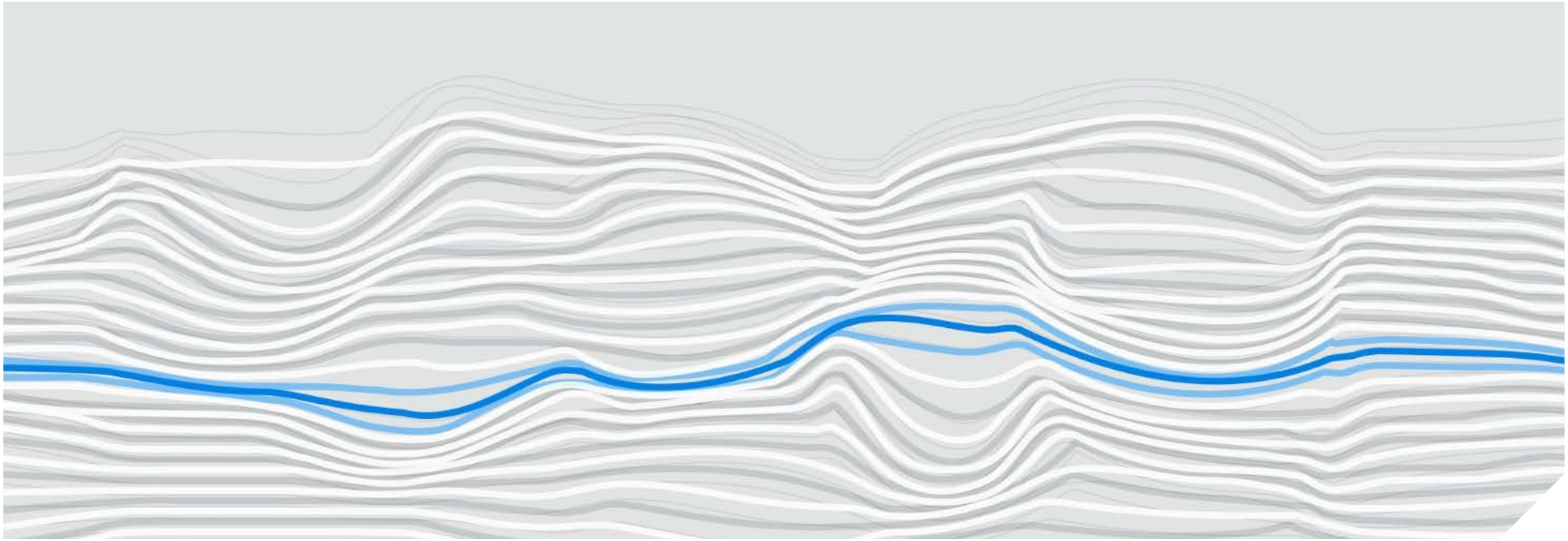
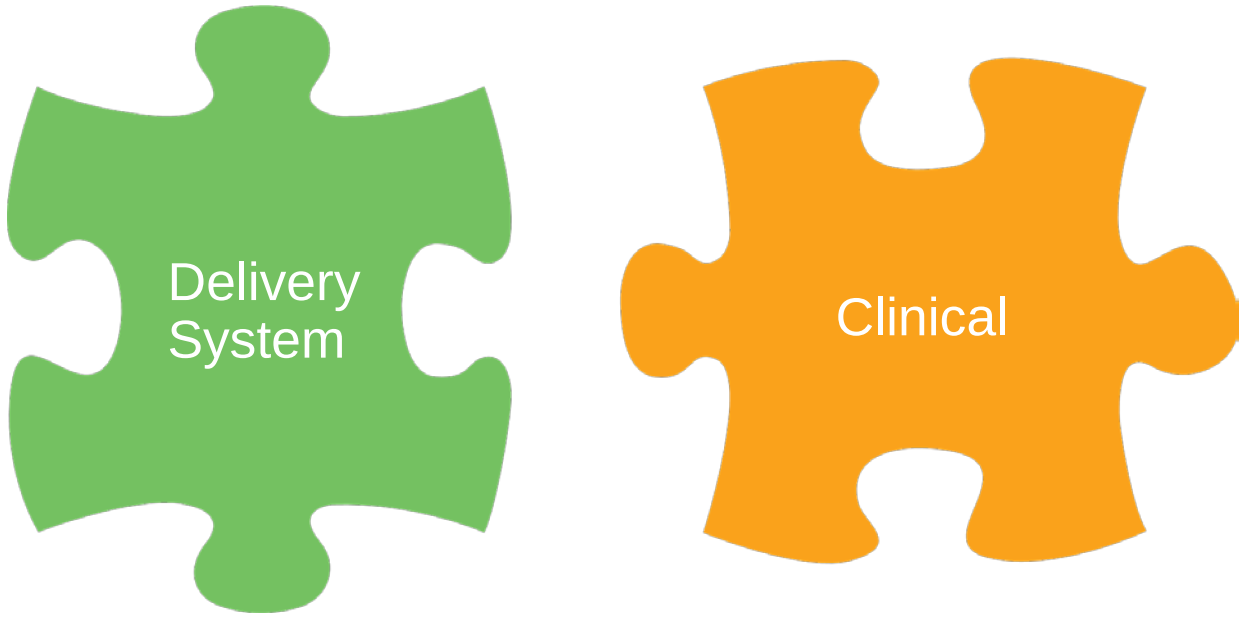


Agenda

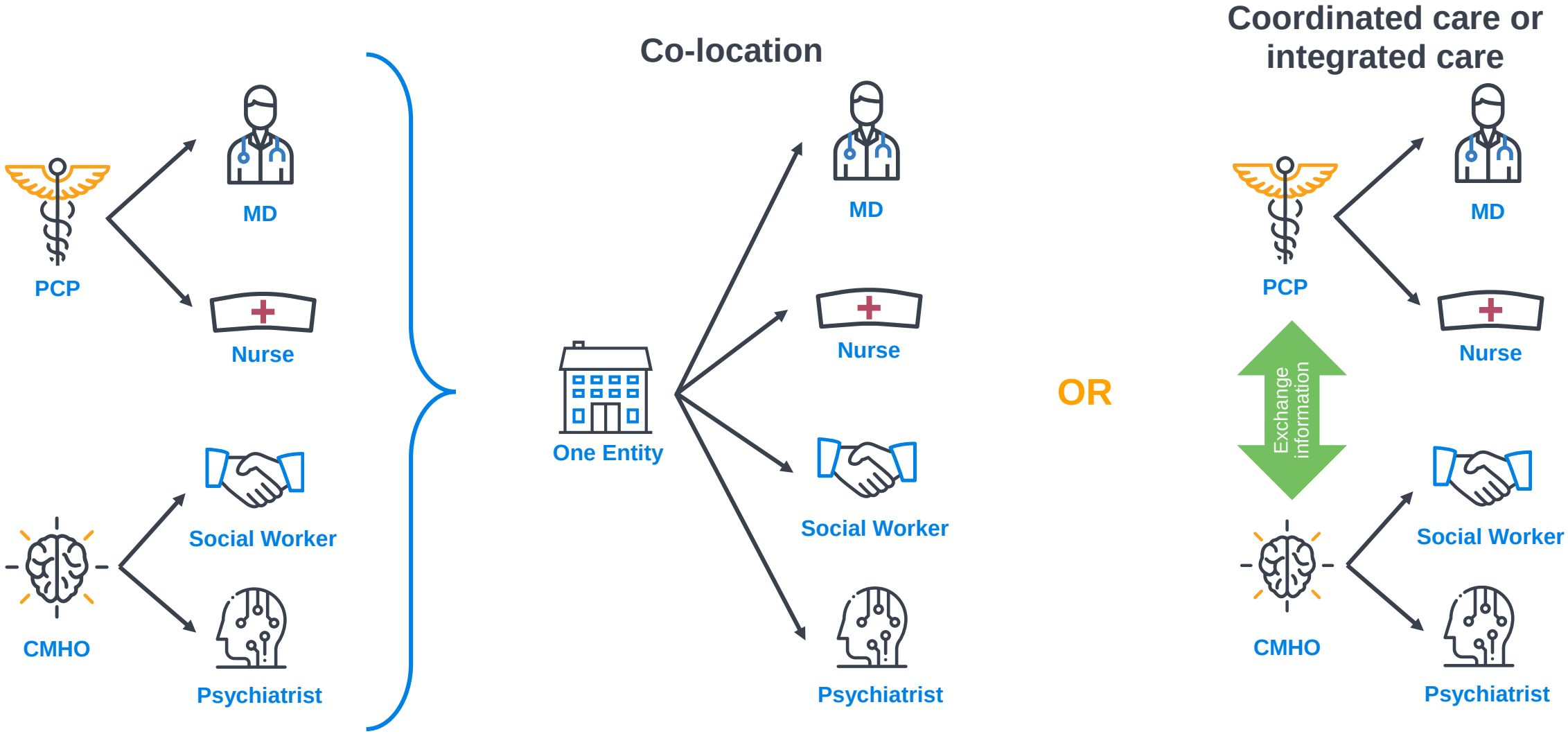
Introduction

Behavioral health integration

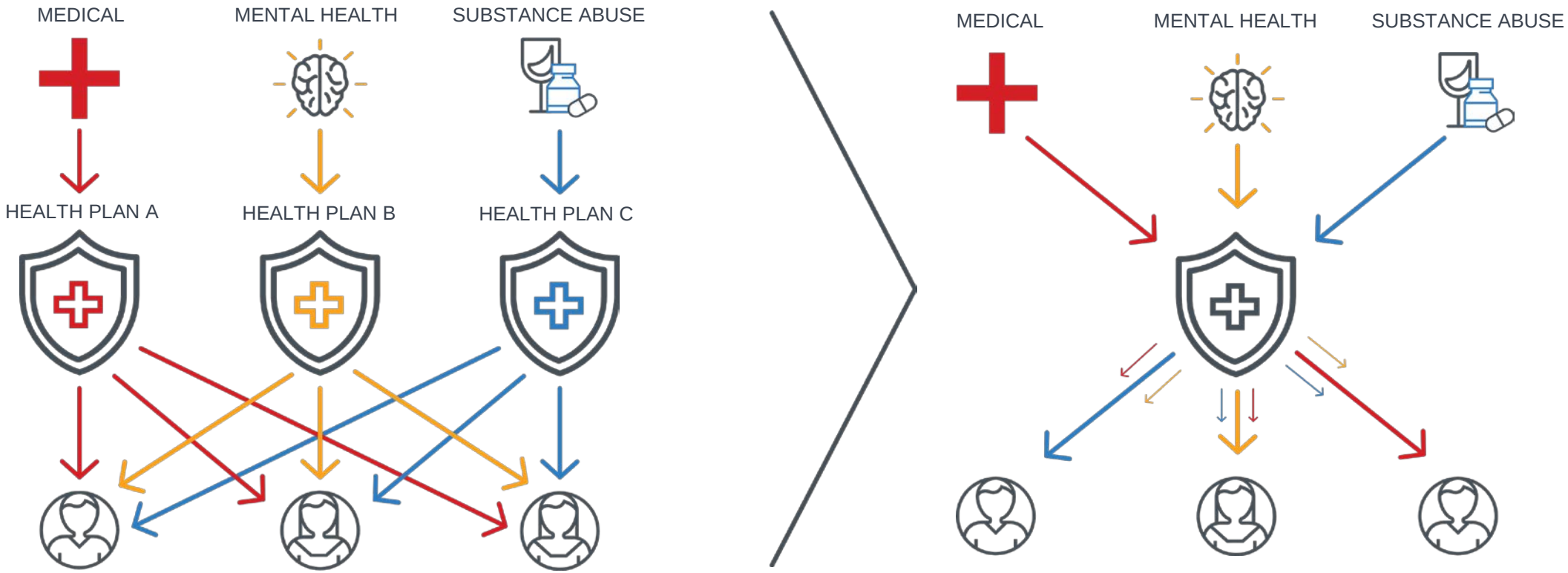
What does behavioral health integration mean?



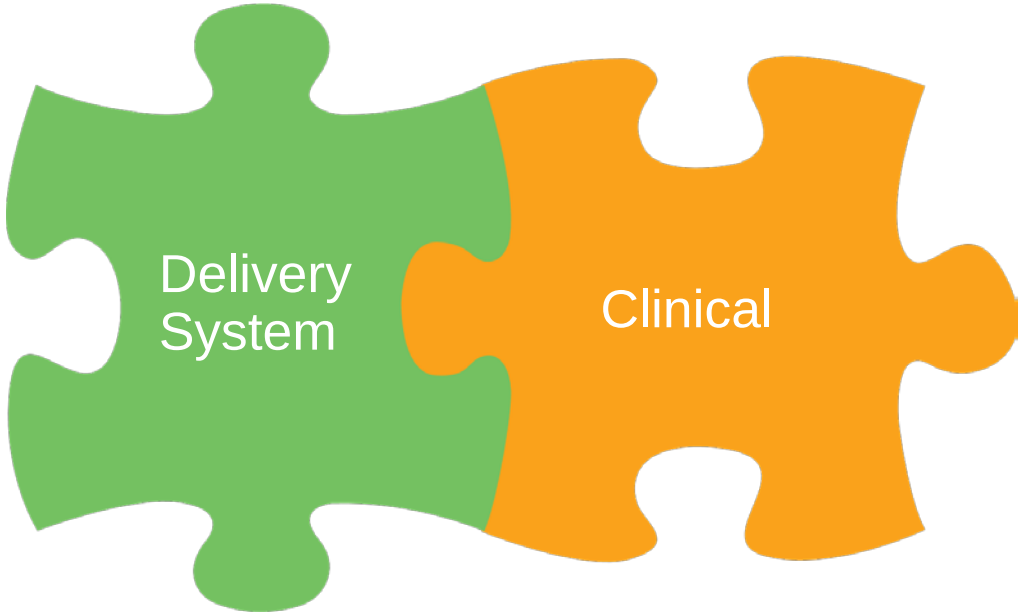
Clinical integration illustration



Delivery system integration



What does behavioral health integration mean?



Clinical integration of physical and behavioral health services may improve health outcomes and reduce costs for individuals with behavioral health conditions, but separate Medicaid financing for physical and behavioral health care can create barriers to coordinated care delivery.

Source: https://www.chcs.org/media/BH-Provider-Brief_070219.pdf

Integration across the diagnosis severity spectrum

Serious Mental Illness (SMI) | Substance Use Disorder (SUD) | Intellectual and/or Developmental Disabilities (I/DD)

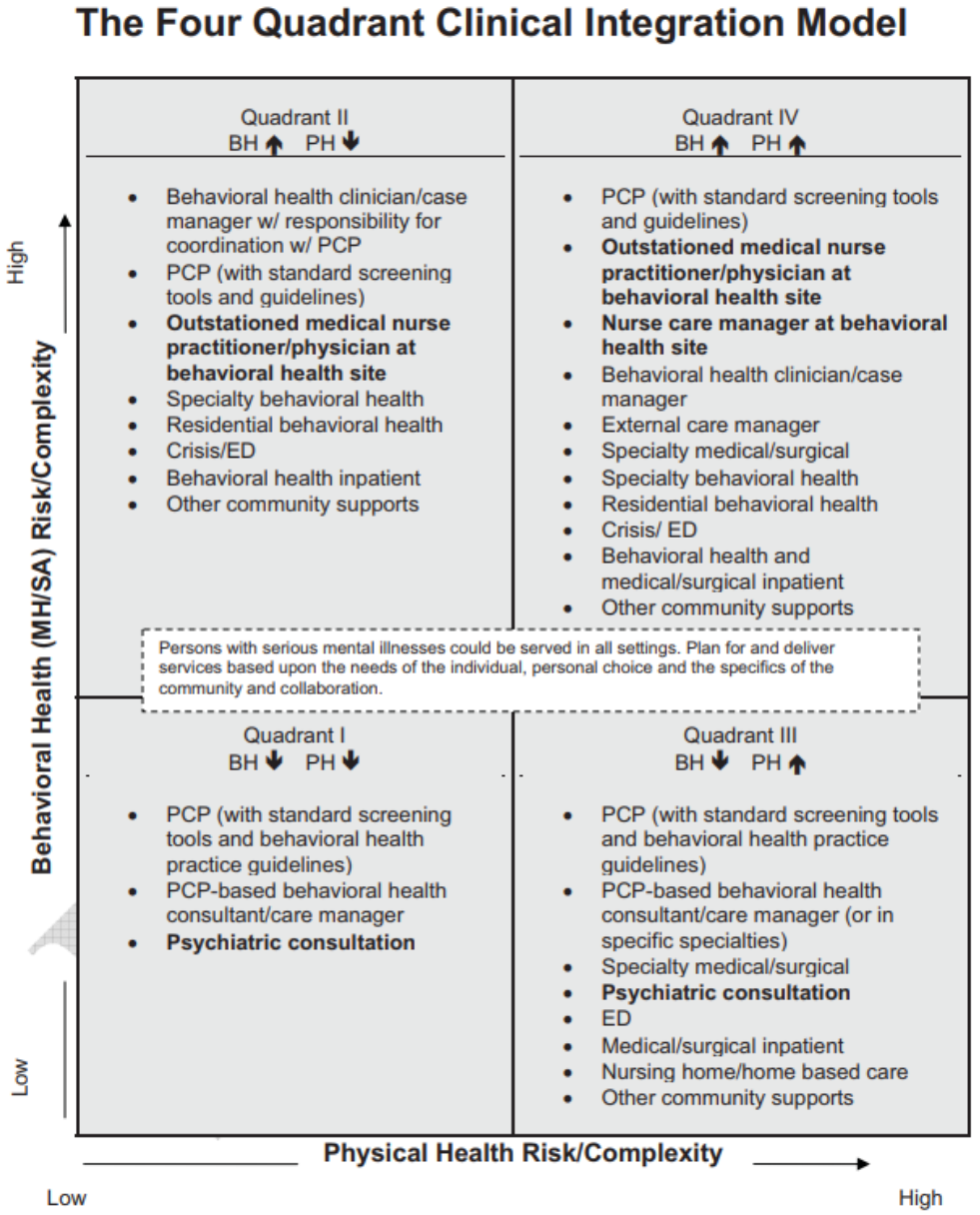
How does clinical integration differ across the spectrum?

- The severity of the behavioral health diagnosis is often determining whether a PCP or CMHO is taking the lead in integration

How does delivery system integration differ across the spectrum?

Current landscape – Clinical integration

- 22 states with Medicaid Health Homes
- 32 states with Patient-centered medical homes
- 4 states with Medicaid ACOs
- States are also considering Psychiatric Collaborative Care Model (CoCM)[1] or other forms of collaborative care



Sources:

https://www.integration.samhsa.gov/clinical-practice/four_quadrant_model.pdf

[1]https://integration.samhsa.gov/BehavioralHealthIntegration.pdf

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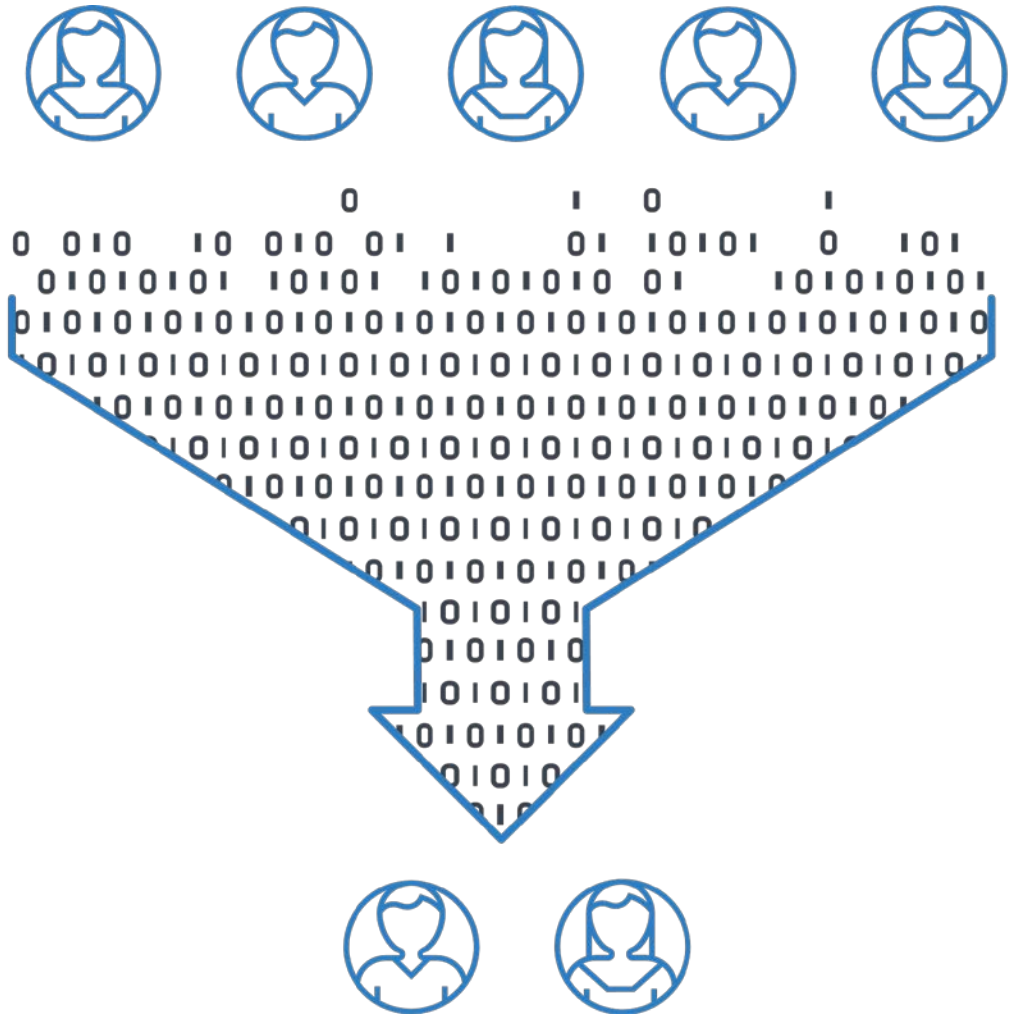
Current landscape – Delivery systems

	States with Medical Managed Care
Full Carve-Out	**32%**
Carved-In[1]	**57%**
Specialty Plan	**11%**

- **Full Carve-Out**: behavioral health benefit separately administered from medical benefit
- **Carve-in**: behavioral health benefit administered with the medical benefit, but paid across all enrollees
- **Specialty Plan**: behavioral health benefit administered with the medical benefit, but paid only for those meeting a certain criteria

[1] 40% of Medicaid health plans in 2017 sub-capitated the behavioral health benefit according to an Open Minds article

Operationalizing integration across the diagnosis spectrum



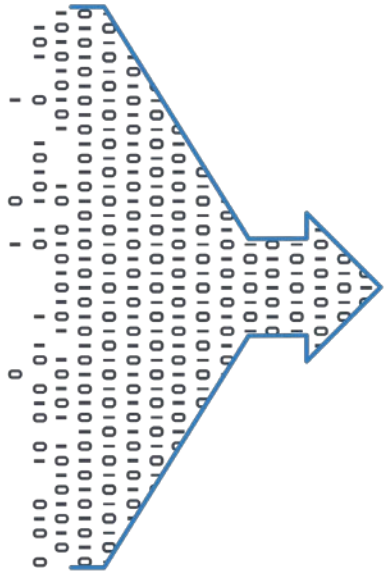
- Criteria are used to determine the clinical model for behavioral health recipients
  - State Medicaid agency personnel could be involved, but may delegate this to contracted entities
- Criteria are also used to determine the delivery system model for behavioral health recipients in Carve-Out of Specialty Plan models
  - State Medicaid agency personnel are heavily involved in Carve-Out of Specialty Plan populations

Operationalizing delivery system integration

Florida specialty plan example

Children and Adults

Standard Health Plans



SMI

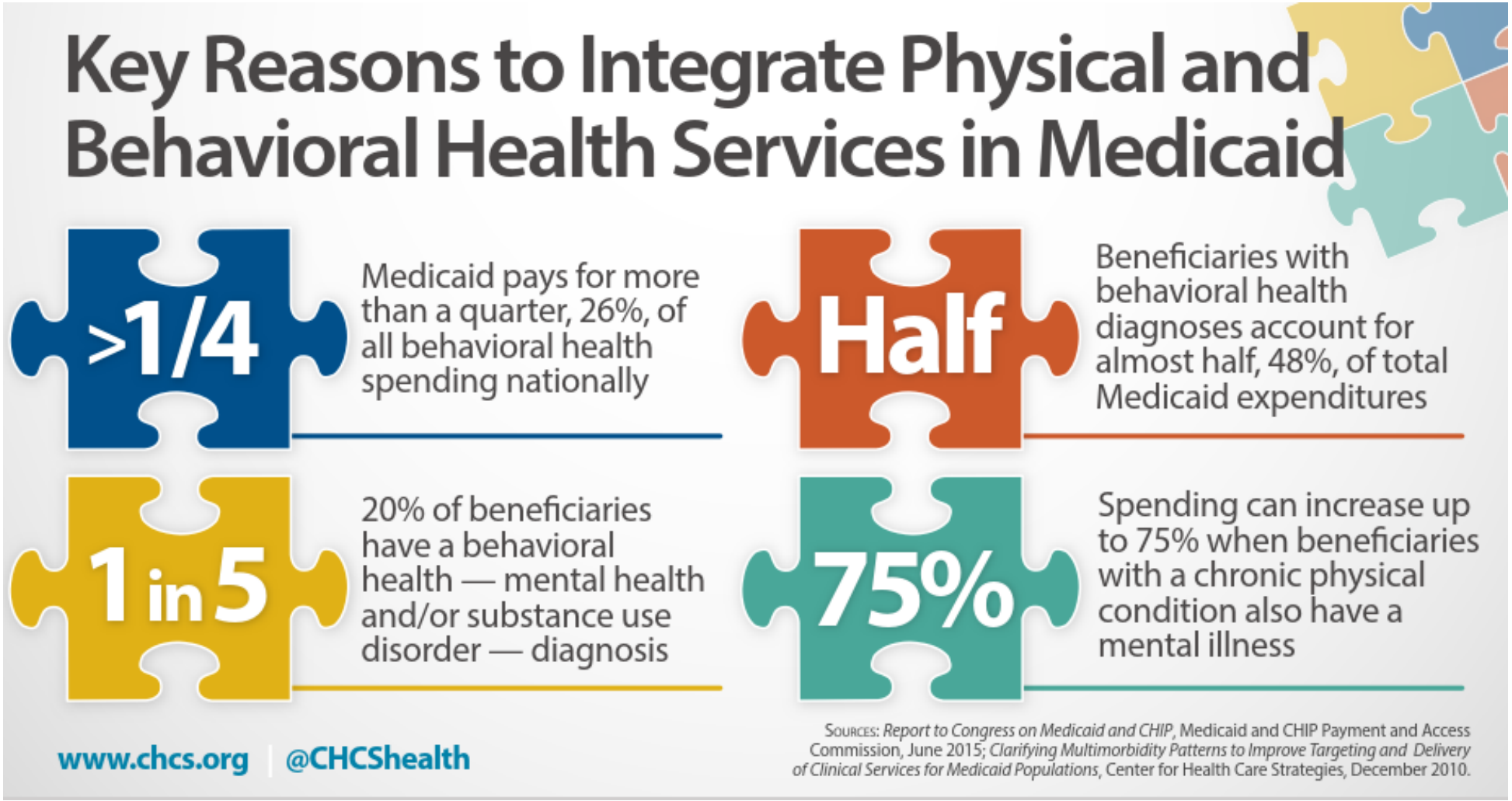
Standard Health Plans

Specialty Plans

Alignment between the state methodology to identify the SMI population for capitation payments and the methodology used for the capitation rate development process is critical

Medicaid's role in behavioral health care

Leading us to savings



Integrated care savings

Medical cost savings

- Mortality difference of 25 years
  - 60%: cardiovascular disease, obesity, COPD, lack of attention to health
  - 40%: suicide and injury
- Common co-occurring chronic physical conditions
  - Diabetes, liver and kidney disease, hypertension
- Behavioral / physical healthcare cost interactions
  - 60-75% increase in cost relative to no BH condition
- Targeted service utilization reduction – emergency and inpatient care
  - Fewer visits and shorter stays

Savings illustration example

Chronic conditions: cost and prevalence

Diabetes example	
Average Cost	$16,750
+60% w/ BH Condition	$26,800
Non-BH Prevalence	18%
+BH Prevalence	22%

Medical condition	Prevalence	
	w/ BH	w/o BH
Cardiac disease	54%	38%
Hypertension	41%	30%
Rheumatism	33%	17%
Kidney disease	29%	18%

Sources:
Average annual cost: https://care.diabetesjournals.org/content/41/5/917
Prevalence: disabled non-dual Medicaid, Table 4-5 https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf

Pre-integration savings estimates

State example

Population cohort	Member distribution	Medical claims cost (in millions)	Savings assumption
PH & MH conditions	4%	$65.0	3%
PH & SUD conditions	2%	$35.0	3%
PH & MH & SUD	1%	$30.0	5%
Other	94%	$620.0	0%
Composite	100.0%	$750.0	0.6%

- Research suggests ~5% integration savings* on physical health services for BH utilizers
  - *Ultimate estimated savings assumption that may be achieved over a period of two to four years.

Source:
Integration savings: http://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf
Illustrative numbers: State Medicaid pilot county ~500,000 disabled members

Post-integration savings calculation considerations

Demographic mix

- Changes in distribution can skew comparability
- age/gender
- aid categories
- regional enrollment

Population acuity

- Risk adjustment algorithms can be used to measure changes.
- Regular Medicaid churn
- economic cycles
- program eligibility changes

Delivery system changes

- Evaluating the total cost of care is critical
- Care patterns can shift between provider types

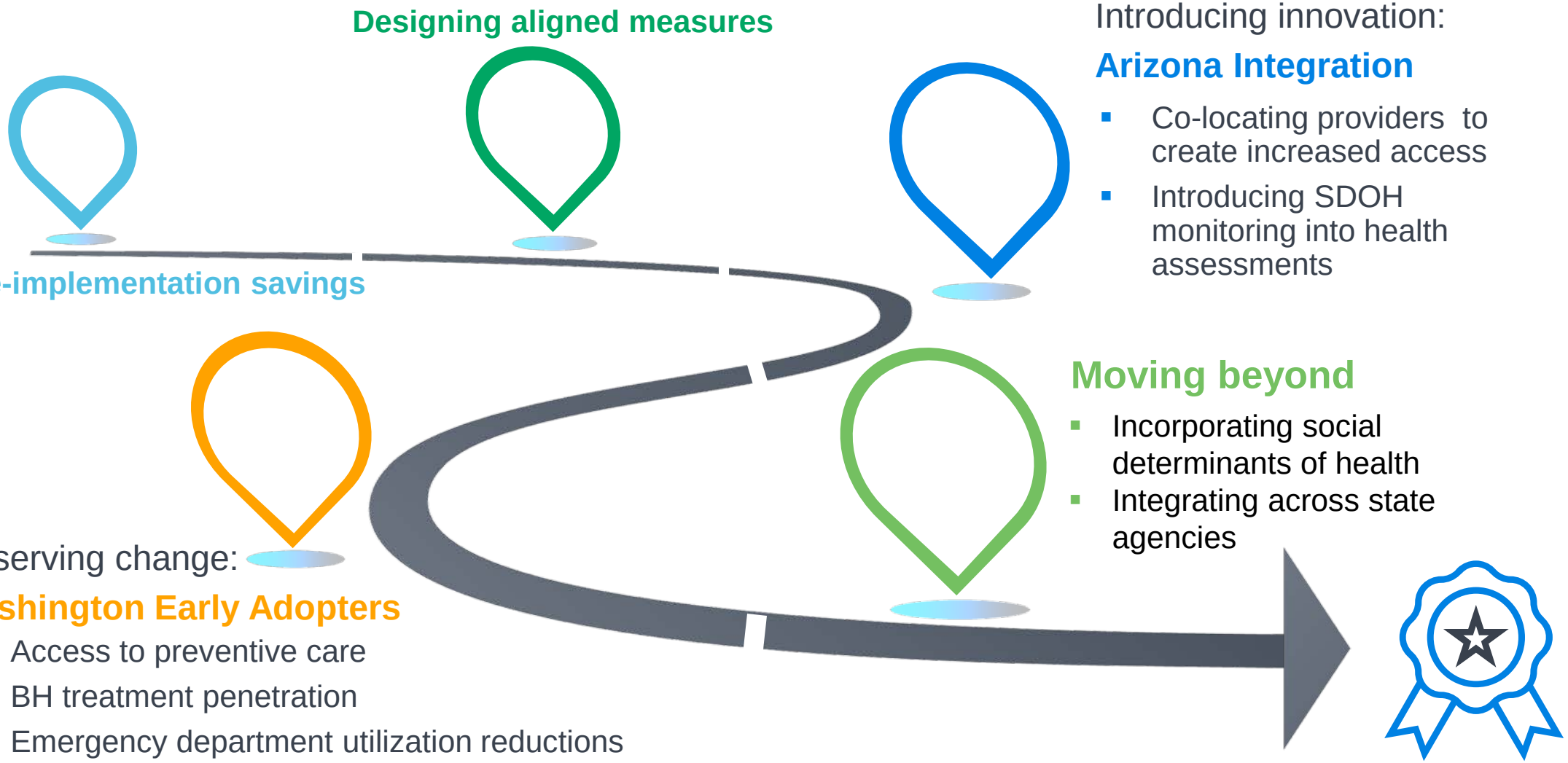
Data quality concerns

- Underreporting issues
- Supplemental service cost reporting
- Stakeholder engagement

Measuring changes beyond cost savings

Measure type	Example
Process *Demonstrate provider efforts*	▪ Improve follow-up after crisis / emergency visit ▪ PH providers screening for SUD ▪ BH providers screening for chronic physical conditions
Structural *Demonstrate provider group/hospital system capacity for treating BH*	▪ Number of PCPs certified to provide medication assisted treatment (MAT) ▪ Capacity for providers to report screening results in EHR ▪ Access to providers and services
Health outcomes *Quantify healthcare improvement*	▪ Percentage of patients adhering to medication ▪ Percentage of patients completing treatment programs
Social outcomes *Quantify non-health improvement*	▪ Employment rates ▪ Justice involvement ▪ Housing stability

Measuring success



Pre-implementation savings

Designing aligned measures

Introducing innovation:

Arizona Integration

- Co-locating providers to create increased access
- Introducing SDOH monitoring into health assessments

Moving beyond

- Incorporating social determinants of health
- Integrating across state agencies

Observing change:

Washington Early Adopters

- Access to preventive care
- BH treatment penetration
- Emergency department utilization reductions
- Increased hemoglobin A1C testing

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State policy recommendations

Data and quality measures	Payment & business practice reforms	Integrated service delivery
Facilitate data sharing between plans, providers, state	Include BH in value-based purchasing models	Invest in provider training & capacity building
Invest in infrastructure for provider health record and billing systems	Invest in provider readiness / system capacity for VBP, unique to BH providers	Collaborate with providers and plans to design and share assessments
Consider complexity of providers working with multiple plans	Develop incentives for providers to integrate care and systems to improve communication	Create same-day service opportunity for co-occurring conditions
Develop meaningful process and outcome measures	Identify reforms to licensing / credentialing as needed	Identify opportunities to incorporate SDOH

Source:
Based on interviews in Arizona, New York, and Washington following implementation: https://www.chcs.org/media/BH-Provider-Brief_070219.pdf

Housing

Introduction

How many people are impacted?

Homeless describes a person who lacks a fixed, regular, and adequate nighttime residence

553,000 are homeless on any given single night

17% of these individuals were chronically homeless

2/3 are staying in emergency shelters or transitional housing programs

Source: https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

Current Medicaid options for housing supports

Housing ***transition*** services

- Identifying barriers to successful tenancy
- Assisting with housing application
- Identifying resources to cover expenses
- Supporting the move-in and ensuring safe environment

Housing and tenancy ***sustaining*** services

- Case management support (Landlord support, etc)
- Advocacy and linkage with community resources to prevent eviction

State-level housing services

- Strategic inter-agency collaborative to identify and secure housing resources

Note: There are several Waiver options for operationalizing these benefits

Source: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf

Potential new housing benefit

- In late 2018, CMS discussed that they were exploring new innovative ideas to provide short-term housing[1]
- Proposed short-term housing options approved in North Carolina 1115 Waiver
  - First month's rent
  - Post-inpatient psych hospitalization

Medicaid coverage will only be available if funding from other federal programs are not available

Source: [1]https://www.modernhealthcare.com/article/20181124/NEWS/181129980

Critical subset of homeless population

Beneficiaries served in inpatient psychiatric setting – Key stats

- Approximately **570,000** beneficiaries were served by state and community psychiatric hospitals in FFY 2017 totaling approximately **$8.8 billion**[1]
  - The majority of these beneficiaries were enrolled in their state's Medicaid program
- There is an estimated **100,000** people discharged from an inpatient psychiatric hospital who are in need of housing[2]
- Risk of suicide is at its highest the **two weeks immediately following being discharged** from a psychiatric hospital[3]

Sources:

[1]https://wwwdasis.samhsa.gov/dasis2/urs.htm

[2]https://www.hcup-us.ahrq.gov/reports/statbriefs/sb152.pdf

[3]https://www.ncbi.nlm.nih.gov/pubmed/23545716

Savings opportunities from providing housing for post-inpatient psych hospitalization

	Expected	Potential Scenario
Assumed inpatient cost per admit	$15,000	$15,000
Re-admission rate	40.0%[1]	10.0%
Expected IP cost over 6 months	$6,000	$1,500

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4978672/

Potential savings **$4,500**

Rent cost
(6 months at $750) **$4,500**

Net cost of benefit **$0**

- This example calculation will vary depending on the geographic area
- This cost/savings analysis only incorporates inpatient admissions and does not incorporate additional healthcare costs
- Even at a net cost of $0 for the benefit, the outcomes from implementing this benefit would be greatly improved!

Discussion

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Thank you

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