

Informational Briefing: Federal Healthcare Reform and the Impact on Mental Health



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Agenda

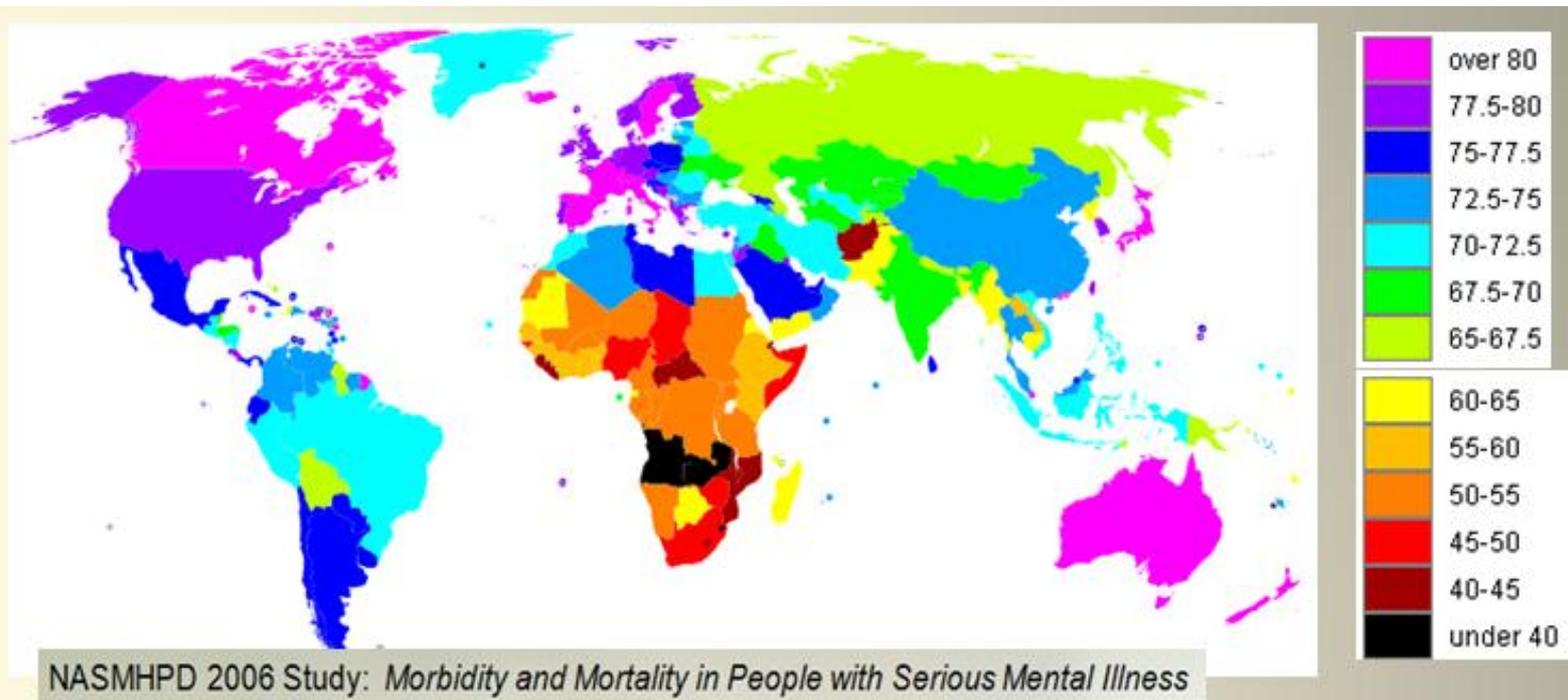
- The Business Case for Mental Health in Healthcare Reform
- Mental Health and Substance Use in California's Bridge to Healthcare Reform (1115 Waiver)
- Recommendations

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

Putting it in Perspective

- Americans with Mild, Moderate, Serious and Severe MH/SU disorders have substantially higher prevalence of **Chronic Health Conditions** and higher **Total Healthcare Expenditures** (2x – 3x greater for SMI)
- The high prevalence of persons with these disorders, combined with high cost, directly affect quality and cost problems



The Business Case for Mental Health in Healthcare Reform

**Bi-Directional Integration:
Behavioral Health Integrated into
Primary Care and Primary Care
Integrated into Behavioral Health**

CMS: The Triple Aim

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of total healthcare <http://www.ihl.org/ihl>
- **MH & SU must be a part of planning and development of new, integrated health systems.**

Research suggests without addressing the healthcare needs of persons with serious Mental Health/Substance Use (MH/SU) disorders and the MH/SU treatment needs of the whole population, it will be very difficult to achieve the Triple Aim.

Problem Statement

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
- 3 or more chronic conditions = 75% of Medicaid costs for people w disabilities
- 45% of Medicaid beneficiaries w disabilities have 3 or more chronic conditions

- October 2009 Center for Healthcare Strategies, Rick Kronick, PhD & Todd Gilmore, PhD

Faces of Medicaid III (cont)

- Psychiatric illness among Medicaid beneficiaries w disabilities = 49%
- 52% of those who have both Medicare and Medicaid have a psychiatric illness (Dual Eligibles)
- Psychiatric illness is represented in 3 of the top 5 most prevalent pairs of diseases among the highest-cost 5% of Medicaid-only beneficiaries with disabilities

Faces of Medicaid III

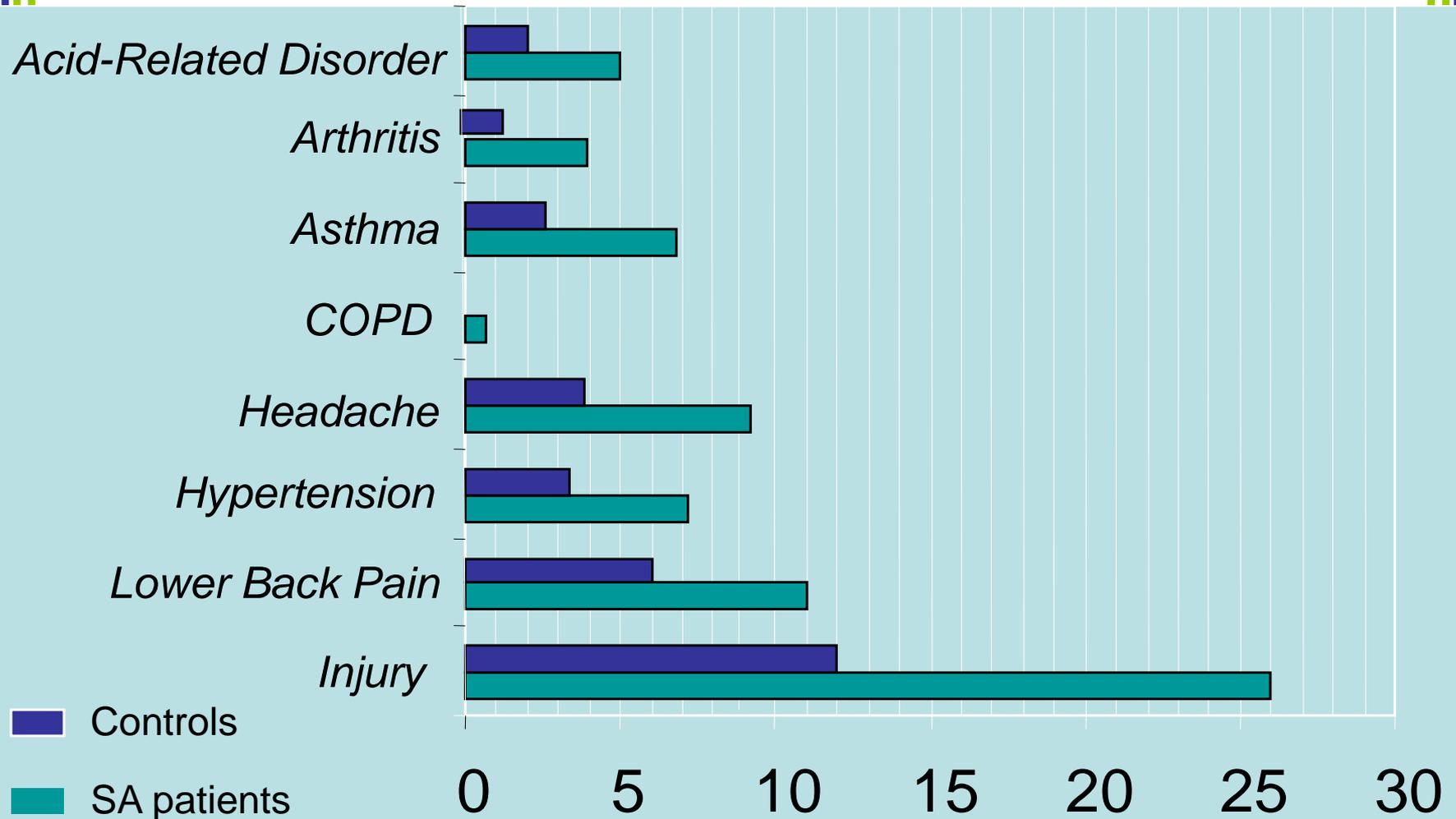
Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data*

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%

Kaiser SU Study: Approach & Rationale

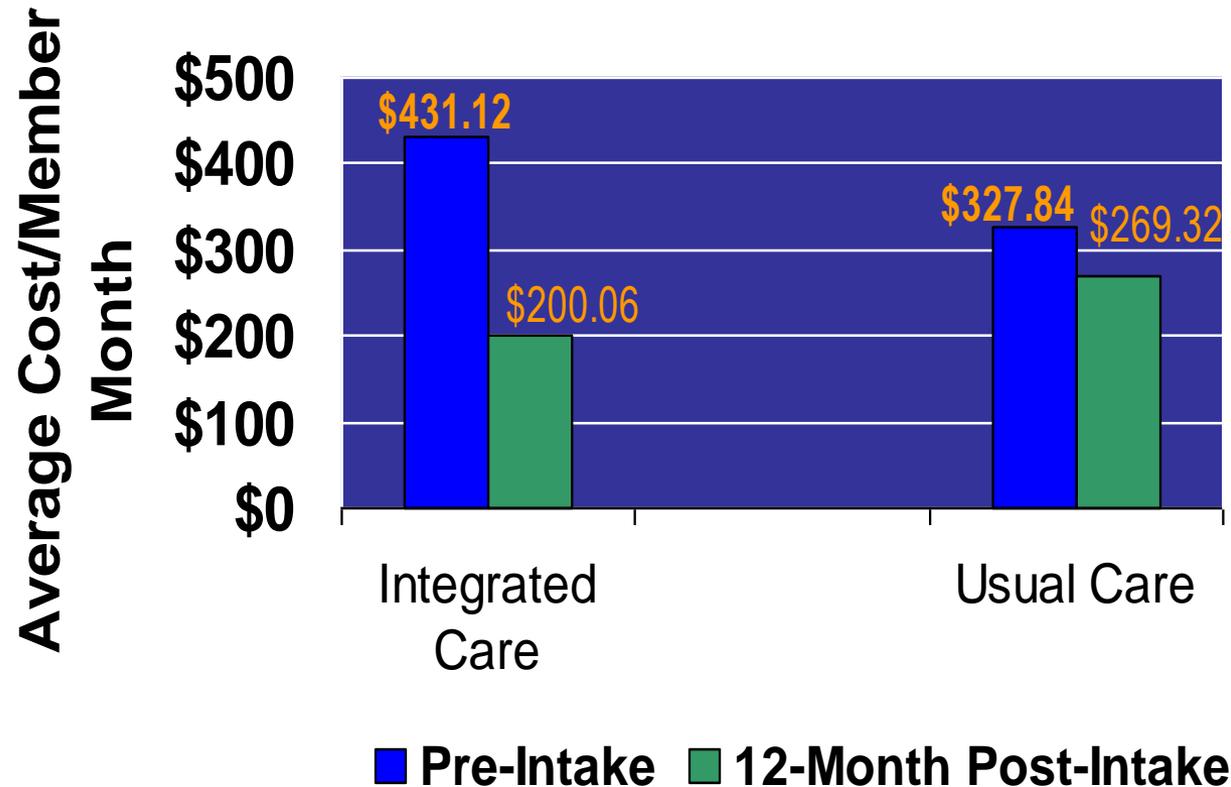
- Context of a health plan
 - Employers are primary purchasers
- Alcohol and drug problems as primary problems and as risk factors for other health conditions
- Treatment can be effective
- Not treating them causes lack of improvement in other health conditions (and problems in work productivity)
- Not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

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 SU Conditions on Healthcare Cost of Family Members

- Kaiser Permanente Northern California: Analysis of the medical conditions and costs of family members of individuals with SU conditions using historical data
- Pre-treatment, families of all SU 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 SU services, if family member w/SU condition were abstinent at 1 year, family members had similar average PMPM medical costs as control group
- Family members of SU 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.

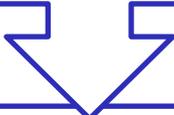
(\$14,365 per person per year compared with \$3,914.)

Making the Case Still More Compelling...

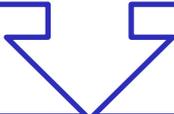
- “if a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders **via an effective integrated medical-behavioral healthcare program**
 - \$5.4 million of healthcare savings could be achieved for each group of 100,000 insured members
 - the cost of doing nothing may exceed \$300 billion per year in the United States.” [Note: this analysis based on commercially insured population]
- Chronic conditions and comorbid psychological disorders, Milliman Research Report, July 2008

Improve the Health of the Population

People with type 2 diabetes have nearly double the risk of depression.



Depression in diabetic patients is associated with poor glycemic control, increased risk for complications, functional disability and overall higher healthcare costs.



There are treatment protocols that can double the effectiveness of depression care resulting in improved physical functioning and decreased pain.

Reduce, or at Least Control, the Per Capita Cost of Total Healthcare

Proven MH/SU treatments and protocols, often integrated with primary care, have been shown to improve health status and reduce total healthcare expenditures, while others improve health status without adding additional costs.

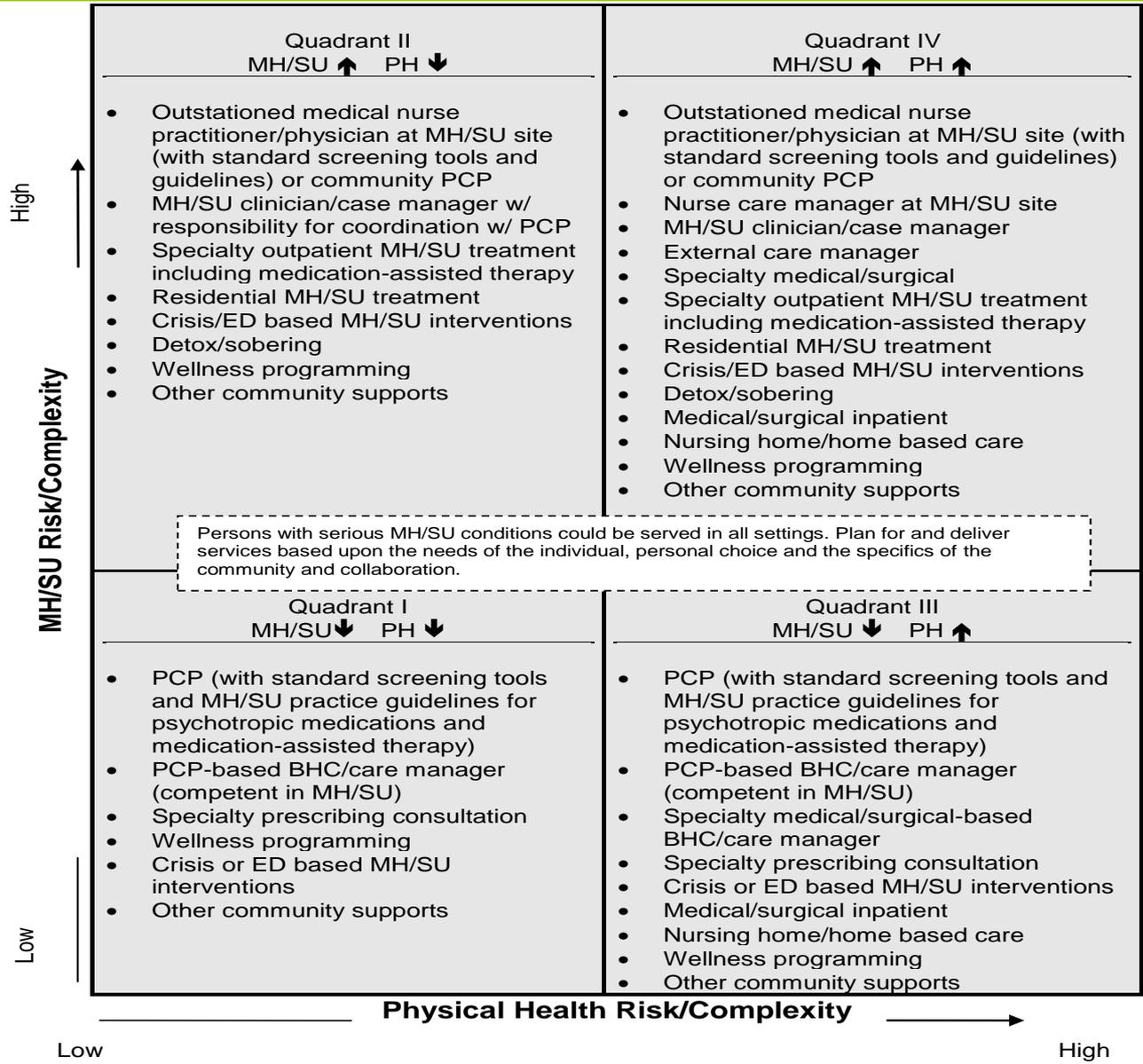
A Kaiser Northern California study showed that those who received SU treatment had a 35% reduction in inpatient cost, 39% reduction in ER cost, and a 26% reduction in total medical cost, compared to control group.

Depression care management for Medicaid enrollees can reduce overall healthcare costs by \$2,040 per year with impressive reductions in emergency department visits and hospital days.

Bi-Directional Care Planning: Behavioral Health Integrated into Primary Care and Primary Care Integrated into Behavioral Health

Planning Using the Four Quadrant Model





Mental Health and Substance Use in California's Bridge to Healthcare Reform 1115 Waiver



Key Programmatic Elements

- Four main elements that represent a restructuring of Medi-Cal and the healthcare system in California:
 - Expand coverage to more uninsured adults;
 - Support uncompensated care costs;
 - Improve care coordination for vulnerable populations; and
 - Promote public hospital delivery system transformation.

Potential Mental Health Focus

- Low Income Health Plans
- Medicare Medi-Cal Dual Eligibles
- Seniors and Persons with Disabilities
- Person Centered Healthcare Homes
- Multiple Chronic Conditions
- Home and Community Based (1915i)
- Money Follows the Person

Low Income Health Program

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

Waiver Conditions

- No state funds: County provides match
- Minimum MH benefits (required for MCE only):
 - Must be diagnosed MI & meet medical necessity
 - Up to 10 days inpatient including PHF per year
 - Psychiatric pharmaceuticals
 - Up to 12 outpatient encounters per year; may be assessment, individual or group therapy, crisis intervention, medication support/assessment

Waiver Conditions

- **Benefits beyond the Minimum:**
counties may propose to establish a scope of benefits that includes additional Medicaid eligible benefits beyond this minimum and receive federal funding under the Demonstration project.
- Can include substance use services

Waiver Conditions

Behavioral Health Services Assessment - By March 1, 2012, the State will submit to CMS for approval an assessment that shall include information on available mental health and substance use service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements, current levels of behavioral health and physical health integration 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, including how the State will coordinate with the Department of Mental Health and Alcohol and Drug Programs outlining the steps and infrastructure necessary to meet requirements of a benchmark plan no later than 2014.

County Planning

- Counties Planning to Submit a LIHP including MH Benefit: 22 +
- Many expanding the MH Benefit
- Counties Planning to Submit a LIHP including MH and some level of SU: 12
- Most Small Counties through CMSP
- Most ALL Counties working on Integration of Primary Care and Mental Health

Dual Eligibles (Medicare/Medi-Cal)

- 2011 – Work w CMS Center for Medicare & Medicaid Innovation & CA stakeholders
 - Draft RFI; Revise proposal; Draft RFP
- 2012 - Counties to submit proposals, pilots selected, pilots begin
- 52% of Dual Eligibles have a Psychiatric Disorder
- **MH must be involved in planning**

Managed Care for Seniors and Persons with Disabilities (SPDs)

- Plan to move Medi-Cal enrollees who are Seniors or Persons with Disabilities (SPDs) into mandatory managed care
 - Goal to provide more coordinated care and contain costs.
 - State must meet specific requirements in order for this transition to managed care to take place.
- 49% of persons w disabilities have Mental Illness
- 35.9% of seniors have Mental Illness
- **MH must be involved in planning**

Additional Recommendations

- MH Work Group
 - Review additional opportunities to develop systems to address current inadequacy, federal funding, address the triple aim
- Reduce Structural Barriers to integration between Primary Care, MH & SU
 - Standards, staffing requirements, financing, billing mechanisms, reporting, information sharing

Additional Recommendations

- Include MH/SU expertise in planning for Health Insurance Exchange Benchmark plans
- State Depts of Managed Care and Insurance need to develop policies and enforcement for parity