

The Business Case for Behavioral Health in Coverage Expansion and Emerging Models



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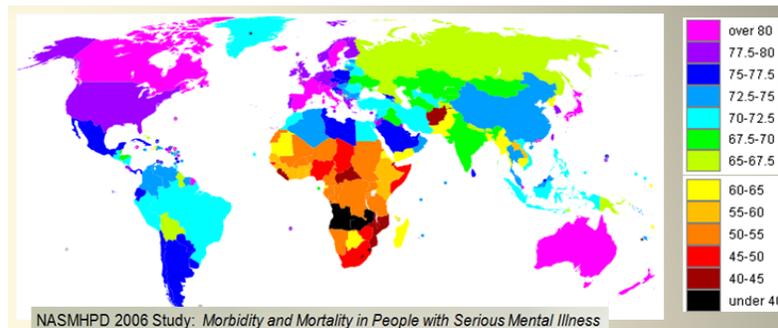
People with Mental Illness Die Younger

- 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
- Substance Use loses 5 more years: average life span 48 years old

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

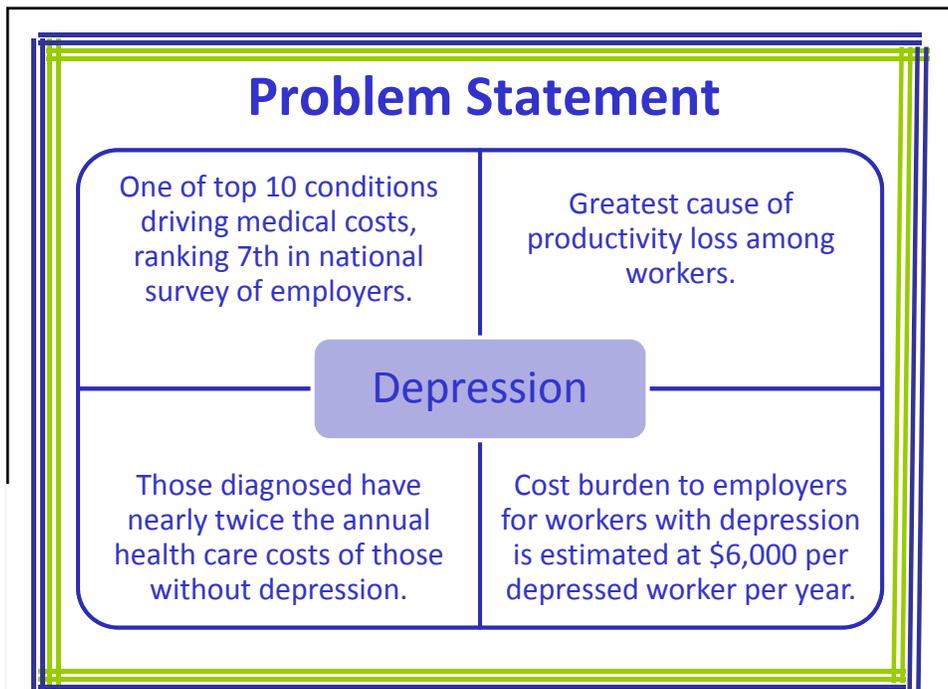
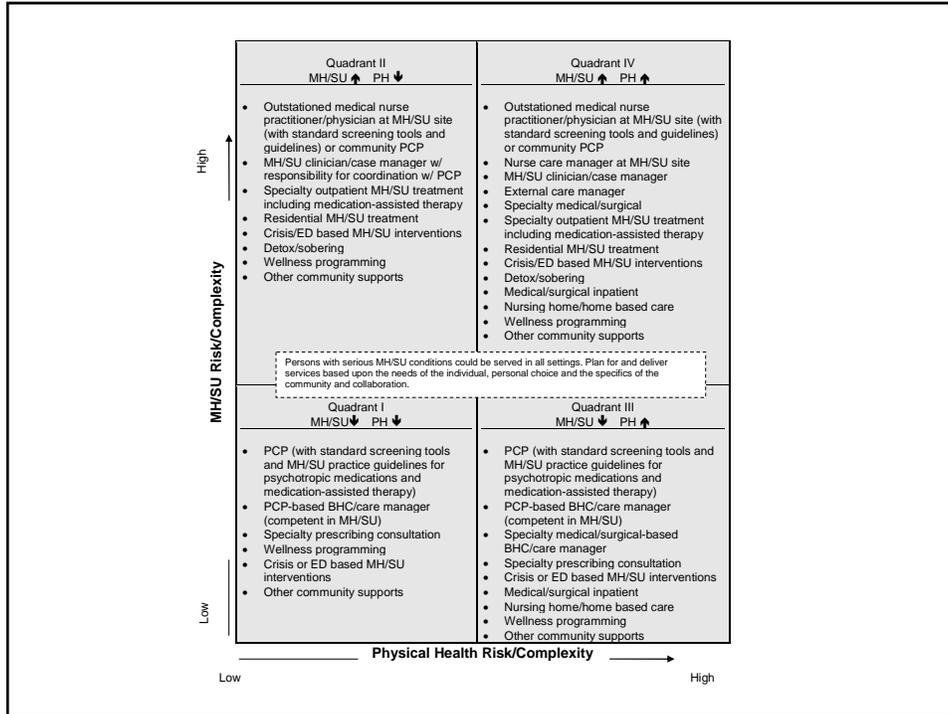
Putting it in Perspective

- 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



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



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
- 45% of Medicaid beneficiaries with disabilities have 3 or more chronic conditions

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

Faces of Medicaid III (cont)

- 49% of Medicaid beneficiaries w disabilities have psychiatric illness
- 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

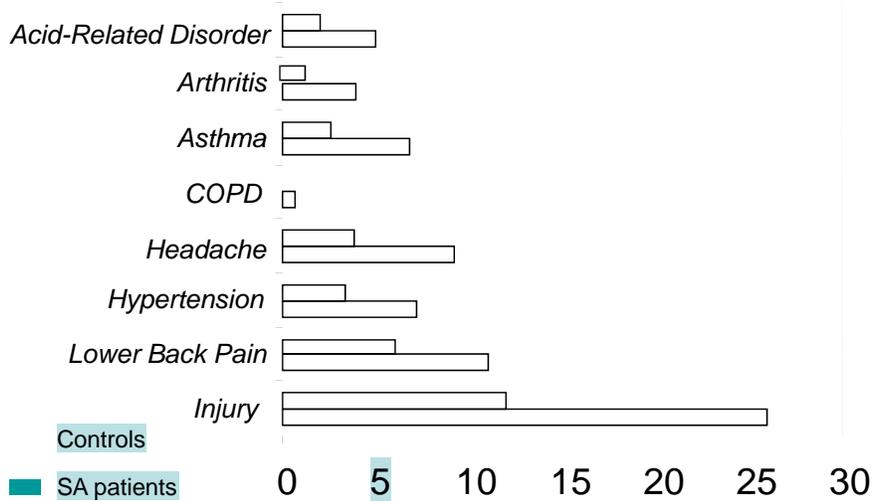
Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data*

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

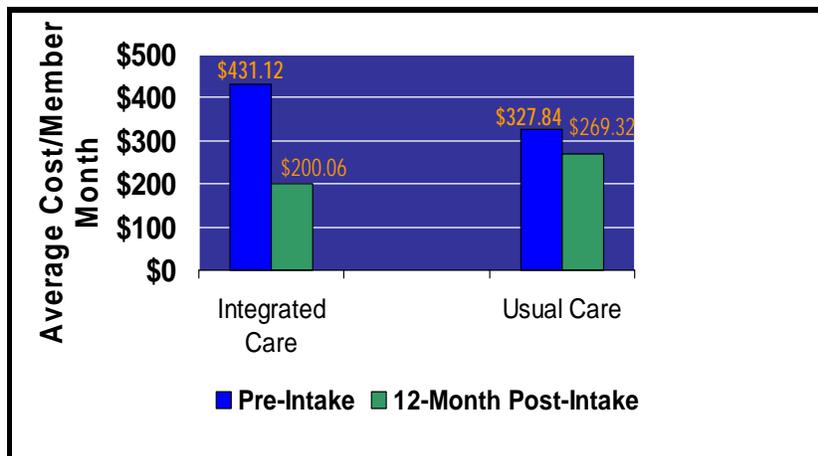
Prevalence in Substance Abuse Patients Vs. Matched Controls



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

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 SU Conditions on Healthcare Cost of Family Members

- 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 medical costs dropped to mirror control group

Washington State: Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment

A two-dollar return per dollar invested . . .

Treatment Costs Associated with Increased Penetration above SFY 2004 Baseline				
GA-U (Disability Lifeline) Medical Savings				
Medicaid Disabled Skilled Nursing Facility Savings				
Medicaid Disabled Medical Savings				
SFY 2006	\$8,365,576	\$752,436	\$1,117,406	\$8,754,315
SFY 2007	\$8,752,190	\$2,568,900	\$1,371,234	\$11,909,113
SFY 2008	\$16,447,831	\$5,361,223	\$2,640,657	\$14,892,548
SFY 2009	\$48,422,203	\$6,789,913	\$4,833,062	\$16,288,973
4-year totals			\$107,422,631 <small>Sum of first three columns</small>	\$51,844,948 <small>Total from above</small>
Return on Investment				\$2.07

- <http://www.uclaisap.org/Affordable-Care-Act/assets/documents/health%20care%20reform/Financing/Bending%20the%20Health%20Care%20Cost%20Curve%20by%20Expanding%20Alcohol-Drug%20Treatment.pdf>

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

CA Emerging Models of Integration

CiMH Survey & Web Site

- Web site to share types of integration; components of development
- Based on county survey
- In progress; live in 2 weeks

Levels of Integration

- Minimal collaboration: MH providers and PC providers work in separate facilities, have separate systems, and communicate sporadically - 0 counties
- Basic collaboration at a distance: PC & BH providers have separate systems at separate sites, but engage in periodic communication about shared patients. Communication occurs by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems. – 7 counties

Levels of Integration

- Basic collaboration on-site: Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture. – 4 counties

Levels of Integration

- Close collaboration in a partly integrated system:
MH professionals and PC providers share the same facility; have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among BH & PH providers. There is a larger team in which each professional appreciates his or her role in working together to treat a shared patient.
- 3 counties

Levels of Integration

- Close collaboration in a fully integrated system:
The mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care. – 3 counties

Not all counties have reported

Planning/Assessment

- Using four quadrant model for planning: 14 counties
- Assessment Process:
 - People In Progress, Los Angeles County - Client self report questionnaire
 - City of Berkeley – clinical assessment
 - People In Progress, Los Angeles County - Client self report questionnaire
 - Modoc County - Currently using a PN at the MH site, but will use a referral/collaborative communication model once a physical assessment is completed by their public health nurse as needed.

Planning/Assessment

- Placer County – If the individual is SMI then specialty MH is provided. As the individual becomes stable then transitioned to their PC physician. If they do not have a PC we assist them to identify someone
- Riverside County - 1) Psychiatric services are available at PC outpatient site that is integrated. Any physical health problem and any mh problem/ psychotropic medications are treated. 2) Serious mental illness (SMI) Mental Health Clinic as a medical home, and 3) Medicated assisted substance abuse treatment is integrated with community primary care provider.

Planning/Assessment

- San Diego County - The paired provider model aims to provide continuity of combined behavioral health/primary care across the entire spectrum.
- Santa Cruz County - Will be using a shared assessment, SBIRT and PHQ9, as a part of their LIHP

NOT ALL COUNTIES HAVE REPORTED