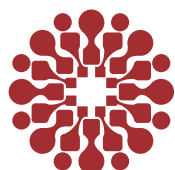


THE 2017 EDITION



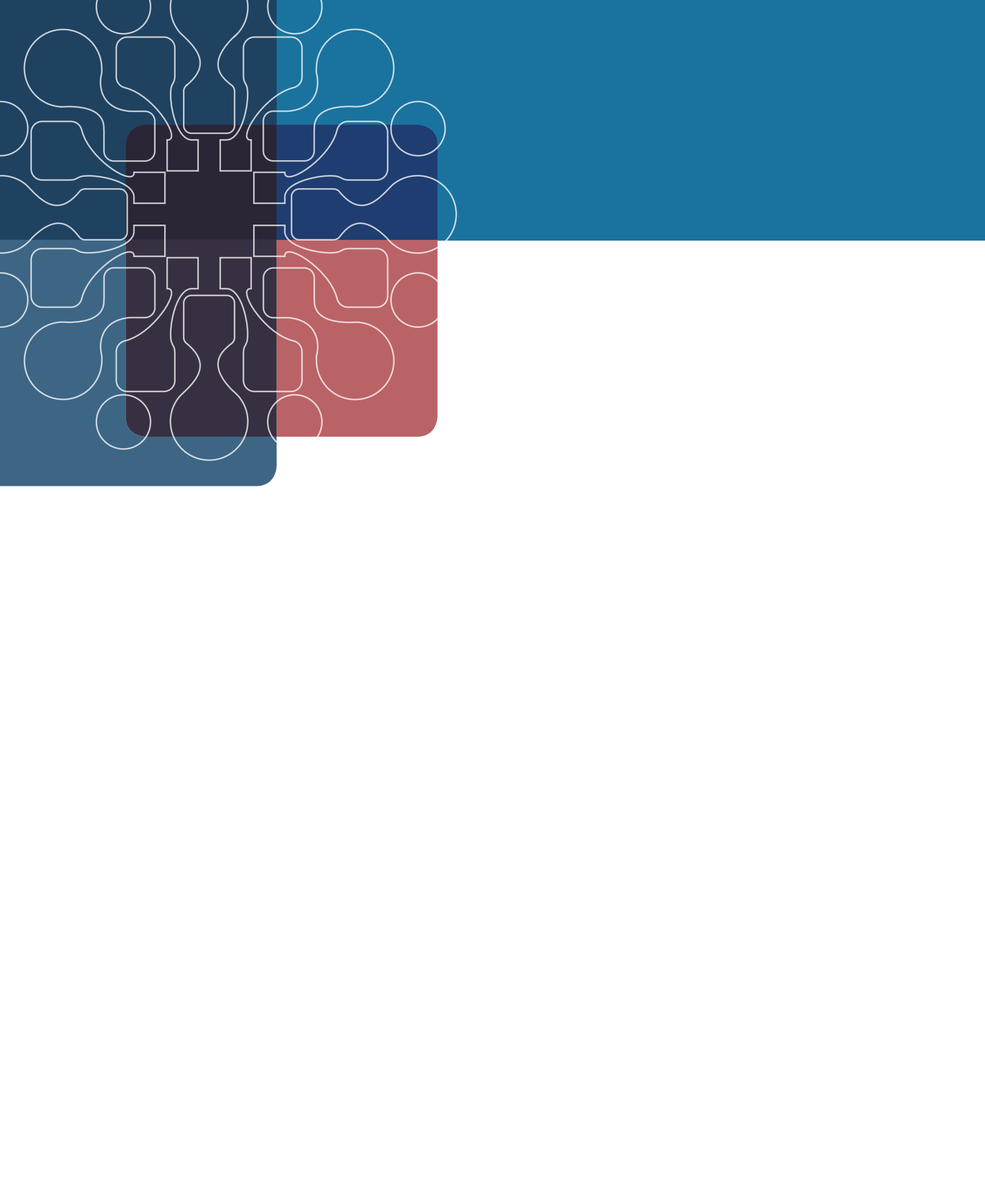
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TRENDS IN BEHAVIORAL HEALTH:

A Reference Guide on the U.S. Behavioral
Health Financing & Delivery System

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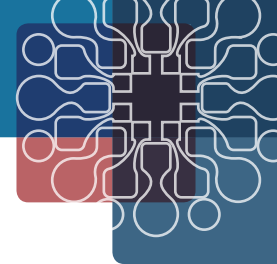
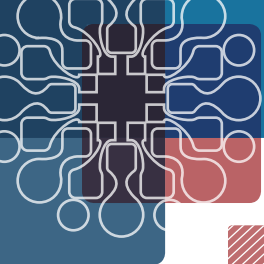


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EXECUTIVE SUMMARY

This 2017 first edition of *Trends in Behavioral Health: A Reference Guide on the U.S. Behavioral Health Financing & Delivery System* (The Guide) provides information and insights into the multi-layered United States behavioral health system. The Guide includes a snapshot of current statistics, current issues, and emerging trends in order to inform the discussions, debates and decision-making of policy-makers, payers, providers, advocates and consumers in today's dynamic health care environment. It begins with the national policy context that is shaping the U.S. health and human services market – and by extension the behavioral health market. The Guide then focuses on the unique state behavioral health delivery systems that were created by a combination of historical practices, federal and state policy, and market factors over the past years. It also examines the practices of health plans that now manage the health care and behavioral health care for over 75% of the U.S. population. Finally, The Guide looks at behavioral health from the consumer perspective in terms of access to inpatient services, quality of care and the performance of the health plans in managing these services.

Overall, there are several trends that are having a profound impact on behavioral health financing, service system delivery and outcomes that are worth noting:

- National health care policy, specifically as related to Medicaid and Medicare, as well as current market trends establish the parameters for behavioral health financing and the behavioral health service delivery. With the majority of consumers with serious mental illness (SMI) covered by public payers, Medicaid and Medicare policy initiatives have the largest impact for this population.
- The national mental health market is moving towards a more comprehensive, value-based system of care. Federal policy is focused on developing better and more cost-effective use of available behavioral health funding to manage access, quality, and thus value of care. Alternative payment models, the end of the Institutions for Mental Disease (IMD) exclusion, coordination of care codes, and delivery system reform and modernization all seek to improve the delivery, integration, and reimbursement of care.
- Overall, health insurance coverage nationally has turned to managed care models to address cost, access, and quality of care. Virtually all individuals with commercial coverage and over 70% of individuals with coverage through Medicaid are in managed care plans. Currently, only about 30% of individuals with Medicare have opted into Medicare Advantage managed care plans.
- Medicaid is the primary payer for behavioral health services, and as the main payer serving the SMI population, state Medicaid programs serve as an important barometer for the behavioral health market. An examination of state-level policy finds two important trends – an increase in behavioral health financing integration into health plans and the emergence of consumer specific specialty health plans focused on the medical and behavioral health needs of the SMI population.
- State Medicaid programs have adopted a number of care coordination and integration initiatives that serve not only consumers with complex medical conditions, but also consumers with behavioral health conditions. There are 41 states with at least one behavioral health care coordination initiative including patient-centered medical home, health home, accountable care organization (ACO), dual demonstration, and certified community behavioral health clinic (CCBHCs) models.

- Behavioral health integration is becoming a greater priority as the health care system improves consumer access, customer satisfaction, and consumer engagement. Payers and providers are increasingly managing high-cost and high-risk groups through population health management innovations that close the gap between members' medical and behavioral needs through evidence-based practices and technologies that increase access to care and empower active individual participation in attaining health goals.

It is clear that national and state policies and practices have surpassed the initial efforts to advance behavioral health, underscoring a greater understanding of its effects on not just the cost of treatment, but more broadly on population health and wellness. The emergence of technology and evidentiary treatment models enable health systems to tailor value-based service delivery models that focus on the access and engagement needs of varying demography and chronic conditions. With these new provisions and innovations, there is more opportunity for person-centered and integrated high-quality health care to be placed firmly at the center of the new value equation.