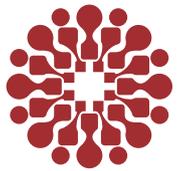
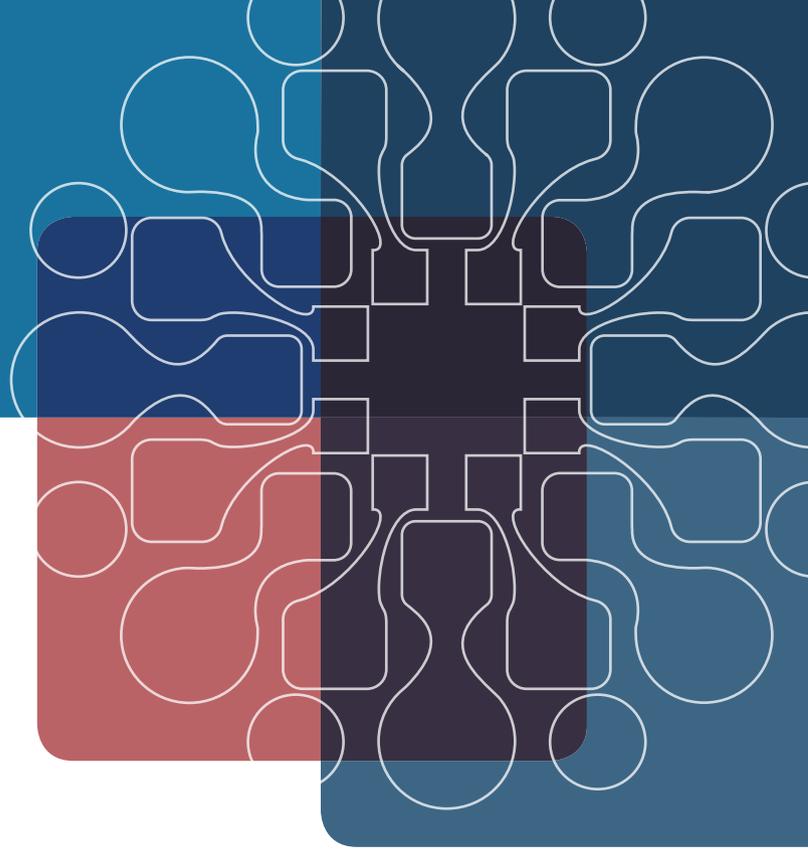


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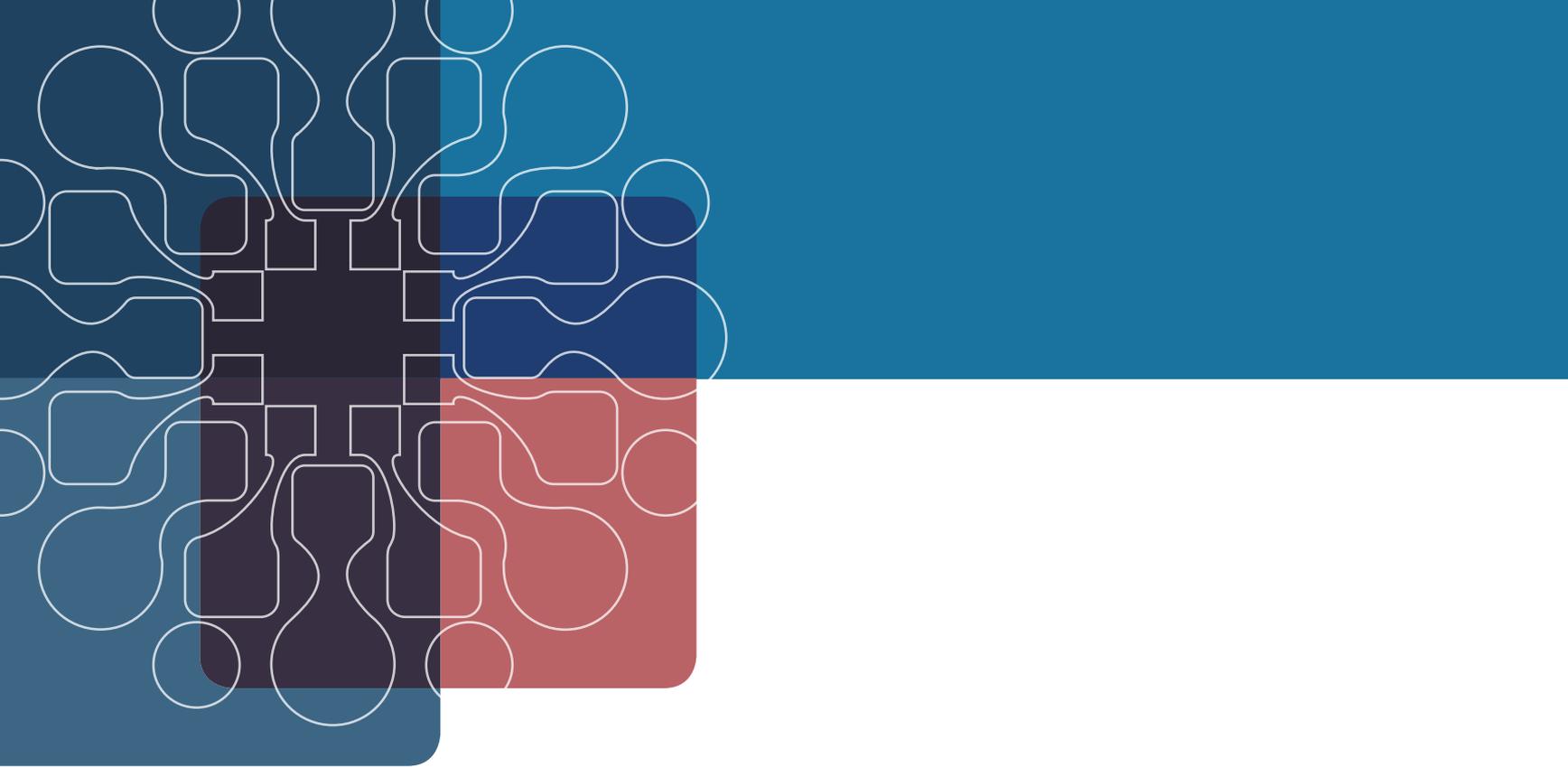


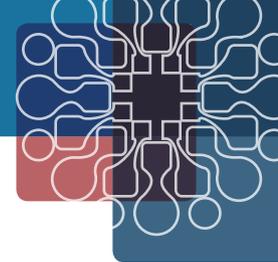
## TRENDS IN BEHAVIORAL HEALTH:

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

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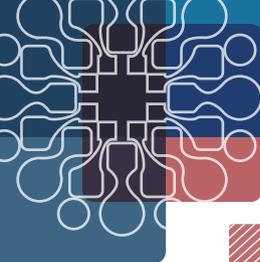




## TABLE OF CONTENTS

<b>I. Executive Summary</b>	<b>6-7</b>
<b>II. National Behavioral Health System Landscape</b>	<b>8-15</b>
• Executive Summary	8
• U.S. Health Care Coverage Trends	8-9
• Federal Behavioral Health Policy Initiatives	10-12
• Veterans and Behavioral Health Care	12-15
<b>III. State Behavioral Health Financing and Service Delivery Systems</b>	<b>16-23</b>
• Executive Summary	16
• State Behavioral Health Systems Typology Chart and Medicaid Behavioral Health Financing Arrangements	16-17
• State Behavioral Health Care Coverage and Reference Chart	19
• State Medicaid Financing Systems for the SMI Population	19
• State Innovation Initiatives and Reference Chart	20-23
<b>IV. Health Plan Population Health Management</b>	<b>24-29</b>
• Executive Summary	24
• Health Plan Current and Future Use of Analytics in Identification and Early Intervention of High Risk Consumers	24
• Health Plan Current and Future Use of Innovations in Improving Consumer Access to Behavioral Health Treatment Strategies	25-26
• Health Plan Current and Future Use of Behavioral Health Consumer Engagement Strategies	26
• Health Plan Current and Future Use of Models to Improve Coordination of Care for Consumers With Behavioral Health Conditions	27
• Health Plan Current and Future Use of Behavioral Health Strategies For Ensuring Quality of Care	28
• Health Plan Current and Future Use of Behavioral Health Provider Partnership Models	29
<b>V. Consumer Access and Delivery of Care</b>	<b>30-37</b>
• Executive Summary	30
• Consumer Access to Behavioral Health Care	30-33
• Behavioral Health Care Quality	34-37
• The Centers for Medicare and Medicaid Services Quality Measures	37
<b>VI. Additional Resources</b>	<b>38</b>
<b>VII. Sources</b>	<b>39-46</b>





## 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.



Over the past several years, the health care system has been driven by the pursuit of three goals: improving the health care of the population as a whole, improving the consumer care experience, and reducing the per capita cost of health care – also known as the “triple aim.”<sup>1</sup> In accordance with these goals, health plans have developed new population health management strategies that focus on improving consumer access to care, consumer engagement, care coordination for consumers with behavioral health conditions, and quality of care in behavioral health.<sup>2</sup>

Many of these new strategies are focused on addressing the support needs of consumers with complex care conditions who are the 5% of the population using almost half of U.S. health care resources.<sup>3</sup> To identify these consumers, health plans are increasingly using analytic capabilities for population segmentation. Over 90% of health plans are using analytic tools to identify complex consumers – and 94% of health plans are using analytics to identify consumers with serious mental illnesses.<sup>2</sup>

Using population segmentation data, health plans are adopting a wide range of strategies to improve the health outcomes and better manage the resource use of complex consumers with behavioral conditions.<sup>2</sup>

In addition to implementing targeted strategies for managing high needs consumers with behavioral health conditions, the provider reimbursement models used by health plans are also changing. Health plans are linking reimbursement to improved value – focused on reducing costs while improving health outcomes.<sup>4</sup>

## HEALTH PLAN CURRENT AND FUTURE USE OF ANALYTICS IN IDENTIFICATION AND EARLY INTERVENTION OF HIGH RISK CONSUMERS

As we move into a new era of health care, built on value and enhanced care coordination, the use of data and analytics is key to improving financial and clinical outcomes. Through a combination of clinical, financial, and operations data, payer and provider organizations can utilize analytics to segment consumers and stratify risk to help understand the needs of the population so that services can be better planned and delivered. Once segmented, best practice interventions can be targeted to meet the needs of a specific population.<sup>5</sup>

Across all payer groups, Medicare, Medicaid, and commercial, health plans have widely adopted the use of analytics for

identification and early management of consumers in need of behavioral health interventions. Over 90% of all health plans report the use of analytics for identification and early management of high-risk consumers in need of behavioral health interventions. Nearly 95% report use of analytics for identification and early management of consumers with serious mental illness (SMI). These numbers are indicative of the greater depth of understanding and acceptance by health plans that behavioral health conditions greatly impact the health and wellness of the populations they manage.<sup>2</sup>

**Figure 11** Use of Analytics in Identification and Early Management of High-Risk Consumers in Need of Behavioral Health Interventions, by Plan\*<sup>2</sup>



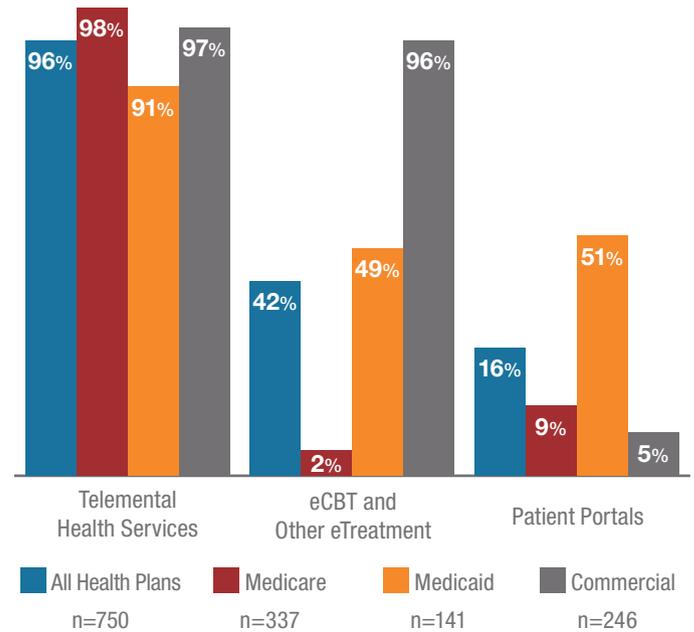
\*TRICARE and Medicare-Medicaid health plans are included in all health plan responses; however, due to low response rate, these plan types are not illustrated as subcategories nor included with other health plan types.

## Use of Analytics in Identification and Early Intervention of High-Risk Consumers with Behavioral Conditions



Figure 12

## Current Use of Technology-Based Innovations in Improving Consumer Access to Behavioral Health Treatment by Plan Type<sup>2</sup>



## HEALTH PLAN CURRENT AND FUTURE USE OF INNOVATIONS IN IMPROVING CONSUMER ACCESS TO BEHAVIORAL HEALTH TREATMENT

Consumer access to services is a critical component to achieving positive health outcomes. Access to services is determined not only by the ability to gain entry into the health care system, the geographic location of services, and availability of clinical professionals to meet the needs of the consumer – but also access to high quality evidence-based care.<sup>6</sup> New innovations in service delivery seek to improve consumer access to behavioral health treatment by closing gaps in care and alleviating health care costs.<sup>7</sup> Innovations fall into two main categories, technology-based solutions and community-based treatment solutions. Technology-based interventions include tools such as telemental health, online therapy, and consumer portals.<sup>7,8</sup>

Among health plans, telemental health services are the most widely adopted technology-based innovation, with more than 96% of health plans reporting that they currently utilize telemental health services.<sup>2</sup> This widespread adoption points to an increasing market maturity and less restrictive state

reimbursement policies. These factors, in combination with workforce shortages among psychiatrists and studies that demonstrate positive telemental health outcomes, have led to widespread acceptance of telemental health as an effective means of service delivery to behavioral health consumers.<sup>9</sup>

The use of eCBT, or internet-based cognitive behavioral therapy, is less widely adopted than telehealth, with 41% of all health plans reporting use. Commercial health plans report the most widespread adoption of eCBT, with 96% of plans offering this service. Adoption among public sector payers is considerably lower, with 49% of Medicaid plans using eCBT and 2% of Medicare plans using eCBT.<sup>2</sup>

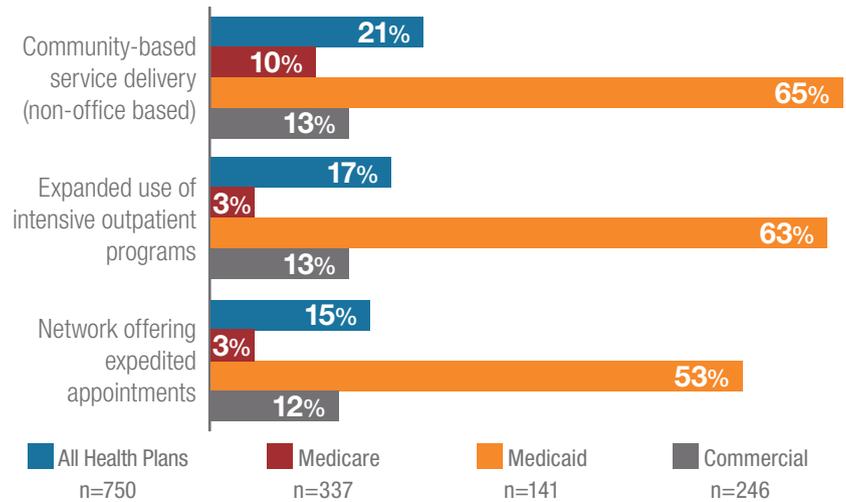
Health plans are utilizing consumer portals less frequently than other technology interventions, with 16% of all health plans reporting adoption of consumer portals for their enrollees. Among all plans, Medicaid reported the highest usage of consumer portals at 51%.<sup>2</sup>



Community-based treatment solutions include networks offering expedited appointments, expanded use of intensive outpatient programs, and expanded use of community-based service delivery, such as assertive community treatment or peer support services.<sup>7,10,11</sup> These types of innovations have not been as widely adopted as technology-based solutions. A little over 20% of health plans report the use of community-based service delivery, 17% report expanded use of intensive outpatient programs, and 15% report having networks offering expedited appointments. Adoption of these initiatives is higher in Medicaid than among other payers. For example, 63% of Medicaid plans have adopted expanded use of intensive outpatient programs while 13% of commercial plans and 3% of Medicare plans have adopted this initiative.<sup>2</sup>

Figure 13

Current Use of Community-Based Innovations in Improving Consumer Access to Behavioral Health Treatment by Plan Type<sup>2</sup>



## HEALTH PLAN CURRENT AND FUTURE USE OF BEHAVIORAL HEALTH CONSUMER ENGAGEMENT STRATEGIES

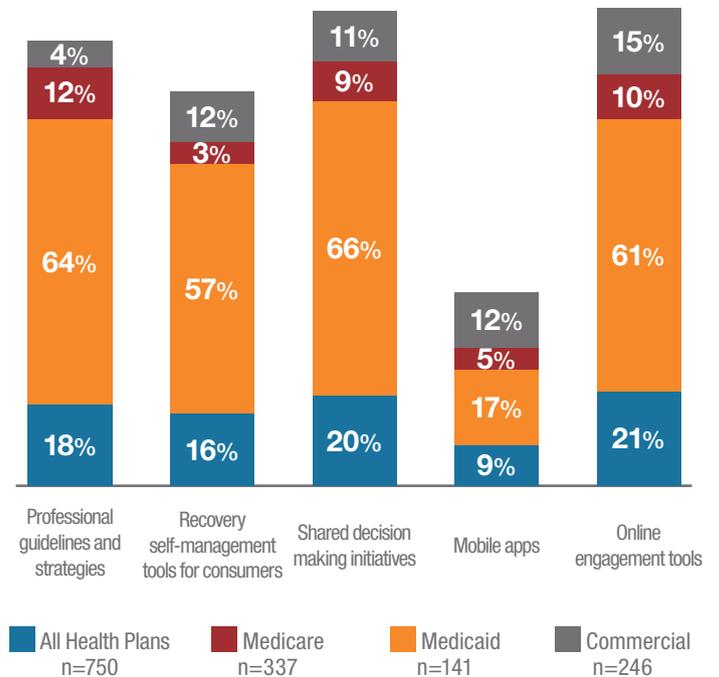
Successful consumer engagement is a strong predictor of retention and ongoing participation in treatment.<sup>12</sup> Engaged consumers take action to become better informed and more proactively involved in decisions and behaviors that affect their health, insurance coverage, and health care.<sup>13</sup> Engagement has multiple dimensions, which goes beyond treatment and includes wellness and connection to family, culture, and community.<sup>14</sup>

Health plans have adopted a wide range of strategies to increase the engagement of consumers with behavioral health disorders. Engagement strategies for consumers can include the use of online tools, recovery management tools, mobile apps, shared decision making initiatives, or guidelines and strategy for staff to better engage consumers and increase shared decision-making. How these different innovations help consumers, varies. For example, mobile apps are particularly helpful to individuals with chronic health care needs providing users medication reminders, refill alerts, and drug interaction warnings.<sup>15</sup> Shared decision-making allows consumers to partner in their care and help make informed treatment decisions.<sup>13</sup>

Adoption of consumer engagement innovations across health plans is low, with no more than 21% of health plans adopting any one innovation. Among payers, Medicaid health plans report the greatest overall current use of innovative engagement strategies – with more than 60% of plans reporting the use of online engagement tools, shared decision-making initiatives, and professional guidelines and strategies for consumers.<sup>2</sup>

Figure 14

Current Use of Behavioral Health Consumer Engagement by Plan Type<sup>2</sup>



## HEALTH PLAN CURRENT AND FUTURE USE OF MODELS TO IMPROVE COORDINATION OF CARE FOR CONSUMERS WITH BEHAVIORAL HEALTH CONDITIONS

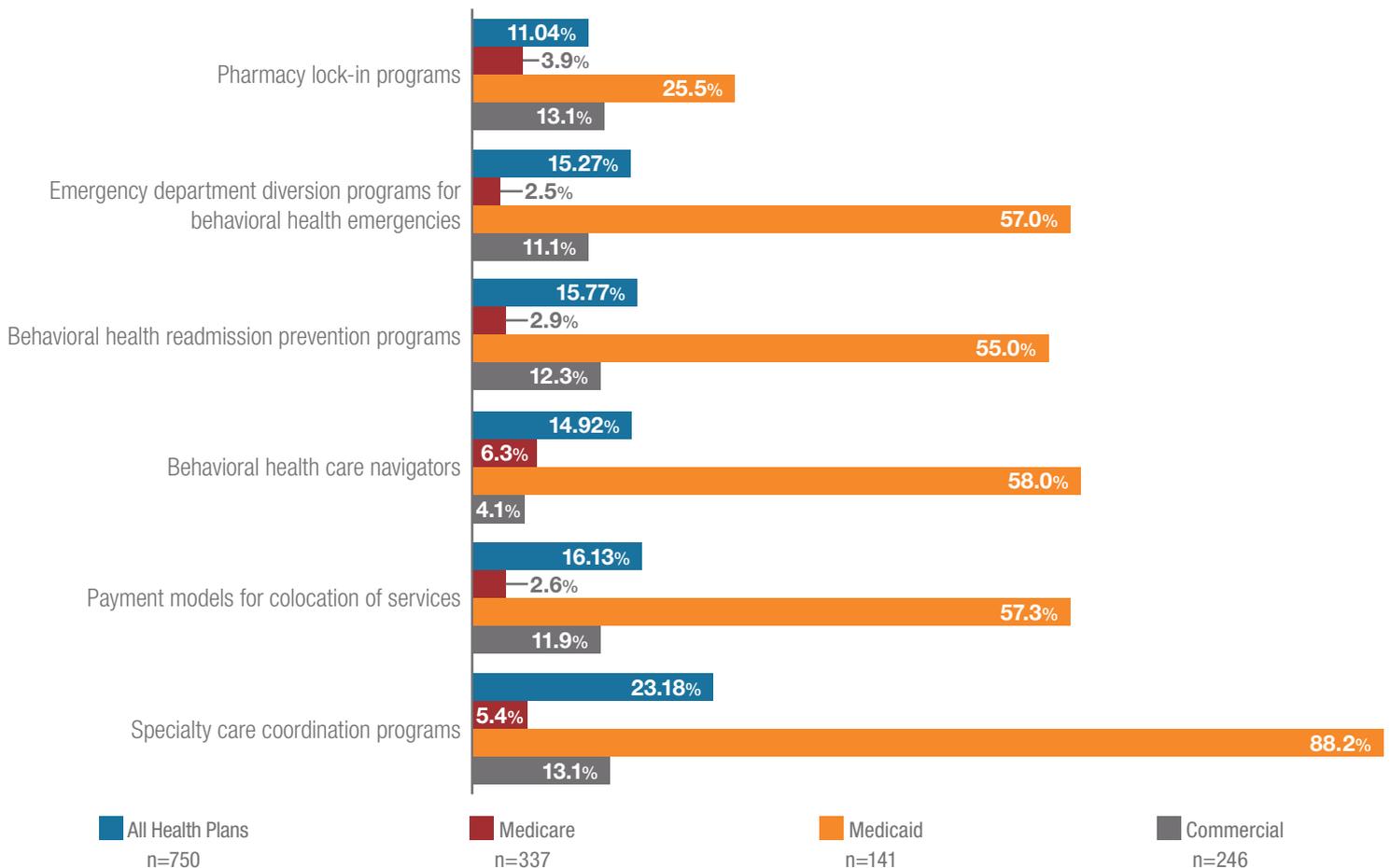
Value-based reimbursement and population health management are built on the premise that payers and provider organizations are focused broadly on the health of consumers. Care coordination has been identified by the Institute of Medicine as one of the key strategies for improving effectiveness and efficiency of the health care system.<sup>16</sup> Chronic medical illnesses such as heart disease, cancer, diabetes, and neurological disorders are frequently accompanied by behavioral health disorders. Due to the intertwined nature of these illnesses, coordination of all types of health care is essential.<sup>17</sup>

Health plans have adopted a wide range of models to improve care coordination for consumers with behavioral health disorders. These models range from specialty care coordination programs, such as a behaviorally-led medical homes; to

reimbursement for the collocation of physical and behavioral health services; to pharmacy lock-in programs, which limit what clinical professionals and pharmacies a consumer can visit.<sup>18,19</sup>

Specialty care coordination programs are the most adopted care coordination innovation across health plans, with 23% of plans reporting use of these types of programs. Least popular among the initiatives is the operation of pharmacy lock-in programs, with only 11% of health plans reporting use. Adoption of care coordination innovations is most popular among Medicaid plans compared to other types of health plans. For example, 88% of Medicaid plans report the use of a specialty care coordination program, compared to 13% of commercial plans, and 5% of Medicare plans.<sup>2</sup>

**Figure 15** Current Use of Models to Improve Coordination of Care for Consumers with Behavioral Health Conditions by Plan Type<sup>2</sup>



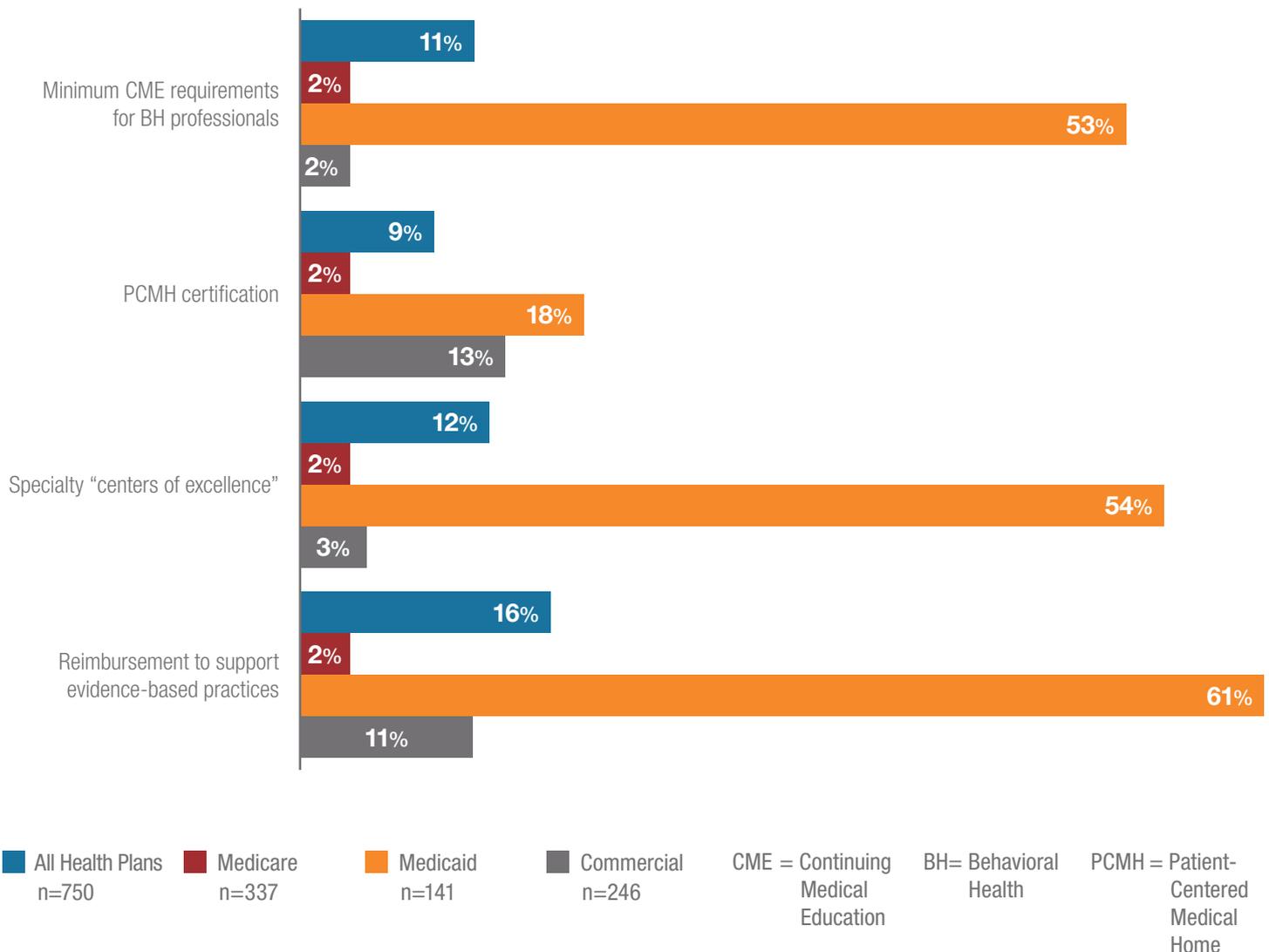
## HEALTH PLAN CURRENT AND FUTURE USE OF MODELS TO ENSURE QUALITY OF CARE FOR CONSUMERS WITH BEHAVIORAL HEALTH CONDITIONS

In addition to implementing programs focused on access, engagement, and coordination, health plans also use innovative strategies to ensure consumers are receiving high quality care. These strategies include reimbursement models built on evidence-based practices, such as intervention for first episode psychosis programs; or certification requirements, such as patient-centered medical home accreditation; or the formation of centers of excellence.<sup>20,21,22</sup>

Adoption by health plans of quality of care strategies that require certification or additional training were less likely to be

adopted than reimbursement strategies. About 12% of health plans have specialty centers of excellence, 11% have minimum continuing medical education (CME) requirements for behavioral health professionals, and only 9% require patient-centered medical home certification. Adoption of these requirements is much higher in Medicaid than in Medicare and commercial health plans. This may be due to the higher number of consumers with SMI being enrolled in Medicaid, resulting in a greater need for behavioral health interventions.<sup>2</sup>

Figure 16 Current Use of Behavioral Health Strategies to Ensure Quality of Care by Plan Type<sup>2</sup>



## HEALTH PLAN CURRENT AND FUTURE USE OF BEHAVIORAL HEALTH PROVIDER PARTNERSHIP MODELS

As part of the move towards greater care coordination, health plans are implementing alternative payment models (APMs) that promote better integrated care management for consumers with co-occurring conditions. APMs move away from traditional fee-for-service (FFS) reimbursement models to reimbursement models that take into account value and/or quality.<sup>23,24,25</sup>

Currently, the majority of health plans, 93%, have behavioral health provider partner models that utilize a FFS reimbursement structure that also includes a pay-for-performance (P4P) component.<sup>2</sup> Typically the P4P component either rewards or penalizes provider organizations for their reporting on quality measures.<sup>25</sup> In addition to this P4P model, the use of episodic or bundled payments for specific acute care episodes is gaining traction among certain payers with 42% of plans using this model.<sup>2</sup> Bundled payments is an “umbrella term” that includes all types of payments that group consumer costs into a single payment, irrespective of the kinds and quantities of the services provided. This includes global payments and other forms of episodic payments.<sup>24,25</sup> Among certain payers, the use of episodic payments varies dramatically. While 95% of commercial health plans use episodic payments, only 2% of Medicare health plans and 47% of Medicaid health plans use these payment arrangements for behavioral health.<sup>2</sup>

In the future, the likelihood that more health plans will adopt these behavioral health partnership models is thought to be slim. Among the plans that do not already have these types of APMs, only 1.2% of all health plans have plans to adopt episodic payments and 3.5% have plans to adopt FFS reimbursement with a P4P component. No Medicare and commercial health plans have plans to implement episodic payments. Medicaid health plans, on the other hand, may be much more likely to adopt new behavioral health provider partnership models in the future. 6% of Medicaid health plans have future plans to adopt episodic payments and 12% have plans to adopt a FFS reimbursement model with a P4P component.<sup>2</sup>

Figure 17

Current Use of Behavioral Health Provider Partnership Models by Model and Plan Type<sup>2</sup>

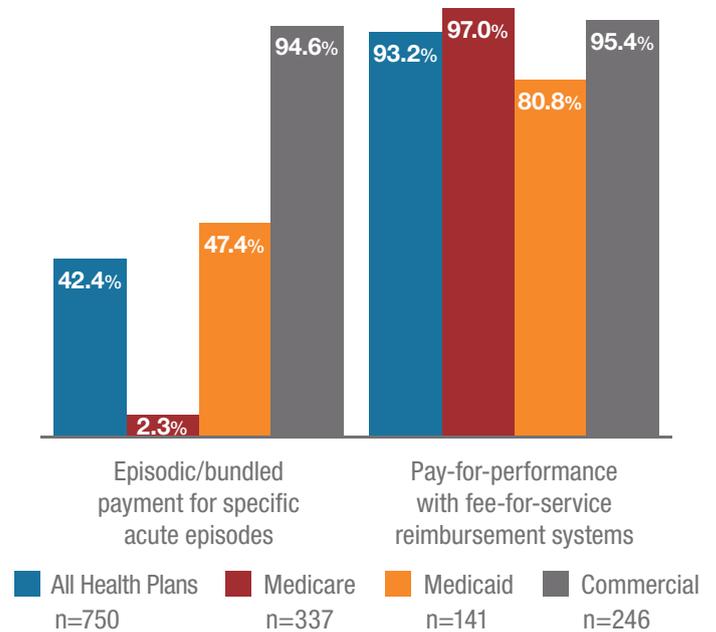


Figure 18

Future Use of Behavioral Health Provider Partnership Models by Model and Plan Type<sup>2</sup>

