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TRENDS IN BEHAVIORAL HEALTH:

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

Brought to you by

Otsuka Lundbeck

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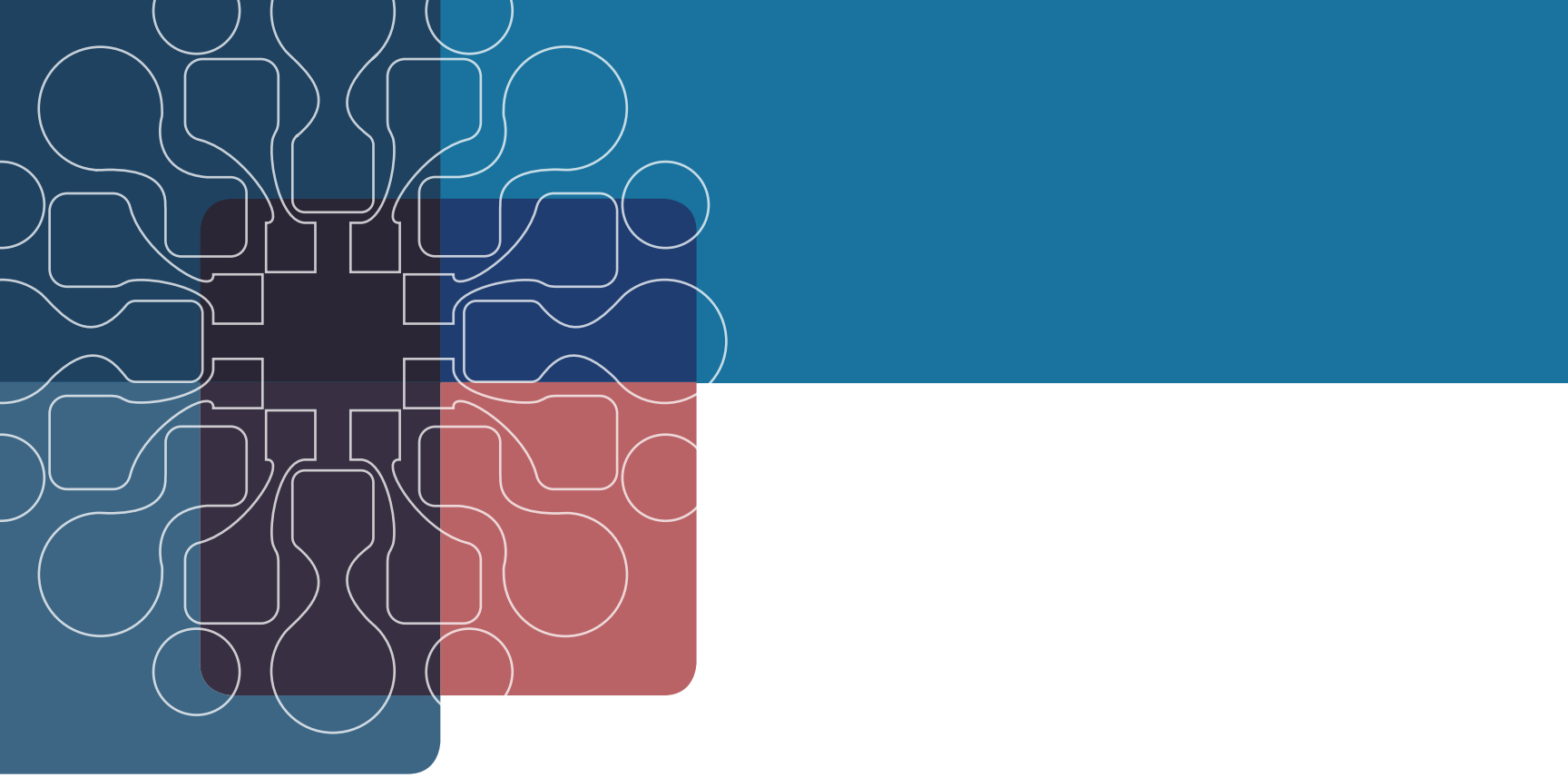

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EXECUTIVE SUMMARY

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.

An estimated 17.9% of adults in the United States have a mental illness (excluding substance use).[1] Of these 43 million Americans, about 43% of those surveyed in 2015 received treatment for mental health disorders in the past year.[2] The shifting health care market demands different financial and service delivery models with consumer access to high-quality care at the center of this new value equation. Despite this shift, questions remain about both whether consumers actually have adequate access to behavioral health treatment and the quality of that treatment. As the health care system shifts towards a more value-based, coordinated approach to care management and service delivery, maintaining and improving prompt access to high quality services is increasingly important.

Access to care is measured in several ways, including structural measures which facilitate care, such as having health insurance, or a usual source of care; assessments by consumers of how easily they can get health care services; and utilization measures, which include the successful receipt of needed services.[3] In considering the factors other than health insurance, the consumer is more likely to trust a clinical professional they are able to see consistently and without delay, and who are able to provide the services the consumer needs.[3] With regard to behavioral health, this means evaluating available psychiatrists and psychiatric beds. An analysis of current U.S. licensed psychiatrists and psychiatric beds reveals that while there is not currently a treatment gap for psychiatrists at the national level,[4] there is a shortage of psychiatric beds nationally.[5] Access to care at the state and local levels varies based on geography and population.

While adequate access to behavioral health professionals and services is crucial, the quality of those services is equally important. Quality of care also has several measures, including those related to structure, such as the number of providers to patients; to process, such as the number of people who received a certain screening; and to outcome, such as rate of adherence or complications.[6] While outcome measures may seem to represent a "gold standard" when considering quality, they are the result of numerous other factors,[6] including the preceding structural and process factors. Measuring behavioral health quality is still a new development, and selecting key behavioral health quality indicators is complicated.[7] The National Committee on Quality Health Assurance (NCQA) Healthcare Effectiveness and Data Information Set (HEDIS) is used by more than 90% of America's health plans to measure performance,[8] and the Centers for Medicare and Medicaid Star Ratings System is the Medicare counterpart for measuring quality and performance.[9] While these performance measurement systems have historically focused on physical health care, in recent years there is an emergence of a small number of measures specific to behavioral health quality and consumer access to health care. NCQA analysis of these behavioral health measures has found health plan performance on the measures to be mixed.[10] While some behavioral health measures have seen performance gains, others have seen performance declines.[11,12,13,14]

Positive treatment outcomes in behavioral health are dependent on consumer access to quality care.[15] The value evolution in health care will continue to drive the need for improved outcomes, which requires consumers to have access to effective treatment, dedicated care coordination, and high-quality health care professionals.

CONSUMER ACCESS TO BEHAVIORAL HEALTH CARE

While the location of treatment service delivery is shifting, consumers require a full behavioral health treatment continuum – with services ranging from acute inpatient services to outpatient and home-based services.[16] A proxy indicator for access to a robust treatment continuum is the number and distribution of both licensed psychiatrists and psychiatric beds. Analyses show that while there is not a shortage of psychiatrists at the national level (while geographic distribution is an issue), there is a shortage of psychiatric beds nationally.[5]

Consumer Access to Psychiatrists

The Health Resources and Services Administration (HRSA) define an adequate number of psychiatrists as one per 30,000 population.[17] Analysis of the 2014 HRSA database of licensed psychiatrists, found that at both the national and state level, the U.S. exceeds this criteria. Nationally, there are an estimated 4.3 psychiatrists per 30,000 people. At the state level, Idaho and Wyoming have the fewest number of psychiatrists per 30,000 at 1.7 and 1.9 psychiatrists, respectively. Washington, D.C. and the Commonwealth of Massachusetts have the greatest number of psychiatrists per 30,000 at 17.3 and 10.8 psychiatrists, respectively.[4]

The number of psychiatrists per 30,000 is not the only indicator of access to psychiatric care. In spite of this distribution across the country, there are areas where the behavioral health care needs of children and seniors especially, may not be adequately served by current delivery models and whose behavioral health care demand may not be reflected in current utilization patterns.[15] Additionally, insurance coverage and a low income may effect a consumer's ability to access care.[15]

Consumer Access to Psychiatric Beds

The industry standard for an adequate number of psychiatric beds was developed by the Treatment Advocacy Center and is defined as 40 to 60 beds per 100,000 people, with a consensus around 50 beds.[16] While some states meet this criteria, the U.S. as a whole does not, with 29.8 beds (including acute care hospital designated psychiatric beds, state psychiatric hospital beds, and private psychiatric beds) per 100,000 people.[18] This number does not reflect the distribution of psychiatric hospital beds by state, Medicaid health care financing arrangements, or by bed type. There are 14 states that have at least 40 beds per 100,000 population, and four states that meet the threshold of 50 beds per 100,000 people.[18]

The type of psychiatric beds—private or state—also affect access to inpatient care. State hospitals are typically seen as a payer of last resort serving the most medically complex patients and those patients that will not be seen by other private provider organizations. Therefore differences in the number of beds per state can effect who receives care.[5] For example, while Iowa has 22.6 private psychiatric beds per 100,000 population, the state has only 2.0 public beds per 100,000 population. Comparatively, Nebraska has only 2.4 private beds per 100,000 population, but 15.2 public beds per 100,000 population.[18]

Figure 19a Psychiatric Beds and Psychiatrists per Population

State	Total Psychiatric Beds Per 100,000 People (2016)[18]	Private Psychiatric Beds Per 100,000 People (2016)[18]	State Psychiatric Beds Per 100,000 People (2016)[18]	Psychiatrists Per 30,000 People (2014)[4]
National	29.8	18.2	11.7	4.3
Alabama	32.7	24.8	7.9	2.5
Alaska	38.5	27.8	10.8	3.6
Arizona	14.8	10.5	4.4	3.2
Arkansas	53.2	45.7	7.4	2.8
California	18.7	3.7	15.0	5.0
Colorado	25.5	15.7	9.8	4.3
Connecticut	39.0	21.8	17.2	9.3
Delaware	46.7	33.9	12.8	3.5
District of Colombia	87.3	45.9	41.4	17.3
Florida	16.2	3.3	12.8	3.0
Georgia	21.8	12.6	9.2	3.0
Hawaii	25.6	11.4	14.1	5.8
Idaho	15.9	5.5	10.3	1.7
Illinois	32.4	21.9	10.5	4.0
Indiana	28.2	15.8	12.3	2.2
Iowa	24.7	22.6	2.0	2.3
Kansas	46.1	30.6	15.5	3.2
Kentucky	39.1	27.8	11.2	3.1
Louisiana	45.9	32.7	13.2	3.6

Figure 19b Psychiatric Beds and Psychiatrists per Population

State	Total Psychiatric Beds Per 100,000 People (2016)[18]	Private Psychiatric Beds Per 100,000 People (2016)[18]	State Psychiatric Beds Per 100,000 People (2016)[18]	Psychiatrists Per 30,000 People (2014)[4]
Maine	25.7	14.9	10.8	5.3
Maryland	25.9	10.1	15.8	7.2
Massachusetts	29.7	20.7	8.9	10.8
Michigan	28.5	21.7	7.3	3.6
Minnesota	20.0	16.4	3.5	3.7
Mississippi	44.2	27.9	16.3	2.0
Missouri	49.9	35.5	14.3	3.6
Montana	30.9	14.2	16.7	2.7
Nebraska	17.5	2.4	15.1	3.1
Nevada	26.2	16.1	10.1	2.2
New Hampshire	23.3	11.5	11.8	5.4
New Jersey	33.1	15.9	17.2	5.3
New Mexico	23.7	12.7	11.0	4.7
New York	53.5	37.2	16.3	9.2
North Carolina	22.8	14.0	8.8	4.0
North Dakota	32.1	13.6	18.5	3.5
Ohio	29.1	19.4	9.6	3.5
Oklahoma	44.4	33.4	11.0	2.6
Oregon	24.8	8.8	15.9	4.2
Pennsylvania	45.8	35.3	10.4	5.2
Rhode Island	17.6	5.3	12.3	8.6
South Carolina	24.0	14.1	9.9	3.6
South Dakota	25.0	10.2	14.8	2.9
Tennessee	27.4	18.9	8.4	3.1
Texas	27.4	19.4	8.0	2.7
Utah	26.9	18.6	8.3	2.4
Vermont	31.2	27.2	4.0	8.3
Virginia	38.5	20.3	18.1	4.2
Washington	24.1	14.1	10.0	3.4
West Virginia	61.4	47.2	14.2	3.1
Wisconsin	25.2	17.3	7.9	3.4
Wyoming	61.7	27.3	34.3	2.0

Figure 20 Number of Psychiatrists per 30,000 Population[4]

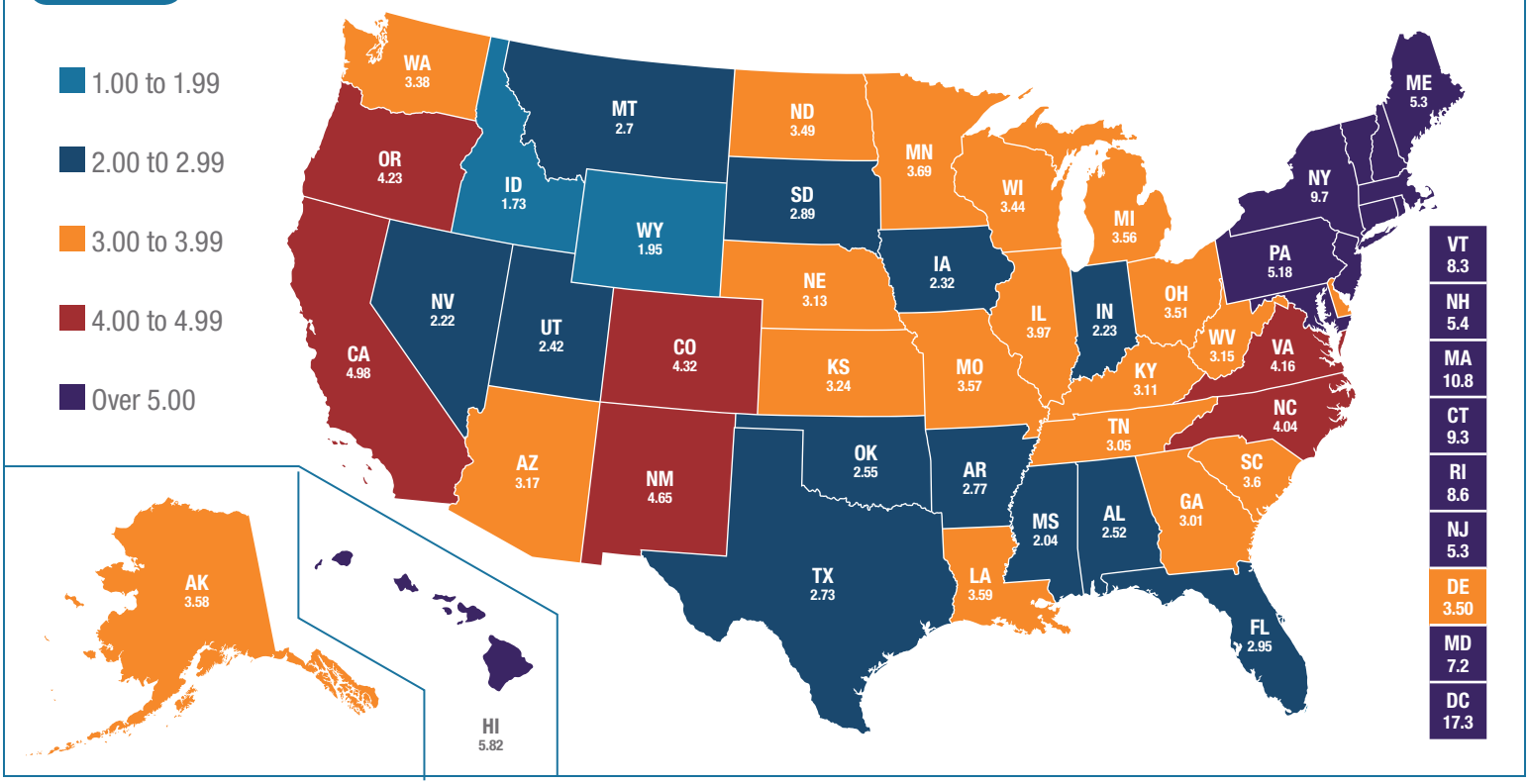
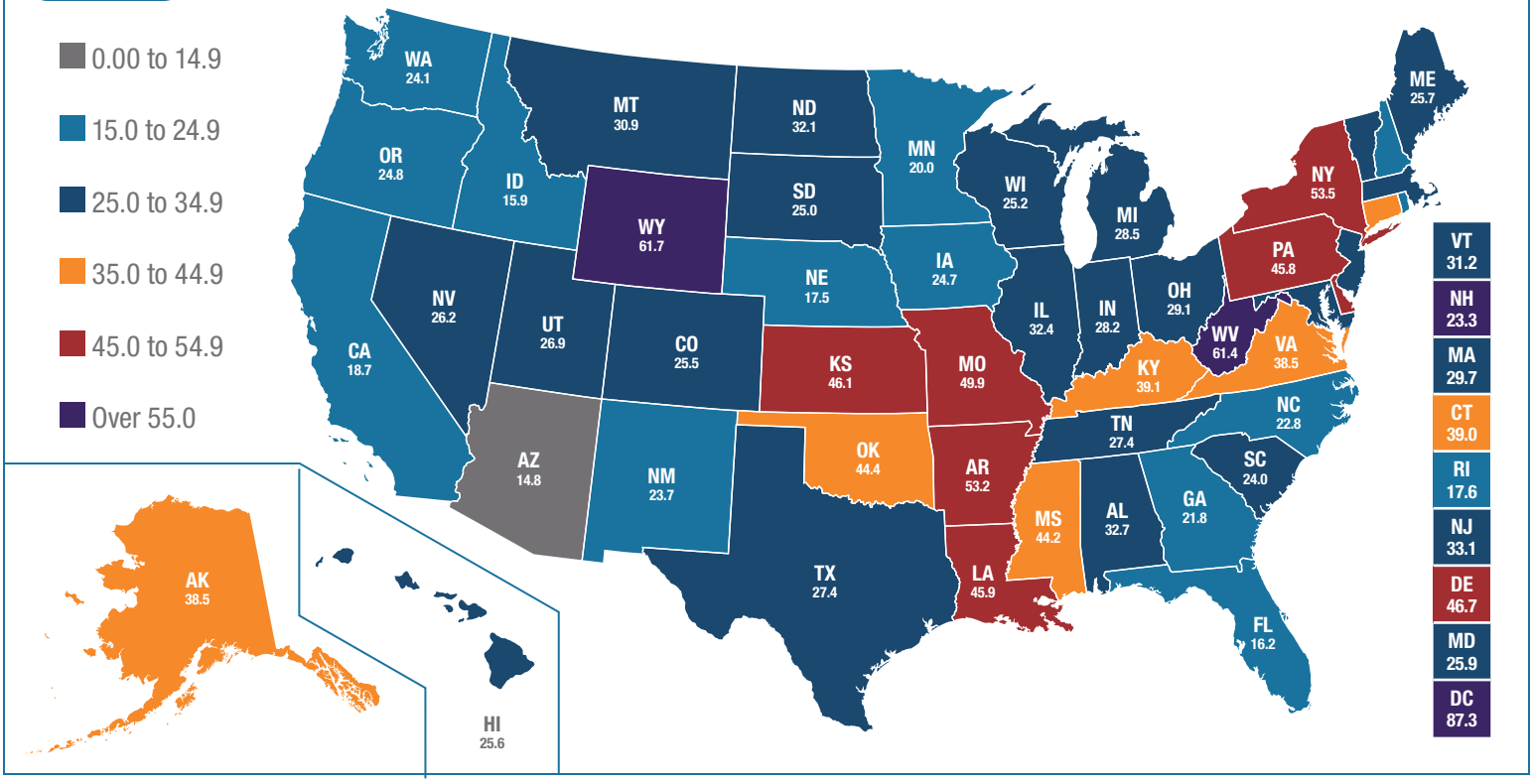


Figure 21 Number of Psychiatric Beds per 100,000 Population[18]



BEHAVIORAL HEALTH CARE QUALITY

Consumer access to health care is built on a foundation of quality. As the health care system shifts toward a more value-based, integrated, coordinated approach to care management and service delivery, the quality of consumer health care is increasingly important. A lack of quality behavioral health treatment affects consumer health overall; behavioral health is crucial to overall well being,[19] as people with behavioral health disorders are at an increased risk of adverse physical health outcomes.[20]

Quality of health care in general – and behavioral health in particular — is measured at different levels and through different criteria throughout the delivery system. With approximately 90% of the U.S. population insured, national payer initiatives to measure the quality of care delivered through managed care have the broadest impact.[21] Both the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and The Centers for Medicare and Medicaid Star Ratings performance measurement sets have a small number of process measures specific to behavioral health and consumer access to health care – meaning that they assess an activity or service for a consumer that is carried out by a health care professional, rather than a clinical outcome, as the result of treatment.[6] NCQA analysis of these behavioral health measures has found health plan performance on the measures to be mixed.[10] While some behavioral health measures have seen performance gains, others have seen performance declines.[11,12,13,14]

The NCQA HEDIS Quality Measures

The NCQA is a private not-for-profit organization that is widely recognized as providing benchmark data on health care quality in organized systems of care.[22] The NCQA HEDIS is used by 90% of health plans to measure performance and for competitive benchmarking.[8] HEDIS is comprised of over 80 measures, with 13 measures that specifically address behavioral health.[23] NCQA tracks performance gains and declines for each measure year after year using average health plan measure rates for each payer.[23] Over the past three to five years,health plan performance on behavioral health measures has varied.[11] Of the thirteen behavioral health indicators, six have available trend data. Of these, one measure has seen significant improvement (follow-up care for children prescribed ADHD medication); two measures have seen significant performance declines: follow-up care after hospitalization for mental illness, within seven and thirty days post-discharge; and, initiation and engagement of alcohol and other drug dependence (AOD) treatment. The remaining measures have not seen either significant performance gains or declines in health plan average scores.[11]

FOLLOW-UP CARE DURING CONTINUATION OF TREATMENT FOR CHILDREN PRESCRIBED ADHD MEDICATION

Medicaid health plans have seen significant performance gains for follow-up care for children ages 6-12 years old prescribed ADHD medication, while commercial health plan performance has remained static on the same measure. The average performance of Medicaid health plans on the number of children receiving follow-up care after the initiation of treatment phase increased 3.4 percentage points between 2011 and 2015 and follow-up care during the continuation of treatment increased 5.0 percentage points. Medicaid and commercial health plan performance on follow-up care for children prescribed ADHD medication was nearly the same between 2011 and 2013; but by 2015, Medicaid health plans were outperforming commercial health plans.[12]

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG TREATMENT

Initiation of Alcohol and Other Drug (AOD) treatment has declined for both Medicare and commercial health plans between 2011 and 2015, while Medicaid performance has remained fairly static. Between 2011 and 2015, average commercial health plan performance decreased 6.5 percentage points, while average Medicare health plan performance decreased 10.3 percentage points. Although the average performance by Medicaid health plans was slightly better than Medicare and commercial plans, all had average scores in the 30s.[13]

Engagement of AOD treatment decreased most dramatically for Medicaid and commercial plans. Between 2011 and 2015, average Medicaid health plan performance decreased 1.7 percentage points and average commercial health plan performance decreased 2.9 percentage points. While Medicare health plans performance decreased the least, at 0.7 percentage points, average Medicare health plan performance was lower than Medicaid and commercial health plans on this measure.[13]

Figure 22 HEDIS Measures Related to Behavioral Health and Payers Reporting Measures

	Medicare	Medicaid	Commercial
First Reporting Year Prior to 2015			
Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder[24]		X	
Antidepressant Medication Management[24]	X	X	X
Adherence to Antipsychotic Medications for People with Schizophrenia[24]		X	
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment[24]	X	X	X
Follow-Up Care for Children Prescribed ADHD Medication[24]		X	X
Follow-Up After Hospitalization for Mental Illness- 7 day and 30 day[24]	X	X	X
2015 First Reporting Year			
Use of Multiple Concurrent Antipsychotics in Children and Adolescents[24]		X	X
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[24]		X	X
Metabolic Monitoring for Children and Adolescents on Antipsychotics[24]		X	X
2016 First Reporting Year			
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults[24]	X	X	X
2017 First Reporting Year			
Follow-Up After Emergency Department Visit for Mental Illness[24]	X	X	X
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence[24]	X	X	X
Depression Remission or Response for Adolescents and Adults[24]	X	X	X

Figure 23a

Follow-up Care After Initiation of Treatment for Children Prescribed ADHD Medicaid[12]

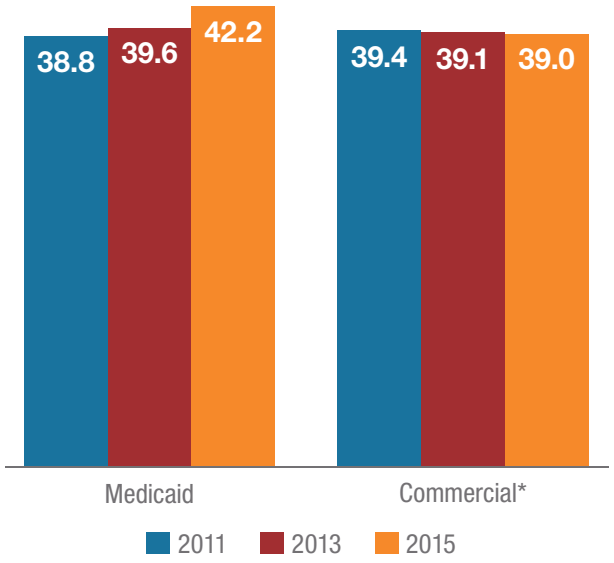


Figure 24a

Initiation of AOD Treatment, Selected Years[13]

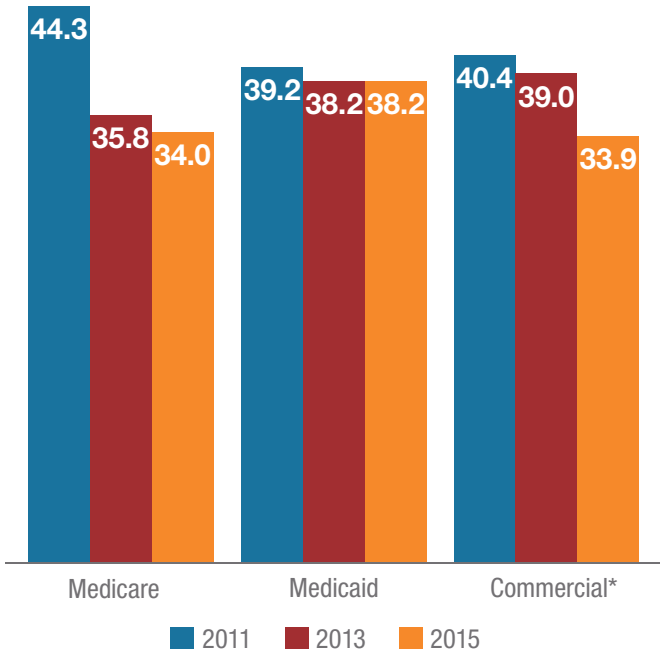


Figure 23b

Follow-up Care During Continuation of Treatment for Children Prescribed ADHD Medicaid[12]

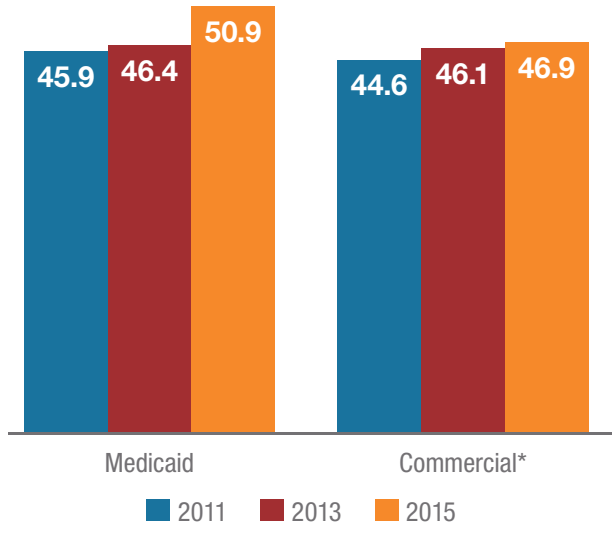
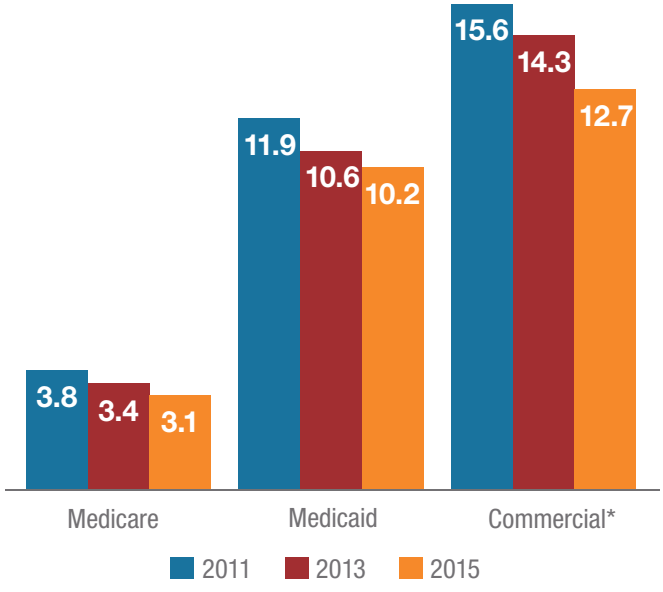


Figure 24b

Engagement of AOD Treatment, Selected Years[13]



*Commercial performance is represented as the average of HMO and PPO health plan HEDIS scores for years 2011, 2013, and 2015.

FOLLOW-UP POST DISCHARGE

Follow-up within 7 days and 30 days post-discharge after hospitalization for mental illness has decreased significantly for all payer types. Between 2011 and 2015, average Medicare performance for follow-up within seven days post-discharge decreased 4.8 percentage points, Medicaid performance decreased 2.9 percentage points, and commercial performance decreased 6.1 percentage points. Commercial health plans have outperformed Medicaid and Medicare plans on average seven-day follow-up post-discharge in all years. Similar results were found regarding payer performance for follow-up within 30 days post-discharge. For this measure during the same five year period, Medicare performance decreased 5.5 percentage points, Medicaid performance decreased 3.8 percentage points, and commercial performance decreased 4.9 percentage points. Once again, commercial health plans outperformed Medicaid and Medicare plans on average follow-up within 30 days post-discharge in all years.[14]

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES QUALITY MEASURES

The Centers for Medicare and Medicaid Services (CMS) Star ratings measure the effectiveness of Medicare Advantage and Prescription Drug (Part D) plans in terms of quality of care and customer service. Consumers are encouraged to use a health plan's star rating to aid in selection.[25] Medicare uses information from member satisfaction surveys, Medicare Advantage plans, and health care providers (there are 32 measures for medical services and 15 for prescription drugs) to give overall performance star ratings to plans.[26] A health plan can get a rating between one and five stars, where five stars is the highest score.[25]

Of the 32 measures for medical services, only one is specific to behavioral health—"improving or maintaining mental health."[26] This measure is defined as the percent of Medicare members whose mental health is the same or better than expected after two years as self-reported by the member in the Health Outcome Survey.[27] Health plan average star ratings have improved consistently on this measure between 2014 and 2016 with the average score rising 1.6 points.[26]

The CMS Star Ratings also explore several measures related to consumer access and care coordination. These measures are general indicators of health plan effectiveness at supporting consumer access to care and higher quality of care. Performance on these measures have either remained static since 2014 or decreased slightly in quality, but not by a significant amount.[26]

Figure 25a

Follow-up Within 7 Days Post-Discharge After Hospitalization for Mental Illness[14]

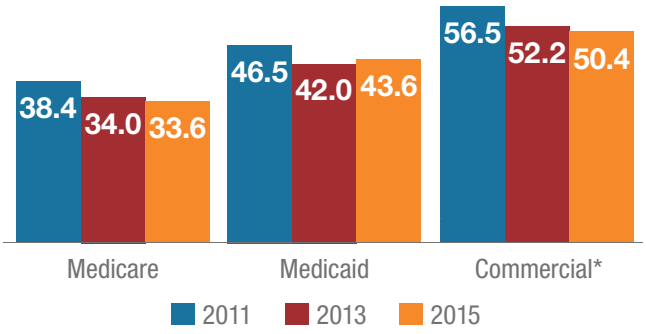
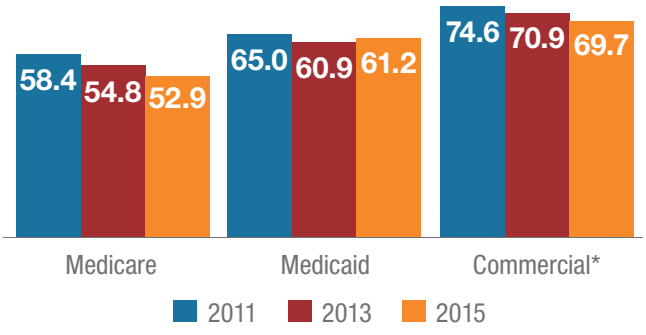


Figure 25b

Follow-up Within 30 Days Post-Discharge After Hospitalization for Mental Illness[14]



*Commercial performance is represented as the average of HMO and PPO health plan HEDIS scores for years 2011, 2013, and 2015.

Figure 26

CMS Star Ratings for Medicare Health Plans Relevant to Behavioral Health Access and Quality, 2014-2017[26]

	2014	2015	2016	2017
Improving or Maintaining Mental Health	2.0	2.5	3.3	3.6
Getting Needed Care	3.6	3.4	3.5	3.3
Getting Appointments and Care Quickly	3.5	3.5	3.4	3.3
Care Coordination	3.4	3.4	3.4	3.4