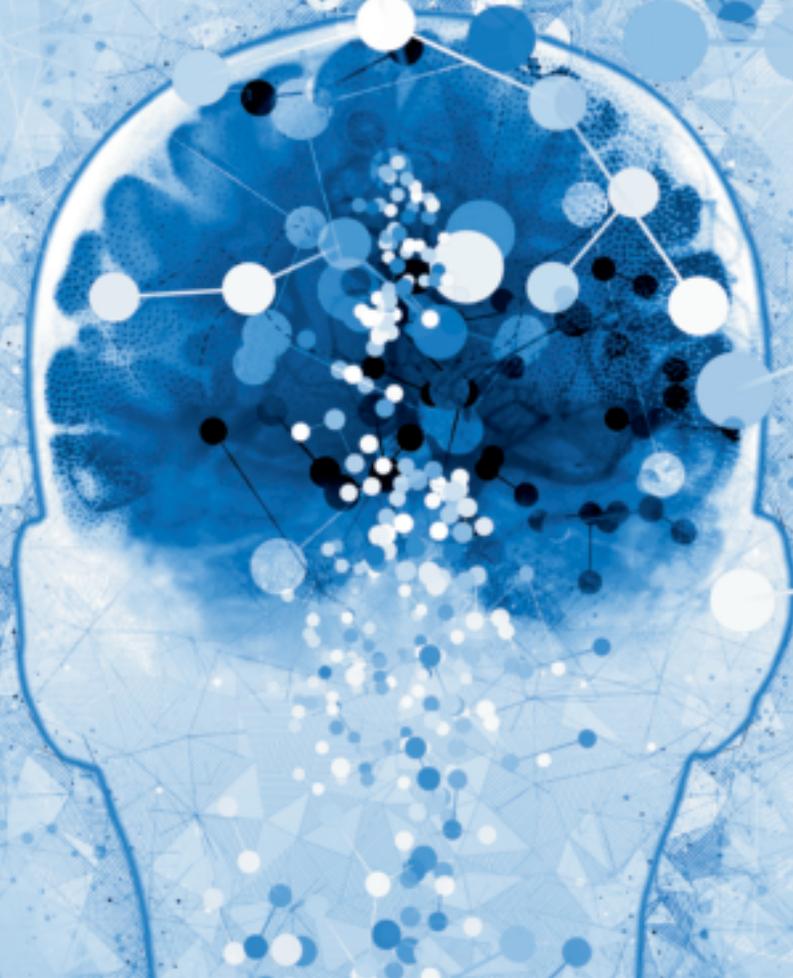


SECOND EDITION

TRENDS ^{IN} BEHAVIORAL HEALTH



A POPULATION HEALTH MANAGER'S REFERENCE GUIDE
on the US Behavioral Health Financing and Delivery System

Brought to you by



2019

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FOREWORD

In 2016, 44.7 million adults in the United States were living with a mental illness. 18.3% of the population. Nearly 1 out of every 5 people.¹ No matter how you look at the numbers, it is clear that mental illness is present, prominent, and prevalent in our society.

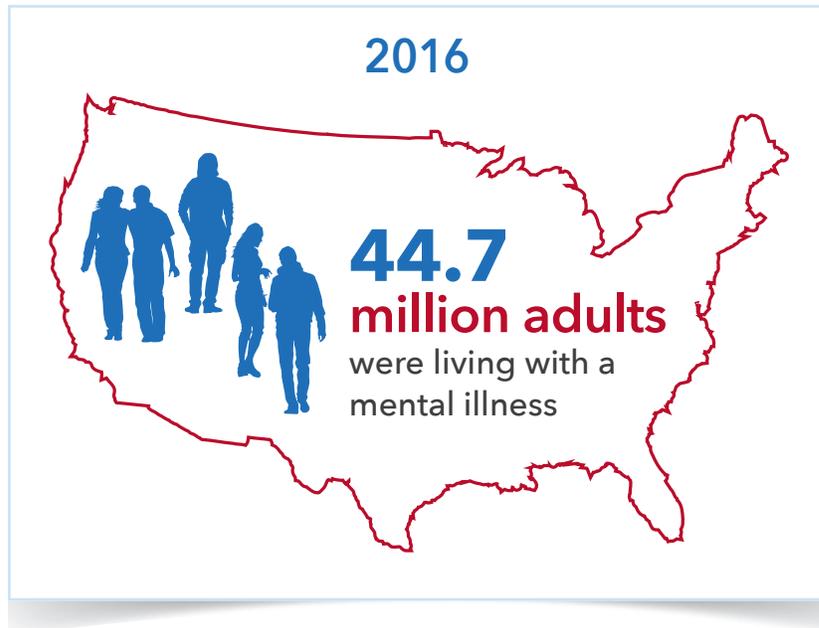
In 2016, suicide was the tenth leading cause of death in the U.S., claiming the lives of nearly 45,000 people.² An

additional 63,632 deaths in 2016 were caused by drug overdose, two thirds of which involved an opioid.³

The continued increase in suicide and overdose deaths has lowered U.S. life expectancy two years in a row.⁴ People with mental illness experience higher morbidity and mortality rates than individuals without mental illness, primarily in relation to untreated and preventable chronic conditions.⁵

State and national regulators, payers, and advocacy organizations are all seeking ways to improve mental health access to effective, evidence-based care and address the negative trends noted in the statistics above. It is in that spirit that in 2017, Otsuka America Pharmaceuticals, Inc. (OAPI) and Lundbeck, LLC compiled an overview of U.S. healthcare policy financing and delivery trends in its Inaugural Guide. We are pleased to now share our second, semi-annual reference guide, 2019 Trends In Behavioral Health: A Reference Guide On The U.S. Behavioral Health Financing & Delivery System (The Guide) to further contribute to the ongoing work of thousands of dedicated professionals in the health care field, focused on improving the lives of individuals with behavioral health issues as well as improving the overall system of care.

Our goal with this Second Edition is to continue to make a positive contribution to the national conversation among key stakeholders, including commercial and government payers, integrated delivery networks, and providers, about the disproportionate effect of behavioral health disorders on the U.S. health care system and the trends currently shaping the field. The Guide includes an update on key national policies, a state-by-state landscape analysis, key metrics on behavioral health service delivery capacity, an update on service delivery and payment innovations, and a national survey of health plans regarding approaches in place or on their road map to improve behavioral health access



and quality. This Second Edition features new innovations leveraged to improve access to care as well as analysis of both public and commercial payers' focus on funding models of care that seek to improve coordination and integration of behavioral and physical health care, including addressing social determinants of health. There is a clear movement towards technological solutions and payer adoption, including telehealth and other digital solutions (e.g., hand-held applications, text-based therapy, and others).

In this Second Edition of The Guide you will also see the significant impact that federal health legislation, policies, and initiatives such as the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act (MHPAEA), and the 21st Century Cures Act are having on national and state healthcare delivery and funding, as well as how states and payers are developing and implementing new payment and delivery models in order to account for these federal level system drivers.

We hope this report not only informs but stimulates its readers to action. We thank the over 1,000 payer organizations who contributed through the survey and hope this guidebook helps payers not only assess their position in the market, but identify practical approaches to improve behavioral health services.



Sincerely,

Sean Phillips, Pharm.D. | Vice President, Market Access, Otsuka America Pharmaceutical, Inc.

Brian McCarthy | Vice President, Market Access, Lundbeck

EXECUTIVE SUMMARY

In 2017, Otsuka Pharmaceuticals and Lundbeck sponsored the inaugural semi-annual edition of the *Trends In Behavioral Health: A Reference Guide On The U.S. Behavioral Health Financing & Delivery System* (The Inaugural Guide). The Inaugural Guide provided an overview of the national behavioral system landscape, state behavioral health financing and service delivery systems, health plan population management

improve quality and cost of care, the management of long-term support services (LTSS), trends in substance use disorder (SUD), and autism.

Most importantly, The Guide now provides a picture of trends in health plan strategies, changes, and new initiatives to address the triple aim. For example, there is pronounced movement toward digital strategies to engage consumers. In the Inaugural Edition, digital strategies centered on telehealth

Payment models

In 2019



Alternative payment models

helped health plans address quality and cost.

93%

Health plans

have now implemented pay-for-performance reimbursement models.

strategies, and statistics on consumer access to behavioral health care. The Inaugural Guide also included a wealth of information on the impact of the Patient Protection and Affordable Care Act (PPACA). What was truly unique about the Inaugural Guide is that it was the first national look at the specific strategies health plans used to manage complex populations. One such example was the widespread adoption of telemental health, with 96% of health plans reporting that they utilize telehealth technology—a trend that has continued in 2019.

This Second Edition of The Guide provides additional insights that were gathered through survey results and interviews with health plan executives. This year's survey included topics not covered in The Inaugural Guide, such as value-based benefit plan design, the use of social determinants of health to guide interventions to

as the focus. With telehealth now in place for most plans, payers have turned to a broader array of digital strategies to promote consumer engagement, including electronic cognitive behavioral therapy (eCBT), consumer portals, applications, and other approaches—many of which are on the payers' roadmap for 2019. Universal to almost all payers is the effort to promote access and consumer engagement in care.

In 2019, health plans continued to look to alternative payment models to address quality and cost. 93% of health plans surveyed—including commercial plans, Medicaid and Medicare—have now implemented pay-for-performance reimbursement models, which is an increase from what was highlighted in The Inaugural Guide. Of note, Medicaid and Medicare plans reported greater use of bundled payment arrangements than commercial plans, the opposite of what was found in 2017. Health plans are also using member incentives through value-based

benefit design. As member out of pocket costs for care have increased empowering and rewarding consumers for making more informed decisions, seeking high value care from high performing providers and better managing chronic conditions are important steps toward containing both payer and member costs.

Beyond value-based benefit design, health plans are implementing multiple technology/digital tools as part of their strategies to promote member access and engagement such as mobile applications, wearables, and online engagement tools. These strategies are also important components of health plan efforts to support consumers to better manage their chronic conditions. Additionally, Medicaid plans are increasingly utilizing peer support to promote better member engagement in care and all payers continue to build out their specialty

Beyond value-based benefit design, health plans are implementing multiple technology/digital tools as part of their strategies to promote member access and engagement such as mobile applications, wearables, and online engagement tools.

services, such as medication assisted treatment, to meet the growing number of individuals in need of evidence-based opioid use disorder treatment.

Compared to findings in The Inaugural Guide, health plan use of specialty care coordination models focusing on members with complex conditions has substantially increased. Across the board, payers have widely adopted Emergency Department (ED) diversion programs, inpatient and behavioral health readmission initiatives, supporting mental health professionals embedded in primary care settings, and collaborative care. As in 2017, states are continuing to implement models of care within their Medicaid programs, such as health homes, Accountable Care Organizations (ACOs), and patient centered medical homes (PCMHs), that aim to improve the coordination of care among complex populations.

For this Second Edition of The Guide, 1,265 payers responded to our health plan trends survey (a 68% increase in response rate compared to The Inaugural Guide), including national and regional payers across all lines of business (commercial, Medicare, and Medicaid). The Guide also updates the national and state behavioral health system and financing landscapes, reflecting both national and state response to some of the core payer challenges and focus noted above, including psychiatric access, high quality and cost-effective addiction and autism treatment, and LTSS.

Response rate

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EXECUTIVE SUMMARY (cont'd)

Legislation and Policy: Legislative changes continue to have a significant impact on the behavioral health industry, and the evolution toward value-based care, improving member outcomes, and tackling rising healthcare costs continues to evolve. Meanwhile, transitions continue for state-level Medicaid programs, including new work requirements and lifetime caps, reimbursement for collaborative care, and increasing managed care penetration within LTSS programs.

Mergers and Acquisitions: Movement in national payer mergers or retail pharmacy acquisitions will be important to watch in the coming years to determine how these new entities will be able to respond to growing consumer demands for healthcare access and convenience.

View of Care: Payers are taking a more integrated, holistic view of their members' overall healthcare needs and the costs associated with individuals with medical conditions who have unmet or undeserved behavioral health conditions.

Consumer Engagement: Payers have focused on enhancing consumer engagement with mobile applications, online engagement tools, and patient portals.

Social Determinants of Health: According to the 2019 survey, 35% of payers are capturing and leveraging social determinants of health to guide interventions to improve overall population health and consumer engagement and 55% have it on the roadmap.

Value-Based Reimbursement: Nearly all payers focused on increasing value-based reimbursement (VBR) with providers, with 92% offering pay-for-performance (P4P) arrangements in addition to an increasing focus on other alternative payment models.

Evidence-Based Addiction Treatment: Payers are seeing increases in substance use spend and use of out-of-network programs that may not offer effective treatment options, prompting them to focus on expanding access to evidence-based addiction treatment, particularly outpatient medication-assisted treatment (MAT).

Applied Behavior Analysis: Payers who are seeing wide variability in treatment quality and costs have focused on expanding access to applied behavior analysis (ABA) for children with autism.

Access to Care: Access to behavioral healthcare has become a growing concern for payers, with 99% incorporating telehealth and other technologies as a means to enhance access to services, and the timely availability of prescriptive capacity being one of the leading challenges.



It is clear that payers' focus on innovations are a direct tie to the market needs in terms of access, quality, and cost of care with greater attention on serving the diverse needs of the whole person.



Executive Summary

Since The Inaugural Guide in 2017, the United States systems for the financing and delivery of behavioral health services has continued to evolve. The ongoing expansion of managed care by state Medicaid programs, number of states awaiting approval for or operating a Section 1115 waiver, greater federal expectations and oversight of these programs, and proposed changes to Medicaid at the state level, (e.g. work requirements, lifetime caps) will continue to have significant impact on behavioral health care delivery. The federal push for greater transparency and accountability within managed care plans, as well as other major provisions defined in the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule and the passage of the 21st Century Cures Act (the Cures Act), will help to expedite the process of new drugs and technology entering the market, and will also improve access to evidence-based opioid use disorder treatment, all of which will continue to shape the national behavioral health landscape.¹ Ongoing rising health care costs, the continuing shift to enhance the value of health care by aligning payment to quality and outcomes, and workforce challenges are all disruptive forces driving change in the nation's health care system.

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With 79% of Medicaid beneficiaries enrolled in Medicaid managed care, CMS' April 2016 release of final rules for Medicaid managed care plans (Medicaid and CHIP Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability: RIN 0938-AS25: 42 CFR Parts 431,433,438,440,457 and 495) will have ongoing impact on the funding and delivery of behavioral health care.² The partial end of the Institution of Mental Disease (IMD) exclusion implemented in July 2016 has improved access to inpatient psychiatric services which, in addition to new network adequacy standards, should lead to greater accessibility of behavioral health services.³ Clarification within the rules gives states the authority to require managed care organizations (MCOs), prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management programs (PCCMs) to all implement service delivery and alternative payment models (APMs) that advance state managed care quality strategies.

NATIONAL BEHAVIORAL HEALTH SYSTEM LANDSCAPE (cont'd)



Executive Summary (cont'd)

The nationwide opioid epidemic, which accounted for 70,237 deaths in 2017, is also impacting the payment and delivery of behavioral health services across the nation.⁴ With Medicaid being the single largest payer of behavioral health services, these national trends will continue to shape the services and supports available to individuals with mental illness and substance use disorders (SUD) and push greater innovation within the Medicaid program.⁵ SUD IMD waivers should promote greater access to residential treatment for Medicaid beneficiaries struggling with opioid use disorders (OUD).⁶

Despite early attempts to roll back the Patient Protection and Affordable Care Act of 2010 (PPACA) and the weakening of some of its key provisions, PPACA has been responsible for reducing the uninsured rates and providing a vehicle for the payment of SUD treatment throughout the nation. States electing to expand Medicaid have made the greatest gains in regard to insurance coverage.

Patient Protection and Affordable Care Act of 2010 (PPACA) responsible for:



Since 2010, 37 states have expanded Medicaid, with three of those states (Utah, Idaho and Nebraska) voting to expand Medicaid during the 2018 mid-term election. In Maine, constituents voted in favor of Medicaid expansion in 2017, only for the governor to block the implementation; fortunately the 2019 governor elect is expected to move forward with the ballot's resolution. Meanwhile, Virginia made 400,000 of its populaces eligible for the 2019 expansion, though the work requirement could potentially be delayed for two years. Support for Medicaid expansion is strong even in Wyoming, which is considered a conservative state, with 56% of the public in favor of expansion.⁷

Health Care Coverage and Coverage of Behavioral Health

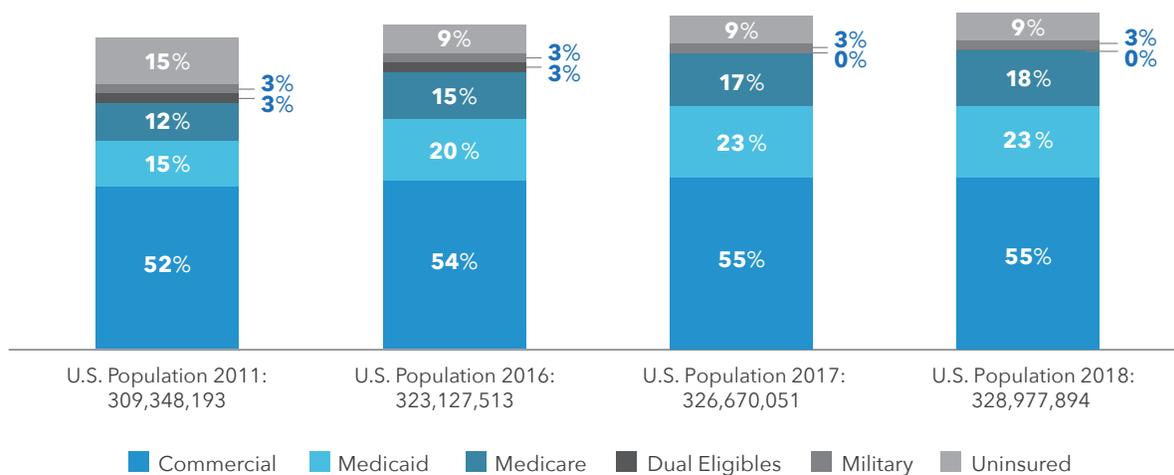
Since 2017, there have been multiple attempts to replace and repeal the PPACA, each failing to garner enough legislative support to proceed from bill to law. The PPACA legislation has fundamentally changed health care coverage throughout the country by reducing the number of uninsured individuals. Between 2011 and 2016, the uninsured rate decreased by 6%. The current uninsured rate is 9% of the U.S. population, or roughly 28.5 million uninsured individuals, which has remained basically unchanged since 2016.⁸

effect, with several states planning to appeal the ruling.⁹

On January 20, 2017, the President signed an executive order to repeal the PPACA. When that proved unsuccessful, changes to the PPACA were made through another executive order on October 12, 2017, which delayed enforcement of PPACA and relaxed the law. These changes have the potential to raise uninsured rates as premiums increase, particularly for sicker individuals, and the uninsured penalty lifting in 2019 will likely exasperate that effect.¹¹ Despite the uncertainty created by executive orders and repeal and replace attempts, particularly the shortening of

Figure 1

U.S. Health Care Coverage, 2011; 2016-2018^{2,8,11}



The repeal and replace bills were anticipated to significantly increase the number of individuals who would be uninsured through elimination of individual and employer mandates, and/or ending the option for states to expand Medicaid. Despite public support, reductions in uninsured rates following the passage of PPACA, and evidence of increased access to behavioral health services, its future remains hard to predict. In December 2018, a federal court in Texas ruled the Affordable Care Act (ACA) unconstitutional; however, the provisions of the law remain in

the open enrollment period for the federal health insurance exchange and 90% reduction in advertising and marketing for open enrollment, a total of 11.8 million Americans signed up for ACA health insurance for 2018, a reduction of only 400,000 from the previous year.¹² Beginning in 2019, changes in federal tax law will end the penalty for individuals who do not have insurance coverage, which, when coupled with new work requirements that have already received federal approval or are awaiting CMS approval, may have a future impact on uninsured rates in the U.S.

NATIONAL BEHAVIORAL HEALTH SYSTEM LANDSCAPE (cont'd)

Figure 2

U.S. Approved and In-Process Waivers by State¹³

State	Waiver Status	Expansion Adults	Traditional Adults	Age Exemptions	Hours Required
Alabama	In Process		✓ (parents 0-18% FPL)	60+	<ul style="list-style-type: none"> • 35/week • 20/week for parents or caretakers with a child under age 6
Arizona	In Process	✓		55+	20/week
Arkansas	Approved	✓		50+	80/month
Indiana	Approved	✓	✓	60+	Ramps up to 20/week
Kansas	In Process		✓ (parents 0-38% FPL)	65+	20-30/week
Kentucky	Approved	✓	✓	65+	80/month
Maine	In Process		✓ (parents 0-105% FPL)	65+	20/week
Michigan	In Process	✓		63+	80/month
Mississippi	In Process		✓ (parents 0-27% FPL)	65+	20/week
New Hampshire	Approved	✓		65+	100/month
Ohio	Pending	✓		50+	80/month
Oklahoma	Pending		✓ (parents 0-45% FPL)	>50	Ramps up to 20/week
South Dakota	Pending		✓ (parents 0-50% FP, in Minnehaha or Pennington County)	60+	80/month or achieve monthly milestones in individualized plan
Utah	Pending	✓		60+	<ul style="list-style-type: none"> • No hour requirement • Specified job search and training activities required unless working 30/week
Virginia	Pending	✓	✓	65+	Ramps up to 80/month
Wisconsin	Approved		✓ (childless adults 0-100% FPL)	50+	80/month

● Pending ● In Process ● Approved

Developed by OAPI & Lundbeck. The Henry J. Kaiser Family Foundation (KFF). (2018, December 21). Medicaid waiver tracker: Approved and pending section 1115 waivers by state. Retrieved from <http://KFF.org>.

Health Insurance Coverage

Since enrollment in 2016, Medicare, Medicaid and commercial insurance have remained generally stable, with a slight increase in the percentage of individuals covered by Medicare. As would be expected, the uninsured rate in non-expansion states remains higher than that in states that have elected to expand under PPACA. The average uninsured rate in non-expansion states (12.2%) is almost double that of expansion states (6.5%).¹⁰

Health Insurance Coverage and the SMI Population

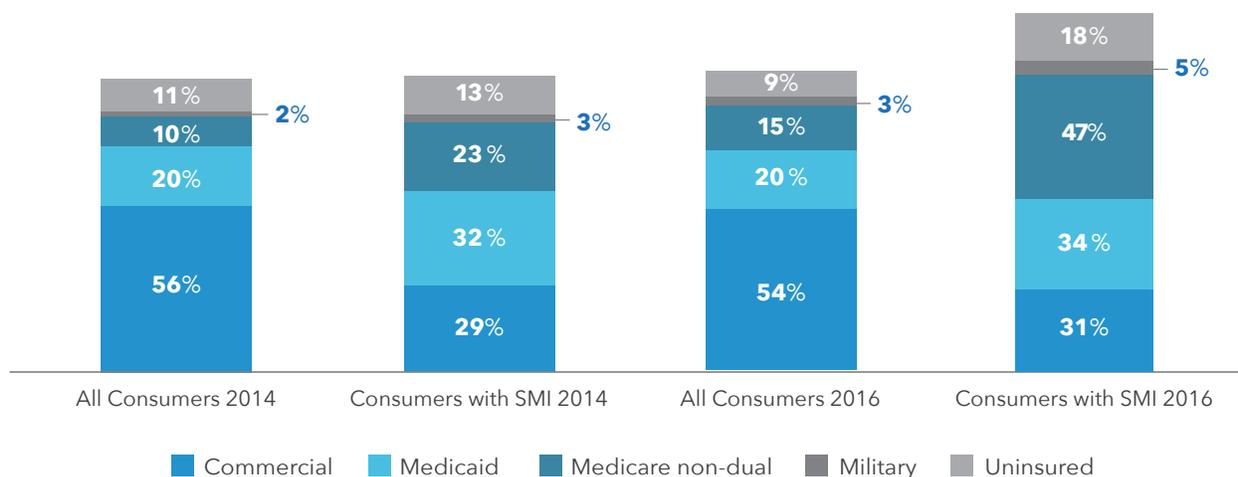
Individuals with SMI (defined as people age 18 and older with a diagnosable mental, emotional, or behavioral health disorder, who meet the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, and who experience serious functional impairment as a result of their diagnosis) remain disproportionately served by public health care systems.¹⁴ As of 2016, 34% of individuals with SMI were served by Medicaid, 31% by commercial insurance, and 18% were

uninsured. Since 2014, Medicaid has remained the largest single payer of behavioral health services for individuals with SMI, including individuals who are dual eligible.¹⁵

Between 2011 and 2018, the use of managed care financing models increased in the U.S. by 17% across all payer types, with 83% of the total insured population enrolled in some form of managed care. From 2016 to present, the use of managed care continues to increase most substantially among public payers. 74% of Medicaid enrollees and 40% of the Medicare population are enrolled in managed care plans.^{2,16} Currently, thirty-nine states contract with MCOs to serve a range of Medicaid covered populations, with risk-based managed care being the dominant delivery system.¹⁷ In fiscal year (FY) 2016, 43% of Medicaid spending was attributed to MCO payments. In 25 Medicaid expansion states, at least 80% of all newly eligible adults are enrolled in managed care plans.¹⁷ From 2016 to 2018, Medicare experienced a 7% increase in the use of managed care for enrollees, and the military population saw a 51% increase in the use of managed care.^{16,18}

Figure 3

U.S. Health Insurance Coverage, All Consumers and Consumers With SMI, 2014 and 2016^{14,15}



Developed by OAPI & Lundbeck. National Institute of Mental Health (NIMH). (2017, November). Mental illness. Retrieved from <http://NIMH.NIH.gov>; OPEN MINDS. (2019). OPEN MINDS Payers With SMI Proprietary Database. Retrieved from OPEN MINDS.

NATIONAL BEHAVIORAL HEALTH SYSTEM LANDSCAPE (cont'd)

Figure 4

Percent of Insured Population Enrolled in Managed Care by Payer Type, 2011, 2016, and 2018^{2,17,20}

Payer Type	Percent of U.S. Population Insured			Percent of Insured Population Enrolled in Managed Care		
	2011	2016	2018	2011	2016	2018
Commercial	52%	54%	55%	93%	98%	99%*
Medicaid	18%	23%	23%	50%	68%	74%
Medicare	16%	18%	18%	25%	33%	40%
Military	3%	3%	3%	57%	49%	100%*
Uninsured	15%	9%	9%	N/A	N/A	N/A
Total	105%	107%	108%	64%	76%	83%

*Data is as of December 21, 2018.

Section 1115 Demonstration Waivers

Currently, 25 states have approved Section 1115 waivers for behavioral health, and an additional 15 states are awaiting approval. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that they find to be likely to assist in promoting the objectives of the Medicaid program.¹⁹ Section 1115 Demonstration waivers provide states with additional flexibility to design and improve their programs and evaluate their approach in order to better serve their Medicaid populations. As more medically diverse and complex individuals are enrolled in Medicaid managed care, this flexibility is seen as essential to improve access and coordination of care and also encourages implementation of alternative payment models (APMs) that will help drive better coordination and outcomes and address social determinants of health (SDoH).¹³

Federal Behavioral Health Policy Initiatives

As noted in The Inaugural Guide, there are multiple factors that can influence change across the health care landscape. Federal legislation, rules, and regulations all have significant impact on the behavioral health system, with many of them being developed in direct response to observed issues and challenges that face the nation.¹⁹ Arguably one of the biggest impacts on U.S. health care policy is the continuing rise of opioid-related overdoses and deaths, as well as the overall economic impact of the opioid epidemic. The growing need to improve access to SUD treatment in response to the opioid crisis has served as the rationale for states to expand Medicaid and also helped lead to the passage of the 21st Century Cures Act (the Cures Act). The Cures Act allocates \$1 billion to be used to help states develop, implement, and fund initiatives aimed to address opioid misuse. In

Developed by OAPI & Lundbeck. OPEN MINDS. (2019). OPEN MINDS Payers Proprietary Database. Retrieved from OPEN MINDS; MCOL. (2018). Managed care fact sheets: National managed care penetration. Retrieved from <http://MCOL.com>; OAPI & Lundbeck. (2017). Trends in behavioral health: A reference guide on the U.S. behavioral health financing & delivery system. Retrieved from <http://PsychU.org>.

addition to the opioid response, the Cures Act aims to foster greater health care innovation, including expediting the drug and medical device approval process, reducing administrative burdens on drug manufacturers, harnessing data and health care analytics to individualize and personalize patient care, continuing the shift to increased use of alternative payment models to improve the coordination of care and drive greater value, and increasing focus on the impact of socioeconomic status as a determinant of health care access and outcomes.^{23,24}

Beyond the Cures Act, there are several major policy initiatives that continue to impact the national behavioral health landscape, including: ongoing efforts to integrate physical and behavioral health both at the payer and provider level, CMS requirements, increasing state Medicaid requirements regarding the percentage of health care spending tied to alternative payment models, increased focus on addressing social determinants, new funding strategies made possible by Section 1115 Demonstration waivers, network access, and new adequacy and quality standards found within the final Medicaid managed care rules.^{13,23,24,25}

Federal Behavioral Health Policy Initiatives: Opioid Response

In 2017, drug overdose deaths in the U.S. claimed the lives of 70,237 Americans, with an additional 142,557 opioid overdose-related hospital emergency department visits proving nonfatal.⁴ One controlled study estimated that health care costs related to opioid misuse typically adds \$4,000 - \$6,000 per patient per year.²⁸ Communities large and small have experienced the devastating effects of the epidemic. Across the nation, states have developed opioid response plans aiming to impact prescribing practices to help reduce the risk of addiction and abuse and to limit the general supply of opioids that can be diverted and sold illegally. These efforts include increasing prescriber education,

implementing and/or enforcing the use of controlled substance registries, limiting the number of pills per prescription, establishing pharmacy lock-in programs, promoting alternative pain management strategies, and providing blanket prescriptions for naloxone, which allows

Across the nation, states have developed opioid response plans aiming to impact prescribing practices to help reduce the risk of addiction and abuse and to limit the general supply of opioids that can be diverted and sold illegally.

individuals or family members to obtain the overdose reversal drug from a pharmacy without a prescription. Enhanced prescription surveillance programs have also become an important tool to identify concerning prescribing patterns. The U.S. Department of Health and Human Services (HHS) has prioritized five specific strategies: strengthening public health surveillance, advancing the practice of pain management, improving access to treatment, targeting availability, distributing over-dose reversing drugs, and supporting cutting-edge research.²⁹

On the national level, the passage of the Cures Act has led to increased funding for states to combat the opioid epidemic through the State Targeted Response (STR) to the Opioid Crisis Grants, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Funding is based on the number of individuals awaiting opioid treatment and the rate of overdoses in each individual state and can be used for an array of prevention and treatment programs. The first round of grant funding was announced in April 2017, where \$485 million dollars in grant funding was distributed across the 50 states and six territories. The second round of funding was released in April 2018.¹

NATIONAL BEHAVIORAL HEALTH SYSTEM LANDSCAPE (cont'd)

Medicare Coordination of Care Codes

In January 2017, Medicare implemented a new coding and reimbursement system for behavioral health services integrated into primary care, furnished via the Medicare psychiatric Collaborative Care Model (CoCM).³⁰ CoCM allows for interprofessional consultation between a behavioral health specialist, who has access and support from a psychiatrist, and the primary care provider. The codes also provide payment for coordination of care activities provided by the behavioral health specialist. Reimbursement for the model has the potential to help ease current geographical shortages, and combat the predicted overall shortage of psychiatrists that is anticipated due to the aging of the current population of specialists. A shift to a more consultative practice model allows psychiatrists to impact a much larger patient population

while also freeing capacity to treat individuals with more complex psychiatric conditions. In the Collaborative Care Model developed by the University of Washington, three hours per week of consultative support can serve a caseload of between 75 and 150 individuals, depending on severity and complexity of patient need.³¹ In 2018, two codes were extended to Federally Qualified Health Centers (FQHCs), allowing for reimbursement for CoCM and behavioral health integration. Also, in 2018, the billing codes were changed from a set of three Healthcare Common Procedure Coding System (HCPCS) G-codes to three new Current Procedural Terminology (CPT) codes: 99492, 99493, and 99494.³² Currently, at least 11 state Medicaid programs allow for the reimbursement of these codes (see Figure 5). It has yet to be determined how broadly this model of care has been adopted, as it represents a change in physician practice.

Figure 5

Medicare CoCM Delivery Methods by State

State	CoCM Delivery Method
Colorado	Colorado Medicaid Accountable Care Collaborative (ACC)
Georgia	The Georgia Collaborative Administrative Services Organization (ASO)
Illinois	Illinois Mental Health Collaborative
Maryland	HealthChoice - Pilot Starting July 2020
Michigan	Michigan Child Collaborative Care
New Mexico	Behavioral Health Collaborative
New York	Behavioral Health Care Collaborative
North Carolina	Patient-Centered Primary Care Collaborative
Rhode Island	Care Transformation Collaborative Patient-Centered Medical Home (PCMH)
Virginia	Commonwealth Coordinated Care Plus
Washington	Washington State Health Care Authority

Alternative Payment Models In Medicare & Medicaid

In January 2015, HHS announced a goal of tying 90% of Medicare fee-for-service payments to quality and 50% of payments to cost and quality by 2018.⁴⁴ In 2017, a study by the Health Care Payment - Learning Action Network (HCP-LAN) found that one-third of all U.S health care payments involved APMs, including shared savings, shared risk, bundled payments and population-based payments.⁴⁵ This study also showed that the percentage of health care payments tied to APMs has steadily increased

over the past two years. The HCP-LAN is a public-private partnership created by the HHS to accelerate the shift from fee-for-service (FFS) to APMs that promote quality, improved health outcomes and lower cost, and tracks the percent of health care payments under APMs.

The HCP-LAN has developed a four-category framework with additional subcategories designed to capture a continuum of clinical and financial risk for provider organizations.⁴⁵ Like CMS, the HCP-LAN has a goal of tying 50% of U.S. health care payments to APMs either built on FFS architecture or on population-based payment.

Figure 6

Alternative Payment Models (APMs) in Medicare & Medicaid⁴⁵

CATEGORY 1: Fee For Service-No Link to Quality and Value

CATEGORY 2: Fee For Service-No Link to Quality and Value

- **Foundational Payments for Infrastructure and Operations** (eg. care coordination fees and payments for Honesty Integrity Trust (HIT) Investments)
- **Pay for Reporting** (eg. bonuses for quality performance)
- **Pay-For-Performance** (eg. bonuses for quality performance)

CATEGORY 3: APMs Built on Fee-For-Service Architecture

- **APMs with Shared Savings** (eg. shared savings with upside risk only)
- **APMs with Shared Savings and Downside Risk** (eg. episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N

- Risk Based Payments NOT Linked to Quality

CATEGORY 4: Population-Based Payment

- **Condition-Specific Population-Based Payment** (eg. per member per month payments and payments for specialty services, such as oncology or mental health)
- **Comprehensive Population-Based Payment** (eg. global budgets or full/percent of premium payments)
- **Integrated Finance and Delivery System** (eg. global budgets or full/percent of premium payments in integrated systems)

4N

- Capitated Payments NOT Linked to Quality

Developed by OAPI & Lundbeck. LaPointe, J. (2017, July 24). CMS considers behavioral health alternative payment model: Health care stakeholders can learn more about a potential behavioral health alternative payment model in a CMS public meeting run in September. Retrieved from <http://RevcycleIntelligence>.

NATIONAL BEHAVIORAL HEALTH SYSTEM LANDSCAPE (cont'd)

According to The Inaugural Guide, across commercial payers, Medicare Advantage, Medicare FFS and Medicaid, 29.8% of payments were made under Figure 6, Category 3 APMs with 21.1% falling under shared savings with upside risk for appropriate care, and 8.7% of payments were made under APMs with upside and downside risk, such as episode of care and bundled payment arrangements. Additionally, 3.8% of reimbursements were made under Category 4, population-based payments, with 1.5% for condition-specific population-based payments, 2.2% under comprehensive population-based payments, and 0.1% under integrated finance and delivery systems. When analyzed by payer, Categories 3 and 4 accounted for 28.3% of commercial payments, 49.5% of Medicare Advantage payments, 38.3% of Medicare FFS payments, and 25% of Medicaid payments.⁴⁵

The percentage of health care payments directly linked to cost and quality is anticipated to increase as the Center for Medicare & Medicaid Innovation (CMMI) continues to research and release new care delivery and payment models.

The percentage of health care payments directly linked to cost and quality is anticipated to increase as the Center for Medicare & Medicaid Innovation (CMMI) continues to research and release new care delivery and payment models. Most recently, CMMI is looking to develop an APM targeting behavioral health services. The model will aim to address issues such as SUD, mental disorders in the presence of co-occurring conditions, Alzheimer's disease and related dementias, and/or behavioral health workforce

challenges—all issues that lead to poor clinical outcomes and potentially avoidable costs.⁴⁶ As the few remaining non-managed care states move under managed care, requirements to move increasing proportions of provider reimbursement to APMs will continue. Moving forward, CMS will likely utilize payment models that provide greater upside benefits in exchange for provider risk, as the impact of APMs without downside risk continues to be scrutinized on the federal level.⁴⁶

State Medicaid programs are also using the flexibility provided by Section 1115 waivers and their contracts with MCOs to tie reimbursement to value with an increased focus on implementing innovative care delivery models, supported by alternative payment and with a focus on behavioral health. Maine, for example, has included spending on behavioral health services in their total cost of care arrangements with their Accountable Communities program ACOs. New York, on the other hand, has implemented an Integrated Primary Care Bundle where providers are responsible for the cost and quality of services provided for 14 chronic conditions related to both physical and behavioral health.⁴⁷

Institution for Mental Disease (IMD) Medicaid Exclusion

In April 2016, the CMS finalized new managed care rules for the Medicaid program. One of these rules, in particular, instructs Medicaid health plans to provide coverage for the care of individuals aged 18-64 in an Institution for Mental Disease (IMD) for up to 15 days as an “in lieu of” service. This population has historically been excluded from receiving psychiatric treatment and SUD residential treatment in facilities with more than 16 beds. To enact this rule, states must include IMDs as an “in lieu of” service in their health plan contract. Health plans are not required to provide the service, and consumers may refuse service in an IMD. Since this rule was implemented, it

is estimated that access to inpatient behavioral health services has improved.³ On, November 13, 2018, CMS announced that state Medicaid programs operating a Section 1115 Demonstration waiver would be able to request the ability to waive the 15 day per month limitation on treatment within an IMD, thus allowing Medicaid funding to be used to pay for mental health and/or SUD residential treatment within an IMD setting beyond the current limitations.⁴⁸

Federal Legislation and Rules

Federal rules and legislation continue to promote access to behavioral health care services. As highlighted in The Inaugural Guide, the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) required private group plans to provide parity for mental health and SUD benefits.⁴⁹ In short, plans that offer behavioral health coverage must not impose financial requirement or benefit plan limitations that are any more restrictive than those for medical/surgical services. Two years later, the PPACA required parity for individual and small group plans, and, in 2016, both the Department of Defense (DoD) and CMS released final rules extending mental health and substance abuse parity to the TRICARE and Medicaid populations, respectively. Additionally, CMS' Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS Final Rule) and the Cures Act continue to promote patient access to health care. The Final Rule more broadly defines network adequacy standards for Medicaid Managed Care plans, whereas the Cures Act provides funding to states to improve access to evidence-based opioid treatment.^{1,50}

Since the full implementation of MHPAEA, several studies have examined the law's impact on utilization of and spending on behavioral health services. A 2017 whitepaper by Milliman

Federal rules and legislation continue to promote access to behavioral health care services.

highlighted that, prior to MHPAEA, members paid 35% of benefit costs out-of-pocket for behavioral health care treatment services, compared to 21% for physical health care treatment services.⁵¹ The study also found increased cost and utilization trends for behavioral health services across commercial preferred provider organization (PPO) and health maintenance organization (HMO) plans since the implementation of the act, surpassing cost and utilization trends for non-behavioral health services. The most significant cost increases for behavioral health services such as partial hospitalization and intensive outpatient treatment which typically had greater levels of restrictions prior to MHPAEA.⁵¹ Other research has indicated that access, utilization and cost related to behavioral health services have increased since the full implementation of MHPAEA. For example, private insurance claim lines for behavioral health diagnoses increased 320% from 2007 to 2017, with the largest increase (202%) occurring between 2010 and 2011, when MHPAEA took effect.⁵²

In addition to expanding health insurance coverage through Medicaid expansion and subsidized marketplace plans, the ACA is influencing access to health care as well. A 2017 study by the Commonwealth Fund found that gaining insurance coverage through the expansions decreased the probability of not receiving medical care by 20.9%-25%. Gaining insurance coverage also increased the probability of having a usual place of care by 47.1%-86.5%.⁵³ It is expected that funding provided to states through the STR grants under the Cures Act will

NATIONAL BEHAVIORAL HEALTH SYSTEM LANDSCAPE (cont'd)

Despite the overall decrease in the number of uninsured individuals within the U.S., 18% of individuals with serious mental illness remain uninsured.

expand access to OUD treatment. Alabama, for example, has used STR funds to provide extra training to care providers working with people diagnosed with OUD, and has also set up a hotline to help connect people to treatment opportunities. They also launched an awareness campaign showcasing the resources available to anyone with OUD. Meanwhile, Pennsylvania was granted more funding to provide treatment services to the uninsured, make additional education available to prescribers, and expand its Prescription Drug Monitoring Program. Additionally, South Dakota is expanding their virtual treatment model access through telehealth delivery and has added a virtual hub where providers treating individuals with OUD can find assistance from a trained workforce. Every state with STR funding has tailored plans for use, which will continue to develop as they craft their strategic plans for year two.⁵⁴

Public Health Care Safety Net

Despite the overall decrease in the number of uninsured individuals within the U.S., 18% of individuals with serious mental illness remain uninsured.^{10,55} These individuals are less likely to receive preventative care and services to manage chronic health conditions. In 2016, 1 in 5 uninsured adults went without medical care due to cost.¹⁸ For these individuals, public safety-net services provided through public hospitals, community clinics, health centers, and local providers that serve disadvantaged communities remain a critical resource for receiving care.⁵⁴ Today, 16 million people receive primary care and behavioral health services through community health centers (CHCs), including FQHCs, that provide health care to medically underserved populations. There are currently 1,400 CHCs, operating 11,000 clinical sites.^{56,57} In 2018, almost \$400 million was awarded to these centers to increase access to and improve quality of SUD services.

Because the majority of funding for safety-net services comes from the federal government, policy initiatives, legislation, and politics can impact funding. Early in 2018, funding for CHCs was delayed as a result of budget disputes in

In 2016



1 in 5
uninsured adults
went without medical care
due to cost

Washington, creating a period of uncertainty until funding was continued. For a brief period in early 2018, funding for CHIP was also caught in the budget negotiation process until it received a six-year reauthorization from a temporary spending bill to prevent a federal government shutdown.⁵⁸

Funding of safety-net services continues to be an area of concern for health care providers. For the second time, reductions to Disproportionate Share Hospital (DSH) payments were delayed for an additional two-year period. DSH payments were slated to be reduced by \$2 billion dollars in 2018, with a total reduction of \$43 billion by 2025.⁵⁸ Provisions of the PPACA required CMS to reduce DSH payments under the assumption that uncompensated care would decrease as fewer individuals became uninsured. Hospitals that serve as a safety net for lower income and uninsured populations maintain that DSH payments are essential to offset losses due to uncompensated care that has not been offset by coverage gains, particularly in non-expansion states.⁵⁹

Looking Forward at the Health Care Landscape

Despite attempts to repeal the PPACA, allegations that the insurance marketplace was on the brink of collapse, and executive branch actions that were seen as attempts to destabilize these markets, the outlook for the survival of the PPACA seems likely. Numerous polls taken during the repeal debates revealed that the majority of Americans were in favor of the ACA, including the continued expansion of Medicaid. In addition, the cost of purchasing health plans through state

exchanges has stabilized and, in several states, insurers offering products on the exchange announced rate decreases.⁷ While the change in the balance of power in Washington will likely end any additional legislative efforts to repeal or substantially weaken the PPACA for at least the next two years, the PPACA's future faces continued uncertainty.⁹

It can also be anticipated that the continued enactment of the CMS Final Rule will further bring access to care, health plan transparency, and

Because the majority of funding for safety-net services comes from the federal government, policy initiatives, legislation, and politics can impact funding.

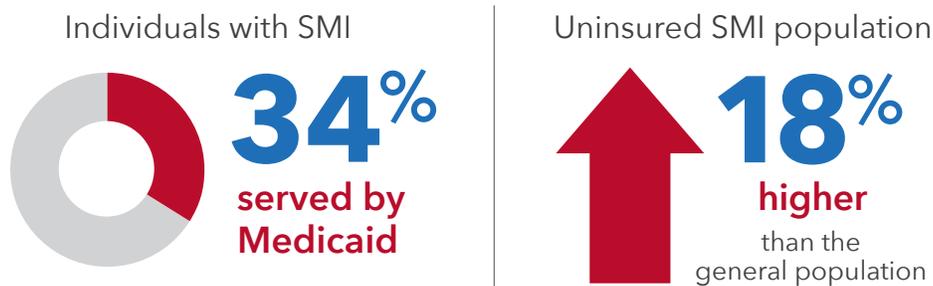
greater focus on accountability and quality to the forefront.⁴⁶ The Cures Act should also significantly improve access to care, and should lead to more innovative ways to tackle the opioid crisis from the use of data analytics and the expansion of evidence-based treatment.²² CMS' push for greater speed of innovation in both the drug and medical device approval process and the goal to tie payment to value will continue.⁴⁷ The Final Rule, the Cures Act, and the CMMI will continue to pioneer the move away from fee-for-service to payment models that promote a greater focus on addressing social determinants of health and that impact both quality and cost.



Executive Summary

Medicaid remains the primary payer for behavioral health services, taking the largest portion of the \$213.3 billion spent on mental health in 2018.^{1,2} Individuals with serious mental illness (SMI) also continue to be disproportionately served by the public health system, with Medicaid serving 34% of these individuals.³ The uninsured rate for this population (18%) is higher than the general population's, leaving a significant number of individuals reliant on state and county supported safety-net services.

Medicaid is the primary payer for behavioral health services



As the primary payer of behavioral health services, much of the innovation within the financing and delivery of these services can be found within the state Medicaid programs. Each Medicaid program is unique to their state, with different benefit plans, eligible populations, and Centers for Medicare and Medicaid Services (CMS) waivers. As such, service delivery and financing models vary widely from state to state, with each program attempting to meet a number of issues and challenges that differ across the country. It is often said that if you have seen one state Medicaid program, you have seen one Medicaid program.⁴

Much of the innovation in behavioral health care is the result of states attempting to finance and implement care models that address the inherent challenges of their population. Some issues states must consider include poverty, homelessness, chronic health conditions, access issues, and medication and treatment adherence challenges—all of which drive costs in these programs. Observing these state systems provides insights into emerging health care trends that are shaping the delivery of behavioral health services.⁴

Across the country, the majority of individuals with Medicaid are enrolled in managed care. As of 2018, 74% of the Medicaid population was enrolled in managed care, a dramatic increase from the 25% enrolled in 2011.^{5,6}

Historically, individuals with SMI and individuals with intellectual and developmental disabilities (IDD) have been carved-out of managed care. Over the past several years, these populations have increasingly been enrolled in managed care and, more recently, into fully integrated health plans. To meet the unique challenges of the SMI populations, states have begun to use vertical carve out models, wherein a state Medicaid program contracts with a health plan or other care management entity to assume responsibility for these members' physical and behavioral health care. In 2018, eight states (Arizona, District of Columbia, Florida, Georgia, New York, Texas, Washington, and Wisconsin) employed the use of a vertical carve-out. In 2018, 5% of states used a vertical carve-out as their primary model, and is projected to rise to 8% by 2020.⁷

As of 2018, 74% of the Medicaid population was enrolled in managed care, a dramatic increase from the 25% enrolled in 2011.

To meet the unique challenges of the SMI populations, states have begun to use vertical carve out models, wherein a state Medicaid program contracts with a health plan or other care management entity.



In addition to greater integration in financing models, states have also looked for ways to improve service coordination and address social determinants of health (SDoH) for this population. In 2017, every state had some patient-centered medical homes (PCMHs), 41 had at least one behavioral health care coordination initiative, 24 had health homes, 15 had dual eligible demonstration programs, 11 had Medicaid accountable care organizations (ACOs) and 8 states participated in the Certified Community Behavioral Health Clinic (CCBHC) demonstration.^{8,9,10}

STATE BEHAVIORAL HEALTH LANDSCAPE (cont'd)

Overview of State Behavioral Health Systems

The key factors that characterize and drive each state's behavioral health system have remained unchanged since 2017, with primary factors including how behavioral health services are financed and who is being served by the system. All states are required to cover children, parents and caretakers, relatives and pregnant women, and aged and disabled populations.¹¹ Under the Patient Protection and Affordable Care Act (PPACA), states have the choice to expand Medicaid coverage to non-disabled adults with incomes below 138% of the federal poverty level. While federal law sets minimum standards, states have the ability to make decisions about additional eligibility, optional benefits available to enrollees, delivery systems, and provider payments. This, in addition to financial support through Medicaid and the use of waiver options, has created great diversity in each state's behavioral health system.

States can implement multiple concurrent waivers and use waivers to cover specific populations of beneficiaries with unique needs.

The majority of states have implemented at least one available Medicaid waiver as a means to change their Medicaid programs. Waivers provide a greater degree of flexibility to innovate, expand services, improve quality and access, and reduce costs. There are two Medicaid waiver programs available to each state: Section 1115 Demonstration waivers and Section 1915 waiver programs. Section 1115 waivers allow states to test innovative ways to design and improve services in addition to offering the flexibility to provide coverage to otherwise ineligible populations. Although Section 1115 waivers are

not necessary to expand coverage with PPACA enacted, it allows states to provide services not typically covered by Medicaid, experiment with cost sharing and other payment reforms, and implement change to their current delivery system.⁴

The Section 1915 program includes three waiver types: 1915(b), which allows for the services to be provided through managed care or to otherwise reduce enrollee choice of provider; 1915(c), which allows states to provide long-term care and supports in home and community-based settings instead of in facilities and institutions; and combined 1915 b/c.⁴ States can implement multiple concurrent waivers and use waivers to cover specific populations of beneficiaries with unique needs. One of the most widely used waivers across the country is the Section 1915(c) Home and Community-Based Service (HCBS) Waiver. In 2016, all 50 states and the District of Columbia used the HCBS waiver to aid people living outside of nursing facilities.⁴ Overall, there are 300 active waiver programs nationwide. As of September 28, 2018, CMS has approved 45 Section 1115 waivers across 37 states, 23 of which have used the flexibility allowed under the Section 1115 waivers to address behavioral health.¹² According to the Henry J. Kaiser Family Foundation, these states are using Section 1115 authority to: use Medicaid funds to pay for inpatient substance use and/or mental health services for nonelderly adults in institutions for mental disease (IMDs); fund other behavioral health or supportive services for people with behavioral health needs (such as supportive housing, supported employment, peer supports, and/or community based mental health or substance use disorder [SUD] treatment services); expand Medicaid eligibility to cover additional people with behavioral health needs who are otherwise uninsured; or to request waiver funding for delivery system reform initiatives (such as physical/behavioral health integration, value-based purchasing, and workforce development initiatives).¹³

State Behavioral Health Systems Typology Chart

The way behavioral health services (excluding pharmacy) are financed determines how consumers receive care, the way that provider organizations are contracted, and how states pay for these services. There are five behavioral health financing arrangements that states typically

use, although states often use different financing arrangements to serve different populations. These five arrangements include behavioral health services in: primary carve-outs to behavioral health organizations (BHOs), primary carve-outs to governmental/regional BHOs, private health plans, the Medicaid fee-for-service (FFS) system, and in consumer-specific specialty health plans (both medical and behavioral).¹⁴

Figure 7

Medicaid Behavioral Health Financing Models¹⁴

Medicaid Behavioral Health Financing Model Definitions¹³

A carve-out is a managed care financing model where some portion of benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed.

1. Primary Carve-Out To Private BHOs: The state Medicaid program delegates some or all behavioral health benefits to a separate private behavioral health organization (BHO) that is at-risk for this subset of services.

2. Primary Carve-Out To Governmental/Regional BHOs: The state Medicaid program delegates some or all behavioral health benefits to a separate governmental or regional BHO that is at-risk for this subset of services.

3. Behavioral Health Service Financing In Private Health Plans: The state Medicaid program contracts with private health plans who are responsible for all behavioral health services, as well as, physical health services.

4. Behavioral Health In Medicaid FFS Plans: The state Medicaid program retains responsibility for some or all behavioral health benefits without delegation to a separate management entity. Other Medicaid services may also be delivered through the Medicaid fee-for-service (FFS) plan or through a health plan.

5. Consumer-Specific Specialty Health Plans: The state Medicaid program delegates responsibility for all benefits (physical health and behavioral health) for consumers with behavioral health disorders (or other specific disorders or needs) to a specialty Medicaid health plan.

There are two key factors that characterize the Medicaid behavioral health market: **who is being served**, and **how behavioral health services are financed**.

STATE BEHAVIORAL HEALTH LANDSCAPE (cont'd)

Medicaid Behavioral Health Financing Arrangements

Between 2016 and 2017, the number of states with primary carve-outs to governmental/regional entities and to private managed care entities remained unchanged with 11 states maintaining a traditional specialty carve-out.¹⁵ This trend, however, is anticipated to change with 50% of states planning on moving to an integrated financing model by 2020.¹⁵ For example, the Washington State behavioral health carve-out model is being phased out and replaced by fully integrated managed care plans, with several of the regional BHOs converting to Behavioral Health Administrative Service Organizations (BH ASOs) and providing an array of crisis services and administration of mental health and SUD block grant funds. In addition, North Carolina will be moving to fully integrated managed care.

Another continuing trend regarding state Medicaid financing arrangements is the use of the consumer specific carve-out, often referred to as a special needs plan (SNP). In a consumer-specific carve-out, the state delegates care of a specific population to a specialty Medicaid health plan rather than delegating specific services. In 2018, Florida expanded their SMI specialty plan to cover a greater number of regions across the state. Through a competitive bid process, Wellcare was selected as the sole health plan to provide the SMI specialty plan, replacing Magellan's Complete Care program, which had been utilized in the state since 2011.¹⁶

As part of their state Medicaid Transformation plan, North Carolina will implement two fully integrated Medicaid financing and delivery models. Individuals with mild to moderate behavioral health disorders will be managed in fully integrated "standard plans," and individuals with SMI and SUD, intellectual and developmental disabilities (IDD), and individuals with traumatic brain injury (TBI) who are enrolled under the state's TBI waiver will be enrolled in fully integrated tailored plans. The standard plans will be operated by four statewide

commercial health plans and up to three physicians health plans (PHPs) that will assume risk and manage care on a regional basis.¹⁷ At the time of this writing, six commercial health plans and two provider led entities (PLEs) had submitted bids in response to a request for proposal (RFP) that

In a consumer-specific carve-out, the state delegates care of a specific population to a specialty Medicaid health plan rather than delegating specific services.

is anticipated to be awarded in February 2019; it will initially launch in several regions of the state in November 2019 and will officially launch to the remainder of the state by February 2020. Initially, the tailored plans will be operated by up to seven of the state's current Local Management Entities/Managed Care Organizations (LME/MCOs), which are quasi-governmental agencies that manage the populations under the state's 1915 b/c waiver and with fully capitated behavioral health carve-outs. The LME/MCOs will undergo a readiness review process in 2020 and will begin operating the tailored plan in 2021.¹⁸

In October 2018, Arizona ended their fully integrated SMI plan for Medicaid enrollees operated by Regional Behavioral Health Authorities. The SMI population are now enrolled in integrated commercial health plans who contract with the state Medicaid authority.¹⁹

State Health Care Coverage

Health care coverage varies across the country based on state-level policies and the characteristics of each state's population, including unemployment rates, socioeconomic status, and other demographic factors. In particular, the PPACA in 2010 affected how many Americans receive health insurance coverage through the federal essential health benefit,

parity requirements, state-based health insurance marketplaces, and continued Medicaid expansion.

In general, states that have expanded Medicaid have a lower uninsured population and a higher Medicaid enrolled population. In 2018, the average uninsured rate was 6.5% among the 37 states that had expanded Medicaid, including the District of Columbia, ranging from 2% (Massachusetts) to 17% (Alaska). Among the 14 states that had not expanded Medicaid in 2018, the average uninsured rate is 12.2%, ranging from 7% (Wisconsin) to 17% (Texas).⁵

In 2018, Medicaid coverage across the country ranged from a high of 17% of the population in Texas (a state that did not expand Medicaid), to a low of 2% of the total population in Massachusetts (a state that did expand Medicaid). Across most states, the largest percentage of the population has commercial insurance coverage (employer-sponsored or other private insurance). North Dakota, one of the states with the lowest rate of Medicaid coverage, had the highest enrollment in commercial coverage at approximately 63% of their population.⁵

Figure 8

Medicaid Expansion and Health Plan Enrollment, by State⁵

State	Medicare Expansion	Total Population	Health Plan Enrollment (% of State Population)					
			Medicaid	Dual Eligibles	Medicare	Military	Commercial	Uninsured
AL	●	4,888,949	11%	5%	13%	3%	56%	9%
AK	●	738,068	12%	3%	7%	NA	50%	17%
AZ	●	7,123,898	20%	3%	12%	2%	48%	11%
AR	●	3,020,327	22%	4%	11%	NA	48%	11%
CA	●	39,776,830	24%	3%	9%	2%	50%	7%
CO	●	5,684,203	19%	2%	9%	NA	54%	10%
CT	●	3,588,683	15%	4%	9%	NA	60%	7%
DE	●	971,180	16%	3%	11%	NA	58%	7%
FL	●	21,312,211	12%	4%	4%	3%	45%	13%
GA	●	10,545,138	14%	3%	9%	NA	49%	16%
HI	●	1,426,393	19%	3%	11%	NA	53%	5%
ID	●	1,753,860	14%	3%	11%	NA	50%	14%
IL	●	12,768,320	19%	3%	11%	3%	58%	6%
IN	●	6,699,629	13%	3%	11%	NA	59%	11%
IA	●	3,160,553	14%	3%	14%	1%	62%	4%

● Adopted ● Not Adopted

STATE BEHAVIORAL HEALTH LANDSCAPE (cont'd)

Figure 8 (cont'd)

Medicaid Expansion and Health Plan Enrollment, By State⁵

State	Medicare Expansion	Total Population	Health Plan Enrollment (% of State Population)					
			Medicaid	Dual Eligibles	Medicare	Military	Commercial	Uninsured
KS	●	2,918,515	10%	2%	12%	NA	57%	11%
KY	●	4,472,265	21%	4%	11%	NA	50%	8%
LA	●	4,682,509	22%	4%	8%	NA	45%	14%
ME	●	1,341,582	12%	7%	11%	NA	50%	10%
MD	●	6,079,602	14%	2%	9%	NA	61%	8%
MA	●	6,895,917	16%	5%	11%	1%	63%	2%
MI	●	9,991,177	16%	3%	11%	NA	58%	8%
MN	●	5,628,162	16%	3%	10%	NA	63%	6%
MS	●	2,982,785	17%	6%	10%	NA	45%	15%
MO	●	6,135,888	11%	3%	12%	NA	55%	12%
MT	●	1,062,330	12%	3%	14%	NA	47%	15%
NE	●	1,932,549	9%	3%	12%	NA	59%	10%
NV	●	3,056,824	15%	2%	10%	NA	52%	15%
NH	●	1,350,575	10%	3%	10%	NA	60%	9%
NJ	●	9,032,872	14%	3%	10%	NA	60%	10%
NM	●	2,090,708	29%	3%	9%	NA	39%	14%
NY	●	19,862,512	23%	4%	10%	1%	55%	6%
NC	●	10,390,149	15%	4%	13%	4%	48%	11%
ND	●	755,238	9%	3%	11%	NA	63%	8%
OH	●	11,694,664	19%	3%	12%	1%	57%	5%
OK	●	3,940,521	14%	4%	11%	NA	48%	16%
OR	●	4,199,563	22%	3%	12%	NA	48%	10%
PA	●	1,2823,989	15%	4%	14%	1%	58%	6%
RI	●	1,061,712	20%	4%	11%	NA	53%	7%
SC	●	5,088,916	18%	4%	11%	NA	46%	13%
SD	●	877,790	10%	3%	13%	NA	59%	10%

● Adopted ● Not Adopted

Figure 8 (cont'd)

Medicaid Expansion and Health Plan Enrollment, By State⁵

State	Medicare Expansion	Total Population	Health Plan Enrollment (% of State Population)					
			Medicaid	Dual Eligibles	Medicare	Military	Commercial	Uninsured
TN	●	6,782,564	17%	4%	10%	NA	51%	12%
TX	●	28,704,330	10%	2%	12%	NA	50%	17%
UT	●	3,159,345	9%	2%	8%	NA	61%	13%
VT	●	623,960	24%	4%	11%	NA	49%	5%
VA	●	8,525,660	8%	3%	12%	7%	57%	9%
WA	●	7,530,552	19%	3%	12%	4%	54%	6%
WV	●	1,803,077	22%	5%	13%	NA	49%	8%
WI	●	5,818,049	16%	3%	12%	NA	57%	7%
WY	●	573,720	8%	2%	11%	NA	59%	13%
DC	●	703,608	26%	4%	5%	NA	55%	5%

● Adopted ● Not Adopted

State Medicaid Financing System for the SMI Population

Federal law requires Medicaid programs to cover certain populations, including those receiving Supplemental Security Income (SSI), namely pregnant women, low-income children, and low-income families.¹⁰ Many consumers with SMI are eligible for SSI. Based on 2017 data from the Social Security Administration (SSA), about 26.7% of the 10.1 million consumers eligible for SSI benefit qualified on the basis of a mental health diagnosis (not including SUDs, which are not a qualifying condition).²⁰

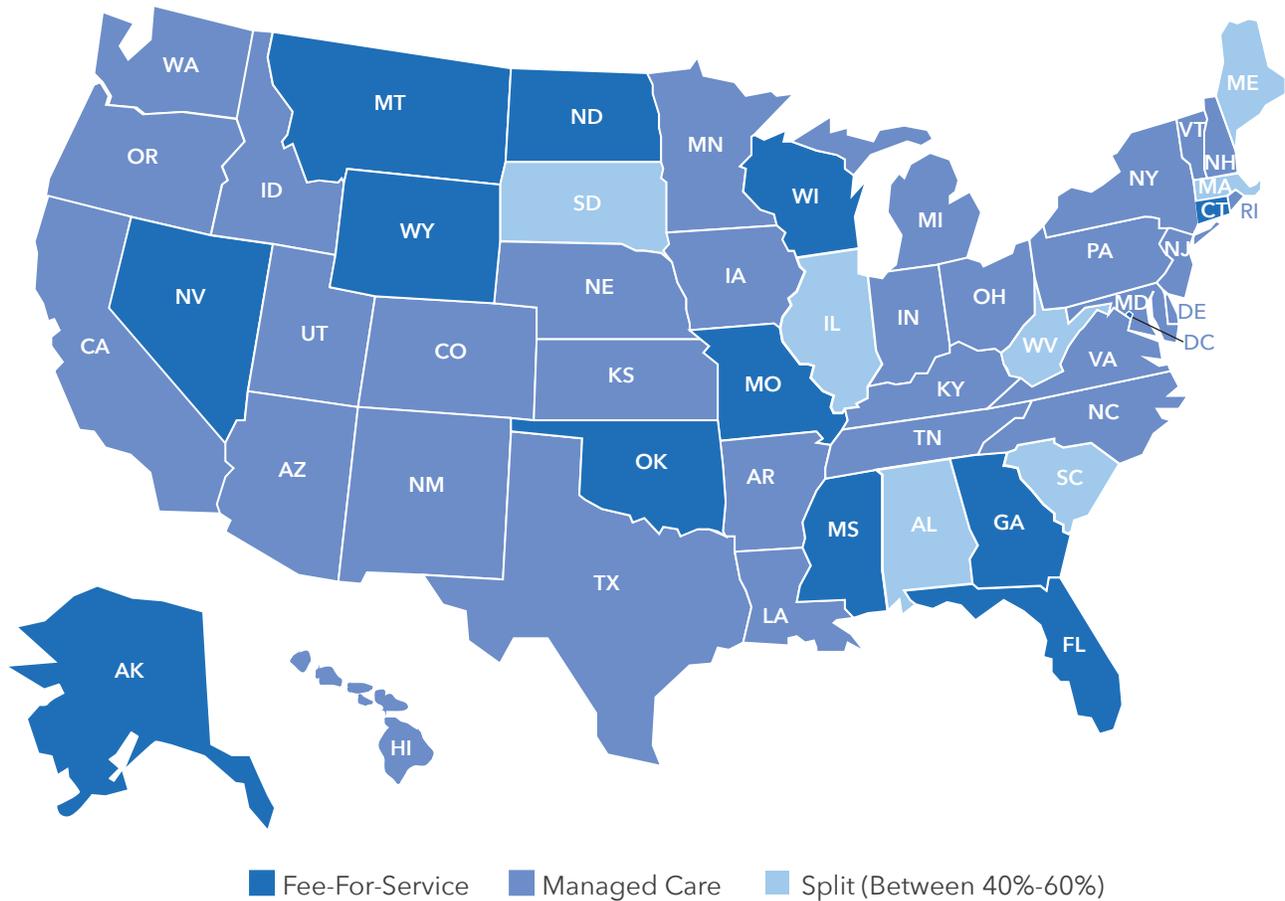
How a consumer qualifies for Medicaid determines under what financing arrangement he/she receives health care services—either FFS, managed care, or a choice of the two. Some states exclude the aged, blind, and disabled (ABD) or SSI population from managed care, though no state excludes consumers from managed care based on a specific behavioral health diagnosis.

In 2018, 13 states required consumers with SMI to enroll more often in a Medicaid FFS plan; 31 states focused enrollment in the Medicaid managed care program; and in 7 states the population was split between managed care and FFS. The split between managed care and FFS programs may be due to either voluntary enrollment by the SMI population or the geographic availability of managed care.⁵ Within the managed care program, consumers may be enrolled in a specialty managed care program that exclusively serves the SMI population or a specialty managed care program that serves the ABD population. In 2017, there were three states (Arizona, Florida, and New York) that enrolled consumers in a consumer-specific specialty plan for SMI, and five states (Indiana, Minnesota, Rhode Island, Texas, and Wisconsin) with a specialty plan for the ABD population.²¹

STATE BEHAVIORAL HEALTH LANDSCAPE (cont'd)

Figure 9

Primary Medicaid Financing for the SMI Population, by State⁵



State Behavioral Health Innovation Initiatives

With Medicaid being the single largest payer of behavioral health services, states have been developing and implementing care coordination and integration initiatives, including implementing federal programs, that aim to improve quality, cost, and member outcomes. These programs are geared to better address the more complex populations served through state Medicaid programs, who tend to have multiple chronic conditions and/or high levels of behavioral health needs. Some of the more common initiatives include:

1 Medicaid Patient Centered Medical Homes (PCMHs)

A model of care rather than a physical place, PCMHs provide enhanced primary care to patients via the provision of comprehensive care, including the use of patient centered care, care coordination, enhanced access, and a focus on quality and safety.²¹ Despite the wide adoption of this model, multiple studies have found either inconclusive or conflicting results of the model's impact on cost and quality.²² A study of nine pilot PCHMs in New Hampshire showed that the model resulted in no significant difference in cost, quality, or utilization.²³

2 Health Homes

Created under the PPACA, the health home model provides whole-person care coordination via six core health home services. Services are available to consumers with two or more chronic conditions, consumers with one chronic condition and at-risk for another, or consumers with SMI.²⁴ The six core health home services are: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, individual and family support, and referral to community and social support services.²⁴

3 Medicaid Accountable Care Organizations (ACOs)

Initially created by the PPACA for Medicare, state Medicaid programs are adopting ACO-like models, through which provider organizations form an agreement to provide care coordination and deliver services for a specific population.²⁵ ACO performance is measured against financial and quality benchmarks. According to The Center for Health Care Strategies, Inc. (CHCS), several states have seen early success of their Medicaid ACO programs. Colorado's Regional Care Collaborative Organizations (RCCO's) have reported \$77 million in net savings for the state's Medicaid program and have low rates of emergency department (ED) visits, high cost imaging, and of hospital readmissions for adult patients who have been enrolled in the

In a consumer-specific carve-out, the state delegates care of a specific population to a specialty Medicaid health plan rather than delegating specific services.

program for six months.²⁴ Vermont has reported \$15.7 million in savings due to their Medicaid Shared Savings Program in the first two years of program operation, and Minnesota's Integrated Health Partnerships have served 460,000 residents while saving nearly \$213 million in their four years of operation.²⁵

4 Dual Eligible Demonstrations

The financial alignment initiative, more commonly known as the dual eligible demonstration, integrates care delivery models for physical health, behavioral health, and long-term services and supports (LTSS) for the dual eligible population. States may implement either a capitated model, where health plans receive a blended capitated rate from Medicare and Medicaid to administer services, or a managed FFS model, where payment, provider networks, and administration remains the same, but quality improvement initiatives are implemented.²⁶ An evaluation of the Washington demonstration program released by RTI International in conjunction with the Centers for Medicare and Medicaid Services (CMS) showed that in the first seven months of operation, the demonstration saved Medicare \$21.6 million dollars, with 6% less spending than the Medicare comparison group; however, 30-day follow-up in a physician or outpatient setting after hospitalization for mental illness decreased to 28.4% as compared to 41.2% during the two year baseline measurement period.²⁷

5 Certified Community Behavioral Health Clinics (CCBHCs)

The CCBHC demonstration was established as part of the Protecting Access to Medicare Act of 2014 (PAMA) and is set to run from 2017 to 2019. Under the demonstration, states certify behavioral health provider organizations as CCBHCs, who will then use a prospective payment system for Medicaid reimbursement.²⁸ CCBHCs are currently operating in eight states that were selected for the

STATE BEHAVIORAL HEALTH LANDSCAPE (cont'd)

demonstration project. According to the National Council on Behavioral Health (the Council), CCBHCs have hired 1,160 new employees, including 73 psychiatrists and 212 staff. A survey conducted by the Council, which received response from 47 of the 67 CCBHCs, highlighted that CCBHCs have helped expand access to behavioral health services, with 87% reporting an increase in the number of patients served.²⁹ CCBHCs have also expanded existing medication assisted treatment (MAT) programs and 38.3% have begun offering MAT.²¹ 72.3% of the surveyed CCBHCs have adopted new technologies to support the delivery of care, including electronic health record (EHR) upgrades, mobile apps, telehealth, and web platforms.²⁹

care setting, in addition to a Healthcare Common Procedure Coding System (HCPCS) code that allows reimbursement of Federally Qualified Health Centers (FQHCs) and rural health centers. As highlighted previously, collaborative care is a mechanism to support better identification, treatment, and coordination of behavioral health care within an outpatient primary care setting. New York and Washington, for example, allow reimbursement of the collaborative care codes under their states' Medicaid plan, and North Carolina has recently added collaborative care current procedural terminology (CPT) codes to the Medicaid benefit.

CCBHCs have helped expand access to behavioral health services



1,160
NEW employees

Survey of 47 CCBHCs showed:

87%

of CCBHCs reported increase in number of patients served

Expansion of medication assisted therapy programs



72.3%

Adopted new technologies to support the delivery of care

6

Additional Innovation Initiatives

Beginning January 2017, CMS approved the use of a set of procedure codes to be used to support collaborative, team-based care within a primary



Considerations

Medicaid programs will continue to drive innovation around care delivery as individuals across the country continue to gain insurance coverage as a result of Medicaid expansion. State Medicaid programs will be faced with addressing consumer access to behavioral health services, in which there are already existing workforce and resource challenges. Models of care that support a greater level of physical and behavioral health integration will continue to be a necessity to address both access and quality of care. As the single largest payer of behavioral health services and the payer that covers the majority of individuals with SMI, Medicaid will continue to push financing models that promote quality, improved coordination of care, and clinical efficiency. With over 79% of Medicaid-eligible individuals enrolled in managed care, all health plans serving this population will be challenged to expand the percentage of provider payments made under alternative payment models and to continue implementing payment models that support greater care management at the provider level.



Executive Summary

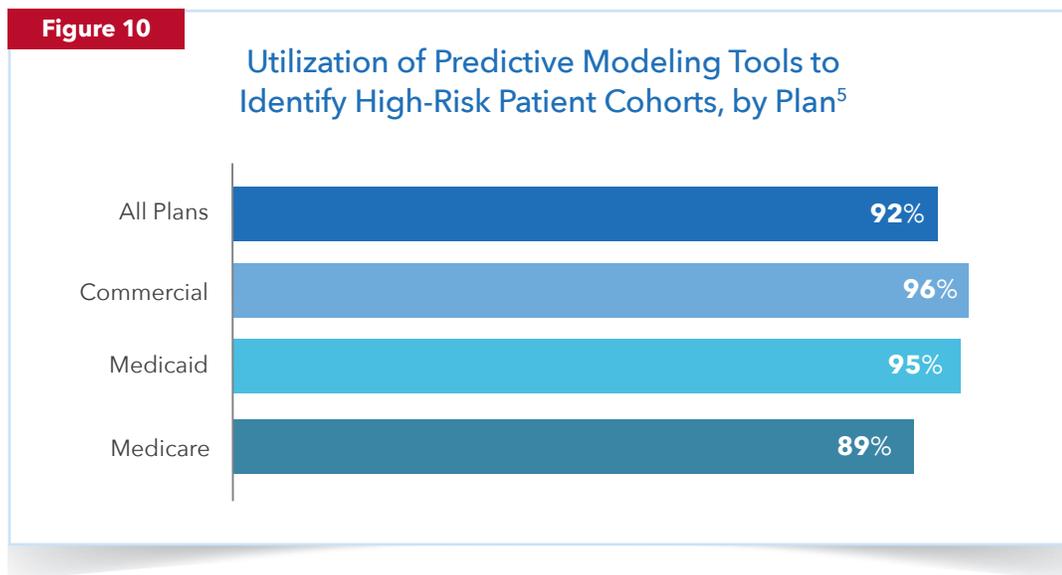
Many of the challenges facing the health care system have remained unchanged for the past several years. As reported in The Inaugural Guide, pursuit of the Institute for Healthcare Improvement's (IHI) Triple Aim continues to drive changes and innovation within the health care system. Payer and provider organizations

Beyond identifying high risk patients, the ability to gain other key insights from health care data continues to drive spending on health care analytics.

continuously strive to improve the patient experience of care, as seen by health plan investments in data analytic tools, the evolution of patient engagement technology, use of high performing networks, preferred pricing, and new care delivery channels. Beyond identifying high risk patients, the ability to gain other key insights from health care data continues to drive spending on health care analytics. A 2017 survey of health

plans with 250,000 members or more revealed that 75% expected to increase spending on data analytics, with 56% of health plans reporting that improving member/customer experience was an important driver of their analytic investment and 49% reporting a goal of reducing costs.¹

Payers are looking to expand access with a primary focus on member convenience, as evidenced by both the merger of CVS and Aetna, which should significantly expand access to care for its members through CVS Minute Clinics, and the recent announcement that Beacon will be opening mental health outpatient clinics in



Continued on next page

HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)



Executive Summary (cont'd)

Walmart stores. Additionally, United Health Group's Optum Division now employs more primary care physicians than Kaiser Permanente.²

Reducing per capita spending on health care continues to drive the move from fee-for-service (FFS) to reimbursement models that reward value over volume. In 2017, roughly 30% of all health care provider reimbursements were tied to models aimed at impacting cost and quality.³

As noted above, cost reduction is also a driver of health plan analytics spending. Consumerism and increased household spending on health care continue to drive the use of value-based benefit designs aimed at reducing out of pocket health care costs while still encouraging health care decision-making.

Health plans are already using data to support population health efforts, including the ubiquitous use of data analytics among health plans to identify high-cost and/or high risk members with complex conditions, the use of predictive analytics to identify emerging risk populations within a health plan's membership, and expanding exploration of the applications for artificial intelligence, which currently has a generally low rate of adoption within the health care industry.⁴

Consumerism and increased household spending on health care continue to drive the use of value-based benefit designs aimed at reducing out of pocket health care costs while still encouraging health care decision-making.



The Guide also contains a summary of how health plans are using innovative approaches as part of their overall strategies to improve health care value and address health inequities. Background is also provided on another national healthcare trend: the increased use of managed care to address quality and cost in state long-term services and supports (LTSS) programs, inclusive of the decrease in institutional care within these programs. Meeting the needs of the LTSS populations will represent an increasing challenge to health plans operating within state Medicaid programs.

Health Plan Current and Future Use of Models to Improve Coordination of Care for Complex Members

People with multiple health and social needs are high consumers of an array of health care services.⁶ Care coordination has been identified by the Institute of Medicine (IOM) as “one of the key strategies for improving effectiveness and efficiency of the health care system.”⁷ Chronic medical illnesses such as heart disease, cancer, diabetes, and neurological disorders are frequently accompanied by behavioral health disorders. Additionally, individuals with chronic health conditions are at 25%-33% greater risk of developing depression than the general population.⁷ Numerous studies have highlighted the impact of co-occurring conditions and untreated mental illness on health, early death, and overall health care spending. Concurrent medical and behavioral health conditions are

Health plans have also implemented a range of alternative payment models that reward greater levels of coordination.

associated with decreased treatment adherence, higher complication rates, early mortality, and doubling the total cost of health care.⁹ Due to the intertwined nature of these illnesses, coordination of all types of health care is essential.¹⁰

Health plans have adopted a wide range of models to improve care coordination for individuals with behavioral health disorders, including specialty care coordination programs such as behaviorally-led medical homes, reimbursement for the co-location of physical and behavioral services, collaborative care and pharmacy lock-in programs, which can limit what clinical professionals and pharmacies a consumer can visit.^{11,12} Health plans have also implemented

a range of alternative payment models that reward greater levels of coordination.

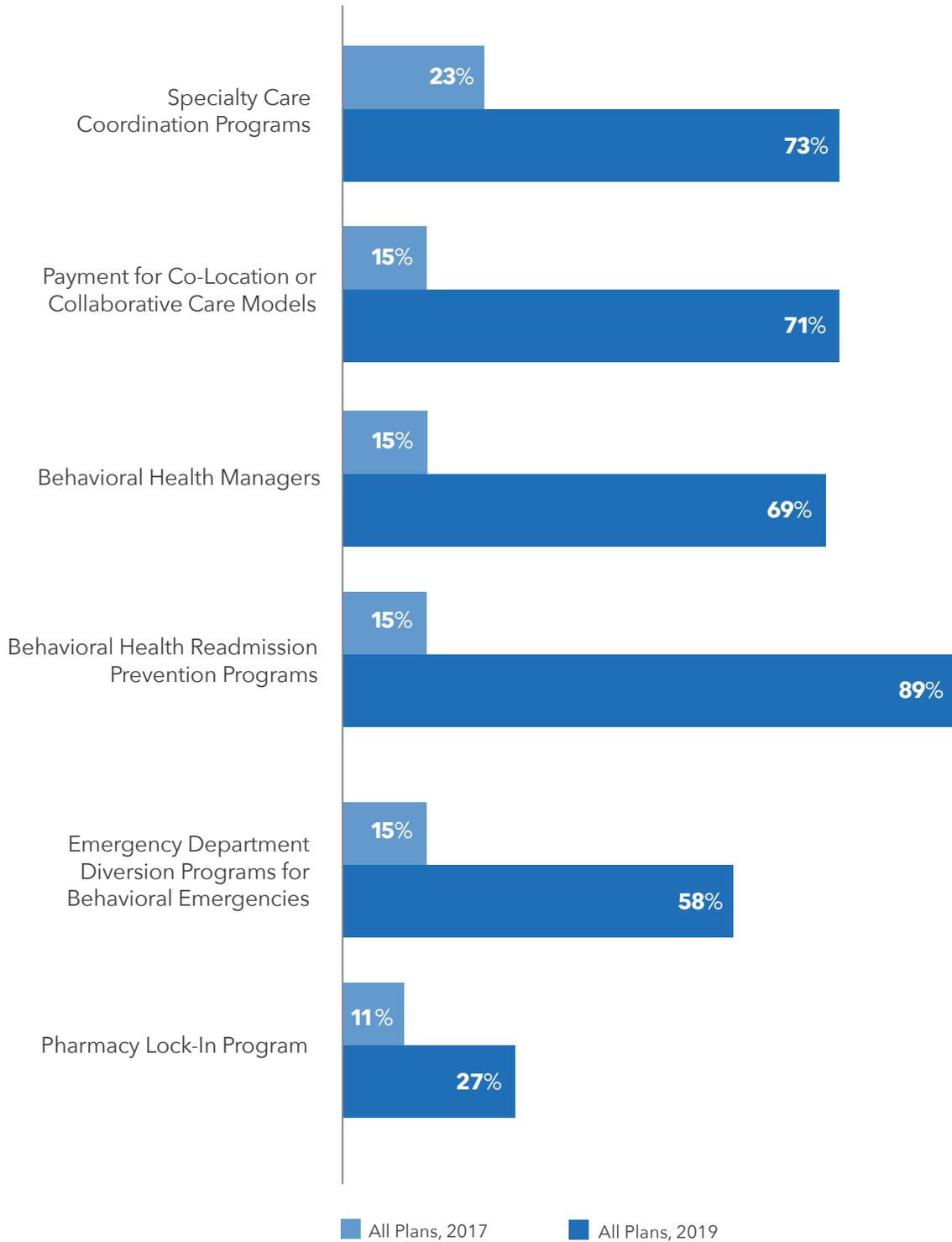
As reported in *The Inaugural Guide*, specialty care coordination programs continue to be the most adopted care coordination innovation across all health plans, with 23% reporting use, while the least popular among the initiatives was the operation of pharmacy lock-in programs with only 11%. Adoption of care coordination innovation has greatly improved since 2017. The most adopted innovation in 2019 shifted to behavioral health readmission prevention programs with 84% of plans reporting use, while the least adopted innovation continues to be pharmacy lock-in programs with only 27%. Lock-in programs have historically been utilized by Medicaid programs to address the noticeably high utilization of controlled substances, so it can be anticipated that there will be an increase in the use of these programs as Opioid Use Disorder (OUD) continues to rise. In 2016, the Comprehensive Addiction and Recovery Act allowed Medicare Part D and Medicare Advantage plans to operate pharmacy lock-in programs, and Anthem announced that all affiliated health plans would operate pharmacy lock-in programs regardless of coverage type.¹³ Adoption of care coordination innovations remain more popular among Medicaid plans than other health plan types. For example, 45% of Medicaid plans report the use of a specialty care coordination program, compared to 75% of commercial plans and 79% of Medicare plans.⁵

The adoption of collaborative care models (CoCM) is beginning to increase among health plans. In 2017, the Centers for Medicare and Medicaid Services (CMS) approved the use of several G-codes, and in 2018 transitioned to current procedural terminology (CPT) codes to support the provision of psychiatric collaborative care. Since that time, four state Medicaid programs have added the codes to their benefit design—New York, Washington, North Carolina, and Virginia. As of 2019, 85% of health plans report covering the collaborative care codes.⁵

HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

Figure 11

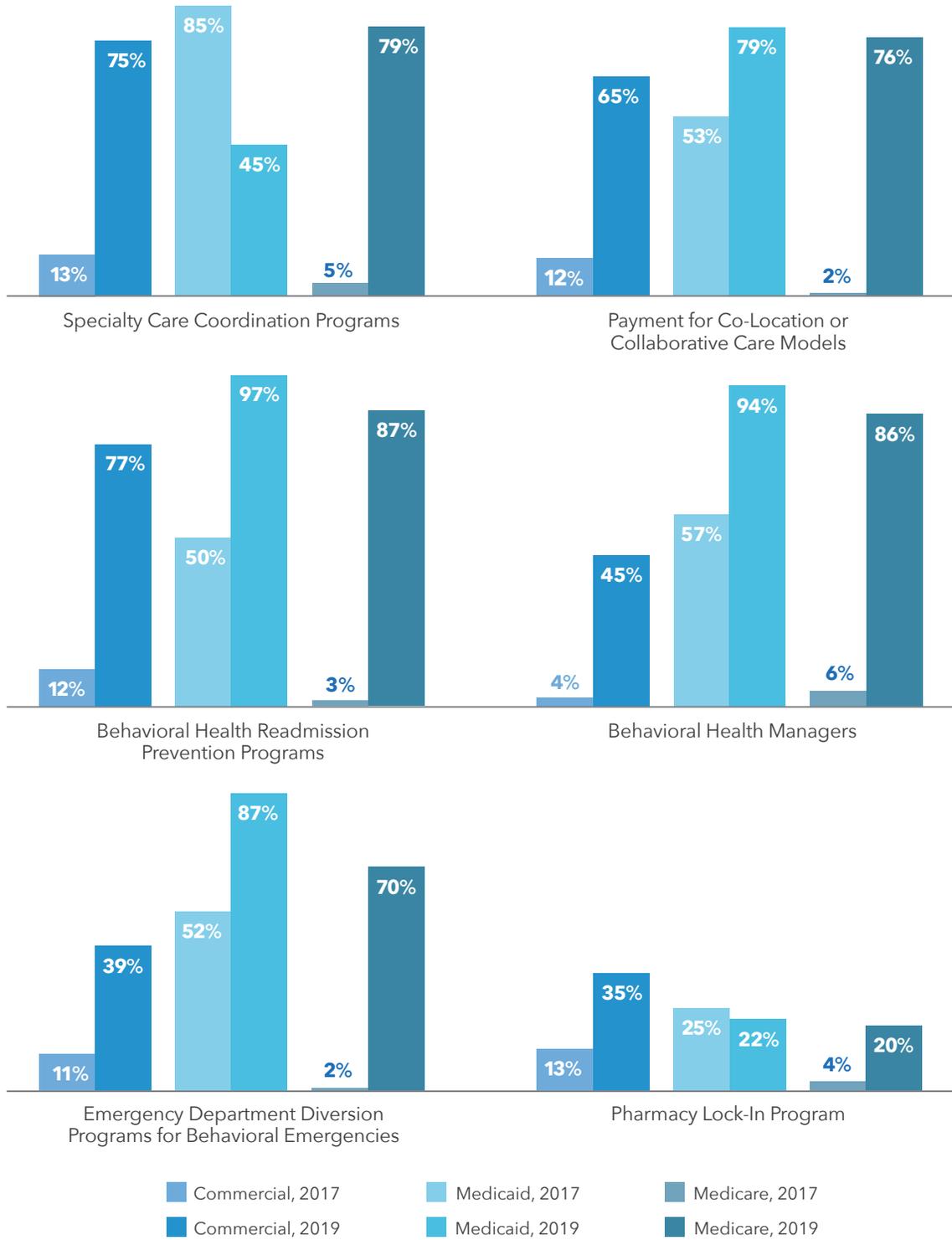
Coordination of Care Strategies, 2017 and 2019, All Plans⁵



Developed by OAPI & Lundbeck. OPEN MINDS. (2019). OPEN MINDS Behavioral Health Delivery System, Proprietary Database. Retrieved from OPEN MINDS.

Figure 12

Coordination of Care Strategies, 2017 and 2019, by Plan⁵



Developed by OAPI & Lundbeck. OPEN MINDS. (2019). OPEN MINDS Behavioral Health Delivery System, Proprietary Database. Retrieved from OPEN MINDS.

HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

Health Plan Current and Future Use of Analytics in Identification and Early Intervention of Individuals With Behavioral Health Needs

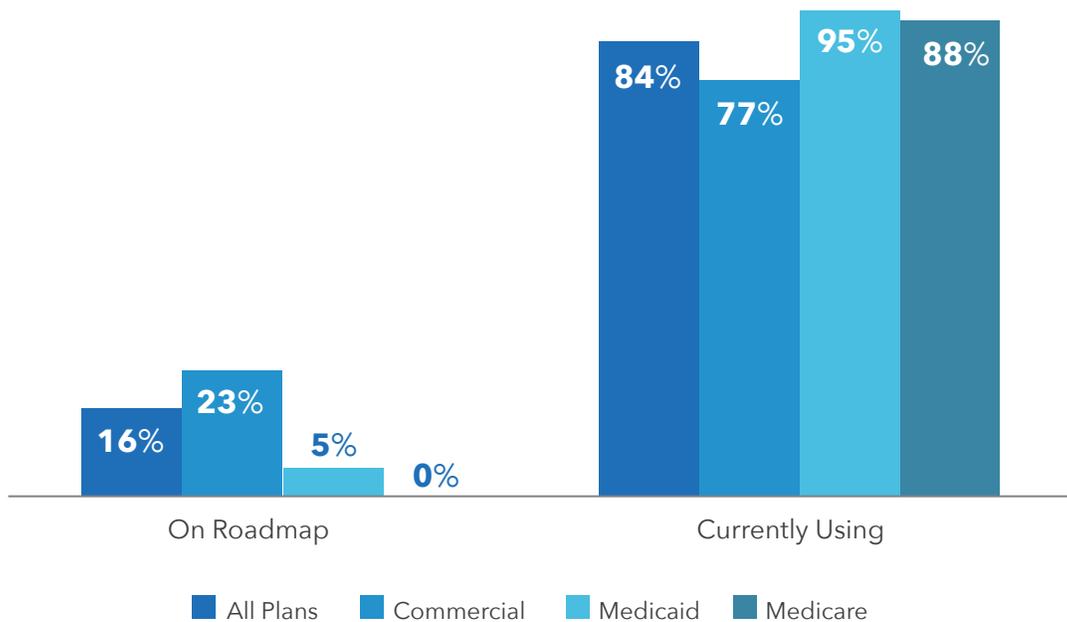
The accelerated push towards alternative payment models (APMs) that aims to incentivize greater coordination of care, value, and efficient use of resources will continue to require the ability of both payer and provider organizations to use data and analytics to manage consumer care and risk. With 20% of the commercially insured population generally accounting for 85% of health care spending, and 20% of the Medicare

domains, including general health, is well researched. The presence of behavioral health conditions significantly impacts health outcomes and spending. A study looking at high cost individuals in Canada found that those with higher behavioral health care costs had higher than 30% greater overall health care costs.¹⁵

Across all payer groups—Medicare, Medicaid, and commercial—over 90% of health plans have widely adopted the use of analytics for identification and early management of consumers in need of behavioral health interventions, and nearly 85% report use of analytics for identification and early management

Figure 13

Current Utilization of Data Analytic Tools, by Plan⁵



population (excluding Part D) accounting for 81% of health care spending, the ability to segment consumers and stratify risk is essential to improve care, identify individuals in need of greater levels of care coordination, and reduce unnecessary health care costs.¹⁴ The impact of serious mental illnesses (SMI) on all life

of consumers with SMI.⁵ These numbers are consistent with our findings in The Inaugural Guide and remain indicative of health plans' greater depth of understanding and acceptance that behavioral health conditions greatly impact the health and wellness of the populations they manage.⁵

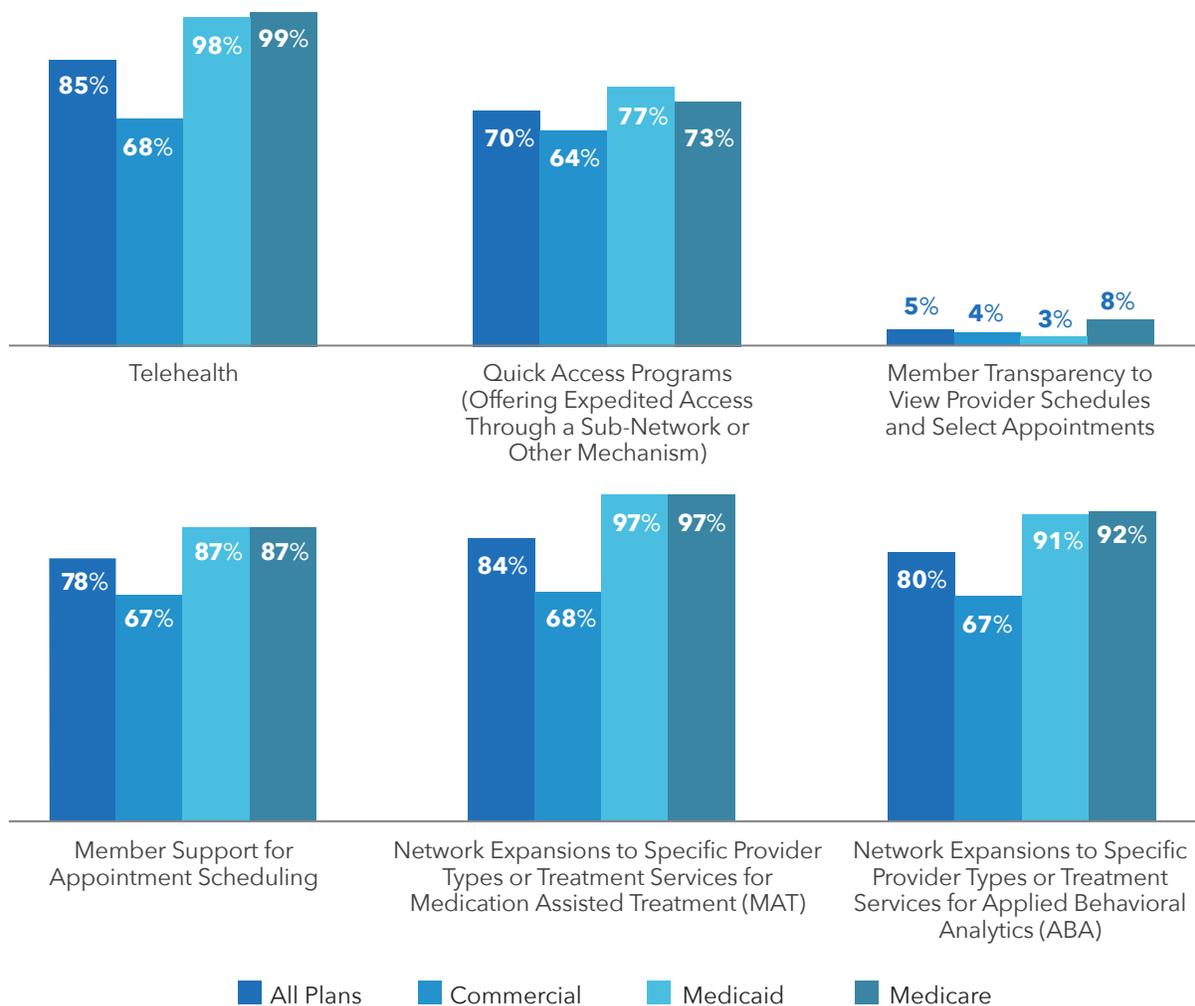
Health Plan Current and Future Use of Innovations in Improving Consumer Access to Behavioral Health Treatment

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for

all Americans.¹⁶ It is important to consider the actual use of services when evaluating access to care as opposed to simpler measures of availability. Therefore, insurance coverage, geographical location of services, and the availability of trusted health care professionals are all key drivers of access and utilization. States, payers, and providers continue to seek innovative ways to overcome frequent barriers to care, which include cost, the lack of service availability, and lack of culturally competent care.¹⁶ This is

Figure 14

Utilization of Access Strategies, by Plan⁵



HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

particularly true for behavioral health services, where workforce challenges have already created access barriers, and is even more critical for the SMI population, for whom social determinants create numerous barriers that require greater innovation to address.

It is important to consider the actual use of services when evaluating access to care as opposed to simpler measures of availability.

Innovations fall into two main categories: technology- and community-based treatment. Technology-based interventions include tools such as telemental health, online therapy, and consumer portals. Open access and walk-in centers and in-home services are examples of community-based treatment innovations aimed at improving access to care.

Today, telemental health services have been universally adopted by health care plans and used to expand access to behavioral health. With the exception of Rhode Island, all state Medicaid programs now cover telemental health, and 30 states, including the District of Columbia, have some form of private insurance coverage parity for telemedicine.¹⁷ Research highlights that patients and providers are increasing acceptance of telemental health services and are seeing it as a viable option for expanding behavioral health services to rural and underserved communities.^{18,19} A further review of the use of telemental health is provided in Domain IV under *Consumer Access to Behavioral Health Care*.

The use of electronic cognitive behavioral therapy (eCBT) is less widely adopted than telehealth, with 23% of all health plans reporting use—a decrease from the survey conducted in 2017 for The Inaugural Guide.⁵ Medicaid health plans report the most widespread adoption of eCBT, with 47% of plans offering eCBT services.

Adoption among other payer types is considerably lower, with 25% of commercial plans and 15% of Medicare plans using eCBT. As with telemental health, a number of studies have confirmed the efficacy and impact on access to care, including that eCBT services may have the greatest impact on access to care for youth. In a study on adolescents with insomnia, 97% chose eCBT programs as opposed to face to face groups.²⁰

Health plans are utilizing consumer portals less frequently than other technology interventions, with 0.5% of all health plans reporting adoption of consumer portals for their enrollees. Among all plans, Medicaid reported the highest usage of consumer portals at 4%.⁵

Health plans are also implementing text-based programs to expand access to care. In December 2017, CMS provided clarification that secure text messaging platforms can be used in health care and accepted that text messages are an increasingly important means of communication in health care.²¹

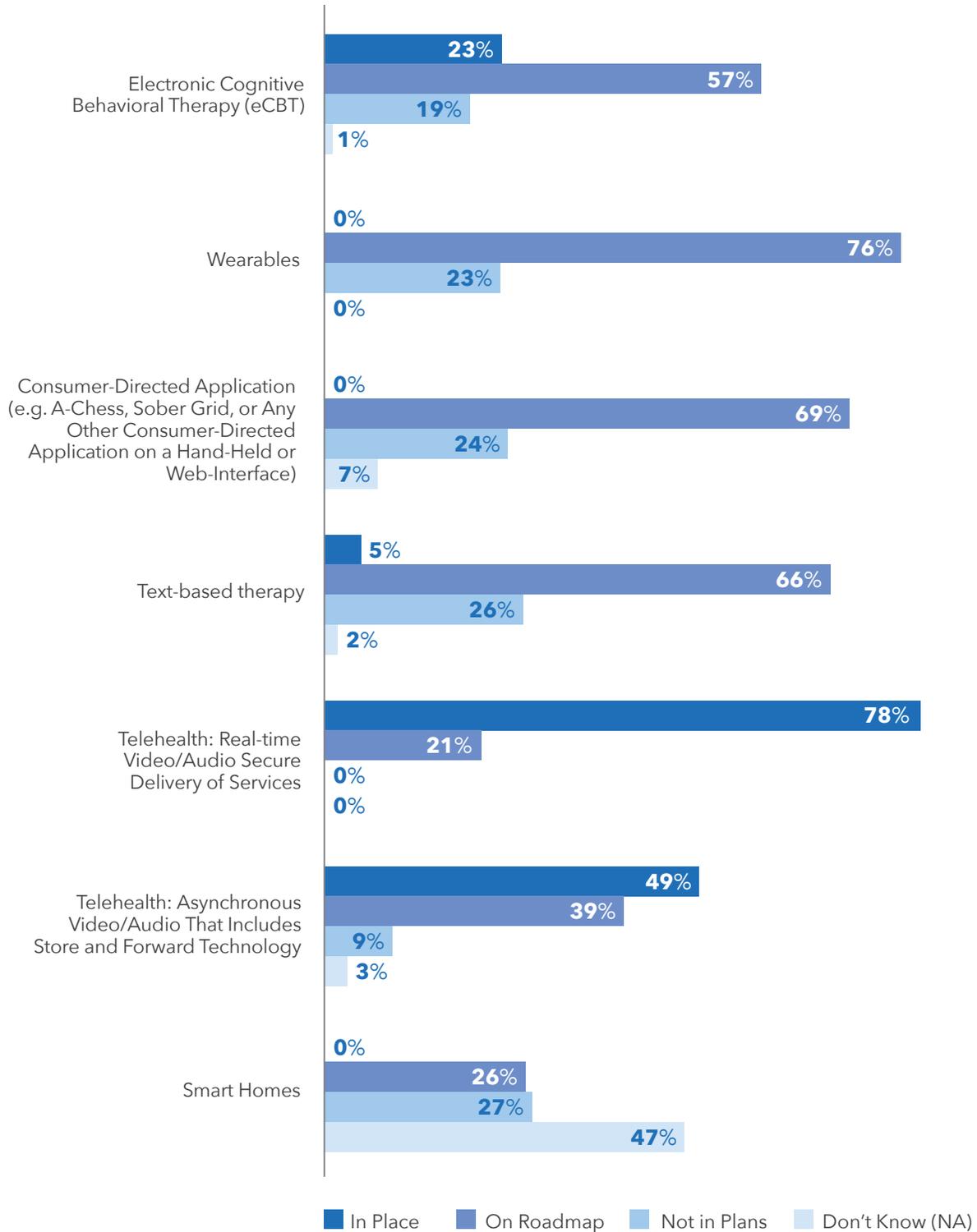
The need to use technology to provide better support of independent living is driven in part by the growing cost of providing long-term care and supports (LTSS), the desire of individuals with intellectual and developmental disabilities (IDD)

Today, telemental health services have been universally adopted by health care plans and used to expand access to behavioral health.

to live as independently as possible within their communities, the aging of adult caregivers, and workforce shortages. Smart Homes are an example of such use of this type of technology—outfitted with a range of devices that can help monitor an individual's safety, provide reminders for important activities, and send alerts to an individual's caregivers. Examples of some

Figure 15

Utilization of Digital Technology Strategies⁵



Developed by OAPI & Lundbeck. OPEN MINDS. (2019). OPEN MINDS Behavioral Health Delivery System, Proprietary Database. Retrieved from OPEN MINDS.

HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

potential reminders and alerts include devices that monitor when an individual opens or closes the doors to their home, provide prompts to turn off the stove or oven, remind an individual to take their medications, and that can be controlled through smart pads or voice controls. Some of the technology used in Smart Homes could be categorized as assistive technology, which means it would be accessible through LTSS.²² Currently, less than 1% of health plans provide coverage for Smart Home technologies that enable more independent living, though 26% of health plans currently have it on their roadmap for the future.⁵

Currently, 99% of health plans surveyed have either already expanded or have initiatives under way to expand access to MAT.

Another growing trend in mental health is the use of wearables, including items such as wrist bands that track changes in activity levels, heart rate, and other physiological responses that are associated with stress and anxiety. Additionally, smartphone applications have been deployed that allow users to track their moods and thoughts, program in locations related to past substance misuse that they wish to avoid, or that send mental wellness reminders. Information from wearables can then be monitored and tracked by care teams to prompt early intervention. A more recent advance in wearables was the U.S. Food and Drug Administration (FDA) approval of an ingestible pill containing a trackable sensor. When the pill is digested, a wearable patch detects the sensor and is able to gather and transmit information to a mobile application.²³ This pill would allow individuals to better track their use of medication and, with the patient's permission, the information can be accessed by caregivers. To date, 73% of health plans either provide reimbursement for wearables or will in the near future.

Community-based treatment solutions include health plan networks offering expedited appointments, often referred to as open access, where patients can receive care on the day they request it. Solutions may include offering expanded use of intensive outpatient programs and community-based service delivery, such as assertive community treatment or peer support services.^{24,25} These types of innovations have not been as widely adopted as technology-based solutions, with just a little over 51% of health plans reporting the use of community-based service delivery, 84% reporting expanded use of intensive outpatient programs, and 69% reporting having networks offering expedited appointments.⁵ Adoption of these initiatives are higher in Medicaid and Medicare than among commercial payers. In Medicaid, the higher trend is not surprising because they are often tasked with overcoming the significant social determinants of health-related barriers to care experienced by their members. Likewise, Medicaid has to utilize employee benefit designs that provide for a greater array of services provided in community settings and that provide a higher level of treatment intensity. For example, 98% of Medicare plans have adopted expanded use of intensive outpatient programs, while 97% of Medicaid plans and 68% of commercial plans have adopted this initiative.⁵

The opioid crisis and additional availability of treatment funding through the 21st Century Cures Act (the Cures Act) has prompted an increased focus on the accessibility of medication assisted treatment (MAT). Currently, 99% of health plans surveyed have either already expanded or have initiatives under way to expand access to MAT. In addition to the opioid crisis, the rising prevalence rate of autism spectrum disorders (ASD) in the U.S., estimated at 1 in 59 children in 2014 by the Center for Disease Control (CDC), is requiring health plans to actively expand access to evidence-based treatment (EBT).²⁶ Currently 95% of health plans have active initiatives to improve access to these services.

Health Plan Current and Future Use of Behavioral Health Consumer Engagement Strategies

Engaging consumers in care and in health promoting behavior is critical to their health and well-being.²⁸ Engaged consumers take action to become better informed and more proactively involved in decisions that affect their health care, insurance coverage, and overall health.²⁷ An individual's support system, necessary knowledge and education, ability to monitor change, and small celebrations for change are all important aspects of consumer engagement.²⁸

Health plans have adopted a wide range of strategies to increase the engagement of consumers with behavioral health disorders, including the use of online tools, recovery management tools, mobile apps, shared decision-making initiatives, or guidelines and strategies for staff to better engage consumers. How these

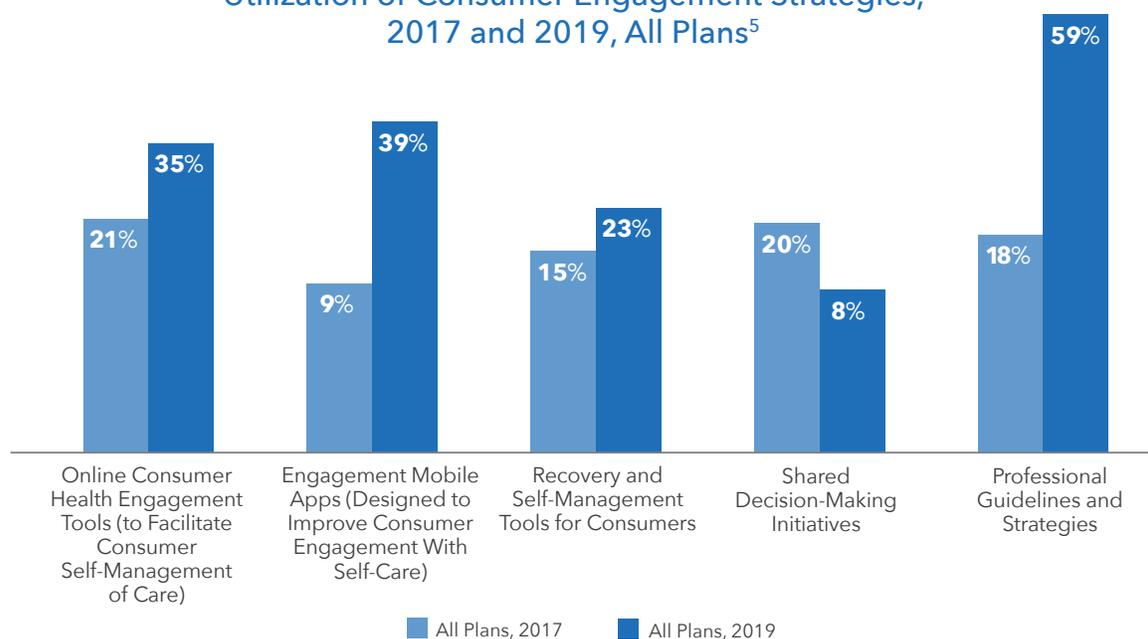
different innovations help consumers may vary: for example, mobile apps are particularly helpful to individuals with chronic health care needs because they provide medication reminders, refill alerts, and drug interaction warnings.²⁹ In addition, shared decision-making allows consumers to partner in their care and help make informed treatment decisions.³⁰

Adoption of consumer engagement innovations across health plans is low, with no more than 59% of health plans adopting any one innovation. Among payers, Medicaid health plans report the greatest overall current use of innovative engagement strategies—with 6% of plans reporting the use of online engagement tools, shared decision-making initiatives, and professional guidelines and strategies for consumers at the same time.

Another engagement strategy primarily seen in Medicaid programs is the use of peer support services. As the primary payer of behavioral

Figure 16

Utilization of Consumer Engagement Strategies, 2017 and 2019, All Plans⁵



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HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

health services for the SMI population, Medicaid plans increasingly promote recovery and the use of peer supports and peer directed programs. Currently, 39 states allow for the billing of peer

support services.³¹ In addition, 73% of Medicaid plans either cover peer support as a benefit or use peers in their specialty care management programs.⁵

Figure 17

Utilization of Consumer Engagement Strategies, 2017 and 2019, by Plan⁵

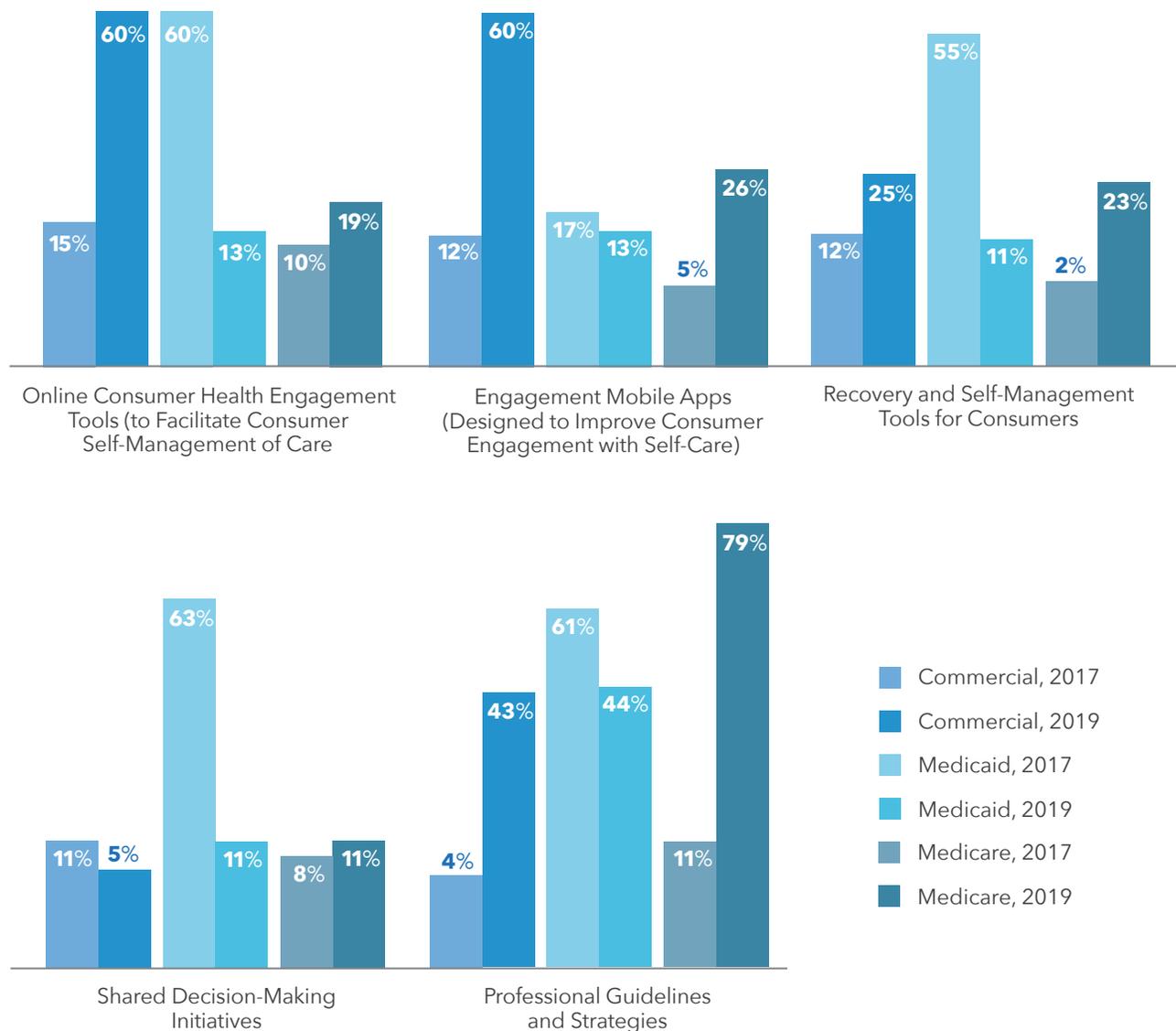
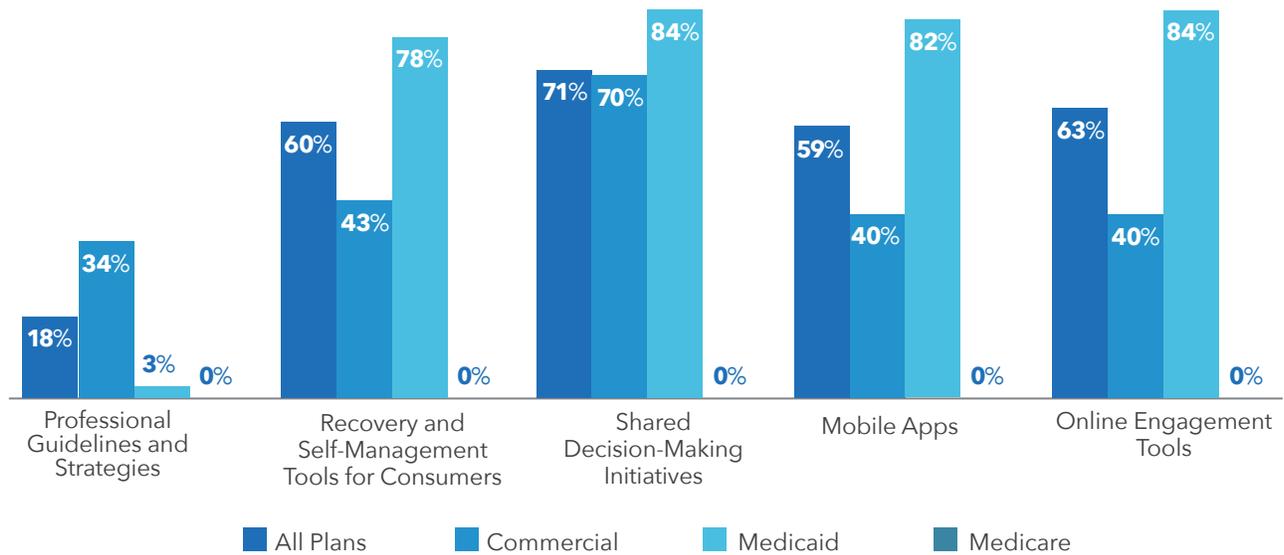


Figure 18

Planned Use of Consumer Engagement Strategies, by Plan⁵



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 continue to use innovative strategies to ensure consumers are receiving high quality care. These strategies include reimbursement models built on evidence-based practices, such as MAT for opioid dependence, certification requirements, such as patient-centered medical home accreditation, or the formation of centers of excellence (COEs).^{32,33} The National Council on Behavioral Health (the National Council) identified five core tenets of a Behavioral Health Center of Excellence:

1. World Class Customer Service Built on a Culture of Staff and Client Engagement and Wellness

2. Excellent Outcomes

3. Easy Access

4. Comprehensive Care

5. Excellent Value³⁴

Quality of care strategies that required certification or additional training were less likely to be adopted by health plans than reimbursement strategies. About 84% of health plans have specialty COEs, 81% offer payment for care coordination activities, and only 51% have peer support credentialing in place. Meanwhile, in 2017, only 12% of health plans had specialty COEs. Adoption of these requirements is much higher in Medicaid than in Medicare and commercial health plans, potentially due to the higher number of consumers with SMI being enrolled in Medicaid, resulting in a greater need for behavioral health interventions.⁵

HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

Figure 19

Utilization of Quality Initiatives, Benefit Design, Innovations, and Member Transparency Strategies, Overall⁵

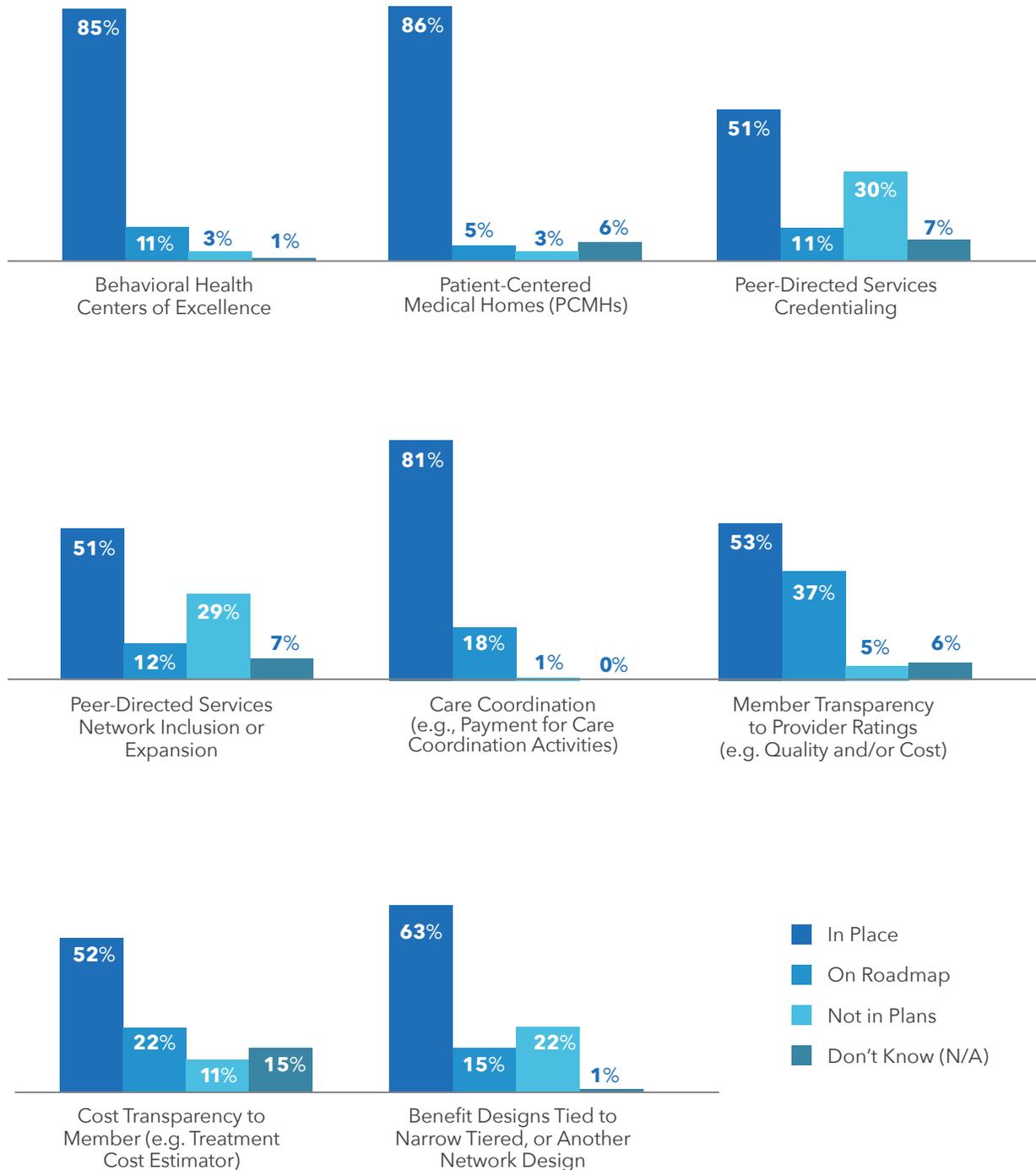
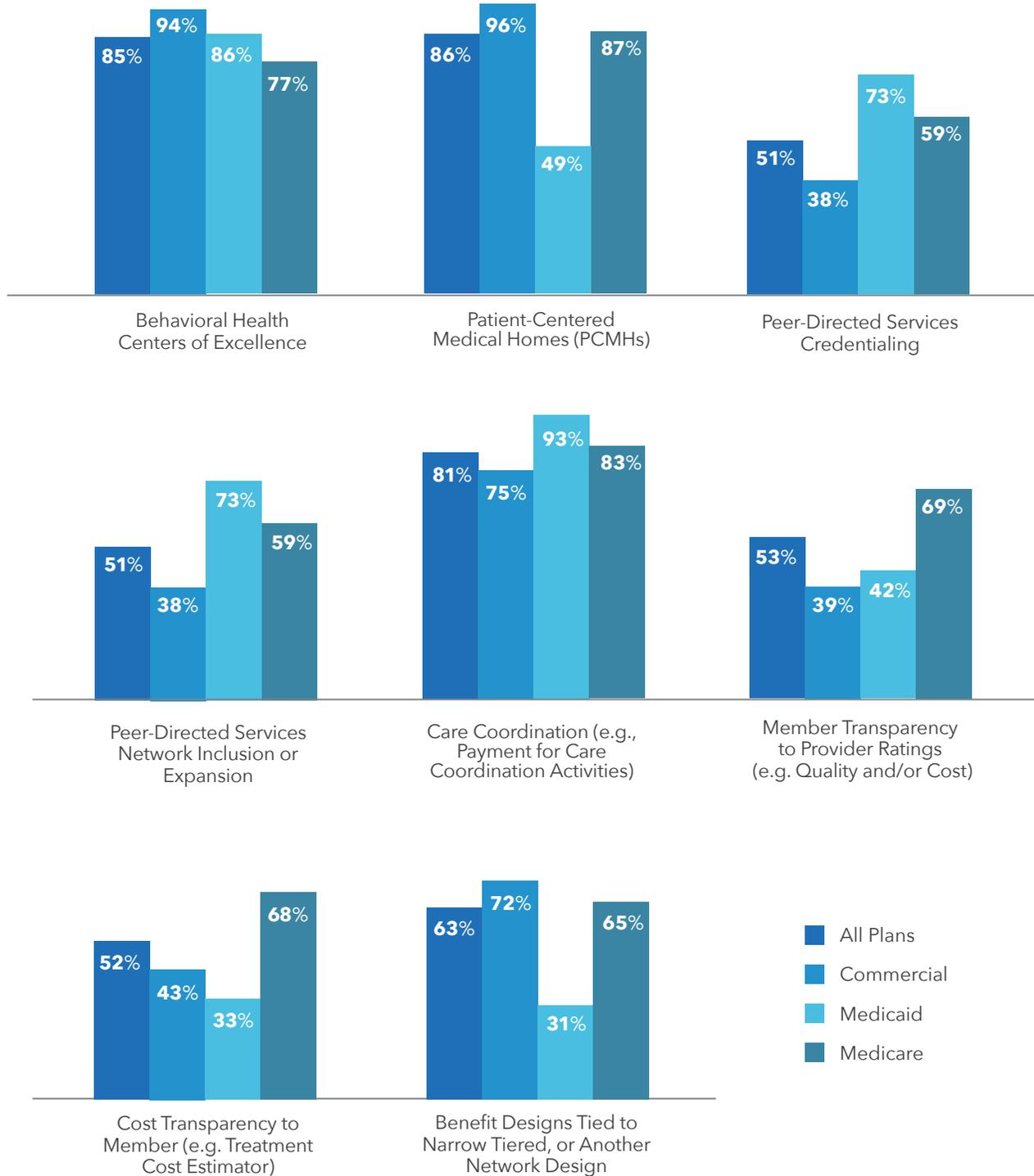


Figure 20

Utilization of Quality Initiatives, Benefit Design, Innovations, and Member Transparency Strategies, by Plan⁵



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HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

Health Plan Current and Future Use of Behavioral Health Provider Partnership Models

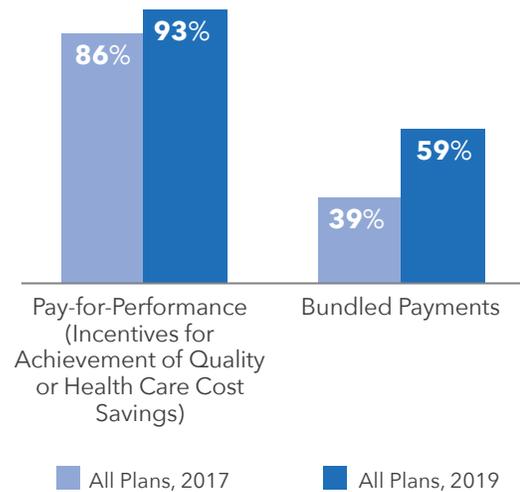
Like many trends highlighted in The Inaugural Guide, health plans continue to implement APMs that promote better integrated care management for consumers with co-occurring conditions at the provider level. ACOs, patient centered medical homes (PCMHs), behavioral health medical homes, and care models such as collaborative care all illustrate the primary role of health care provider organizations in the provision of care management.

It is important to consider the actual use of services when evaluating access to care as opposed to simpler measures of availability.

Currently, the vast majority of health plans (93%) have behavioral health provider partner models that utilize a fee-for-service (FFS) reimbursement structure that also includes a pay-for-performance (P4P) component.⁵ Typically, the P4P component either rewards or penalizes provider organizations for their reporting on quality measures. In addition to P4P models, the use of episodic or bundled payments for specific acute care episodes is gaining traction among certain payers, with 59% of plans using this model.⁵ Bundled payments is an umbrella term used to describe the grouping of 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.³⁵ Among certain payers, the use of episodic payments varies dramatically. While only 40% of commercial health plans use episodic payments, 71% of Medicare and 88% of Medicaid health plans use these payment arrangements for behavioral health.⁵ This is compared to 95%, 2%, and 47% respectively from 2017.³⁷ The use of value-based payments under

Figure 21

Utilization of Alternative Reimbursement Strategies, 2017 and 2019, All Plans⁵

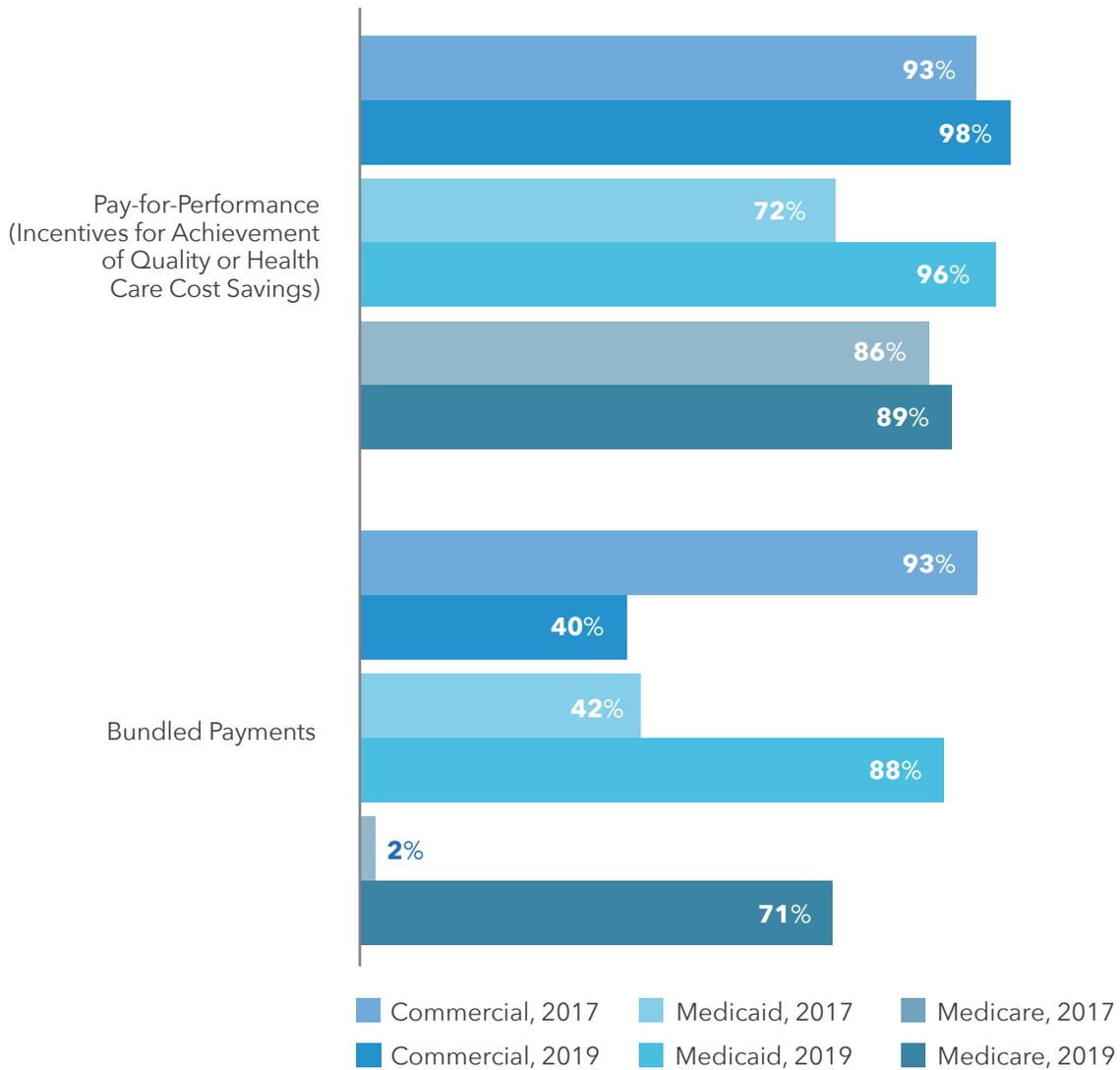


Medicaid to improve quality and reduce costs lags behind physical health.³⁶

As predicted in The Inaugural Guide, the likelihood that more health plans would adopt these behavioral health episodic or case rate payment arrangements was slim. The outlook for expansion remains bleak amongst the plans that do not already have similar APMs, with only 59% of all health plans accepting case rates and only 64% having adopted capitation.⁵ Medicaid health plans may be much more likely to adopt new behavioral health provider partnership models in the future. According to a report released by the National Association of Medicaid Directors (NAMMD), 67% of state Medicaid programs analyzed are working on creating new reimbursement protocols at the provider level, and states are requiring their contracted Medicaid managed care organizations (MCOs) to implement MCO and/or state designed APMs.³⁸ Their report highlighted how provider and payer partnership reimbursement models are expected to overall improve integration of care. In 2017, 6% of Medicaid health plans had future plans to adopt episodic payments and 12% had plans to adopt a FFS reimbursement models with a P4P component.³⁷

Figure 22

Utilization of Alternative Reimbursement Strategies, 2017 and 2019, by Plan⁵



Health Plan Current and Future Use of Value-Based Benefit Design

The Large Employers’ 2019 Health Care Strategy & Plan Design Survey found that “employers project the total cost of providing medical and pharmacy benefits will rise 5% for the sixth consecutive year in 2019. Including premiums and out-of-pocket costs for employees and

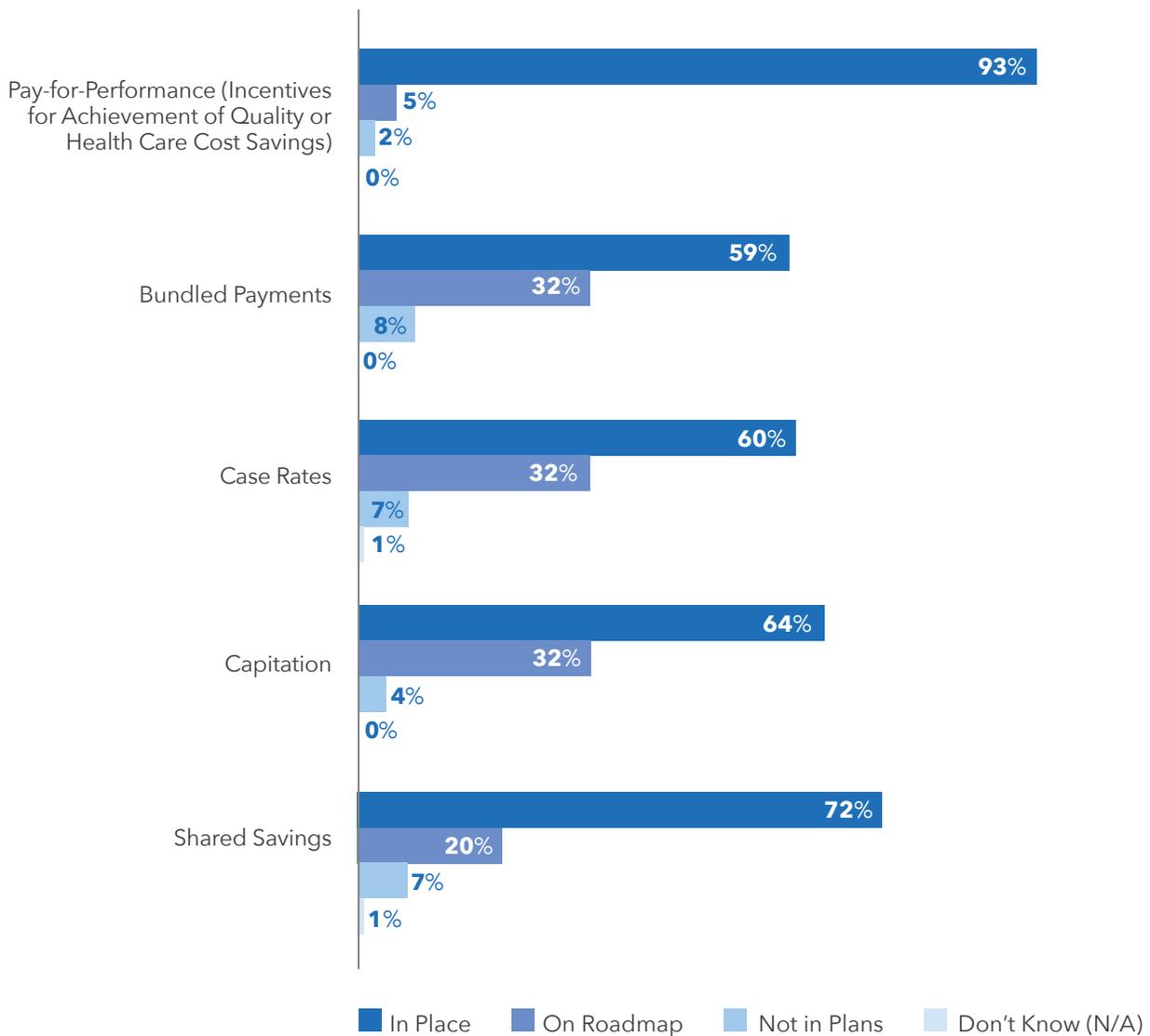
dependents, the total cost of health care is estimated to be \$14,099 per employee this year, and projected to rise to an average of \$14,800 in 2019. Employers will cover roughly 70% of those costs; employees will bear about 30%. Employers cited high cost claims, specialty pharmacy,

Developed by OAPI & Lundbeck. OPEN MINDS. (2019). OPEN MINDS Behavioral Health Delivery System, Proprietary Database. Retrieved from OPEN MINDS.

HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

Figure 23

Utilization of Alternative Reimbursement Strategies, Overall⁵



and specific diseases as key drivers of cost increases.^{39,40} As health care costs increase for employers and the percentage of care covered by households through premiums and out-of-pocket expenses also increases, employers and health plans continue to look towards value-based benefit designs as one of several strategies to help lower costs at the point of care. Value-based

benefit design aims to increase health care quality and decrease costs by using financial incentives to promote cost efficient health care services and consumer choices.³⁹

Value-based benefit design may be used to encourage enrollees to adopt appropriate use of high value services, including certain prescription drugs and preventive services, the adoption

of healthy lifestyles such as smoking cessation or increased physical activity, and use of high-performance providers who adhere to evidence-based treatment guidelines.⁴⁰ In essence, adjusting cost-sharing requirements is expected to influence consumer health care decisions such as use of high and low value health care services and improve adherence to high value treatment. In a 2016 position paper, The American College of Physicians recommended the implementation

Value-based benefit design aims to increase health care quality and decrease costs by using financial incentives to promote cost efficient health care services and consumer choices

of value-based insurance design as a potential solution to make patient cost-sharing more equitable. The paper states “consumer cost-sharing, particularly deductibles, may cause patients to forgo or delay care, including medically necessary services.”⁴¹ The National Business Group on Health’s annual examination of employer health benefit packages shows value-based designs haven’t “grown much since 2016.”⁴² However, their 2018 survey did reveal that 40% of large employers surveyed reported the use of some form of value-based benefit design aimed at encouraging consumers to better manage chronic conditions and to promoting high-value care.³⁹

Other promising value-based benefit designs include reference pricing, use of tiered and narrow networks, and COEs. The goal of these models is to encourage patients to use providers that health plans have determined to be high performing and cost-effective. Central to these

models is transparency to cost and quality. Medicare and large health plans have developed decision support tools to help individuals better understand quality and cost, including the financial benefits or burdens for the use of certain services, providers, facilities, and medications. Research on these benefit design strategies has shown mixed outcomes.

In 2019, 77% of health plans have either already implemented or will be implementing narrow or tiered networks, 89% either already have or will be implementing decision support tools and pricing and quality transparency to members, and 95% either have or will be implementing behavioral health COEs.⁵

Health Plan Current and Future Use of Models to Address Social Determinants of Health

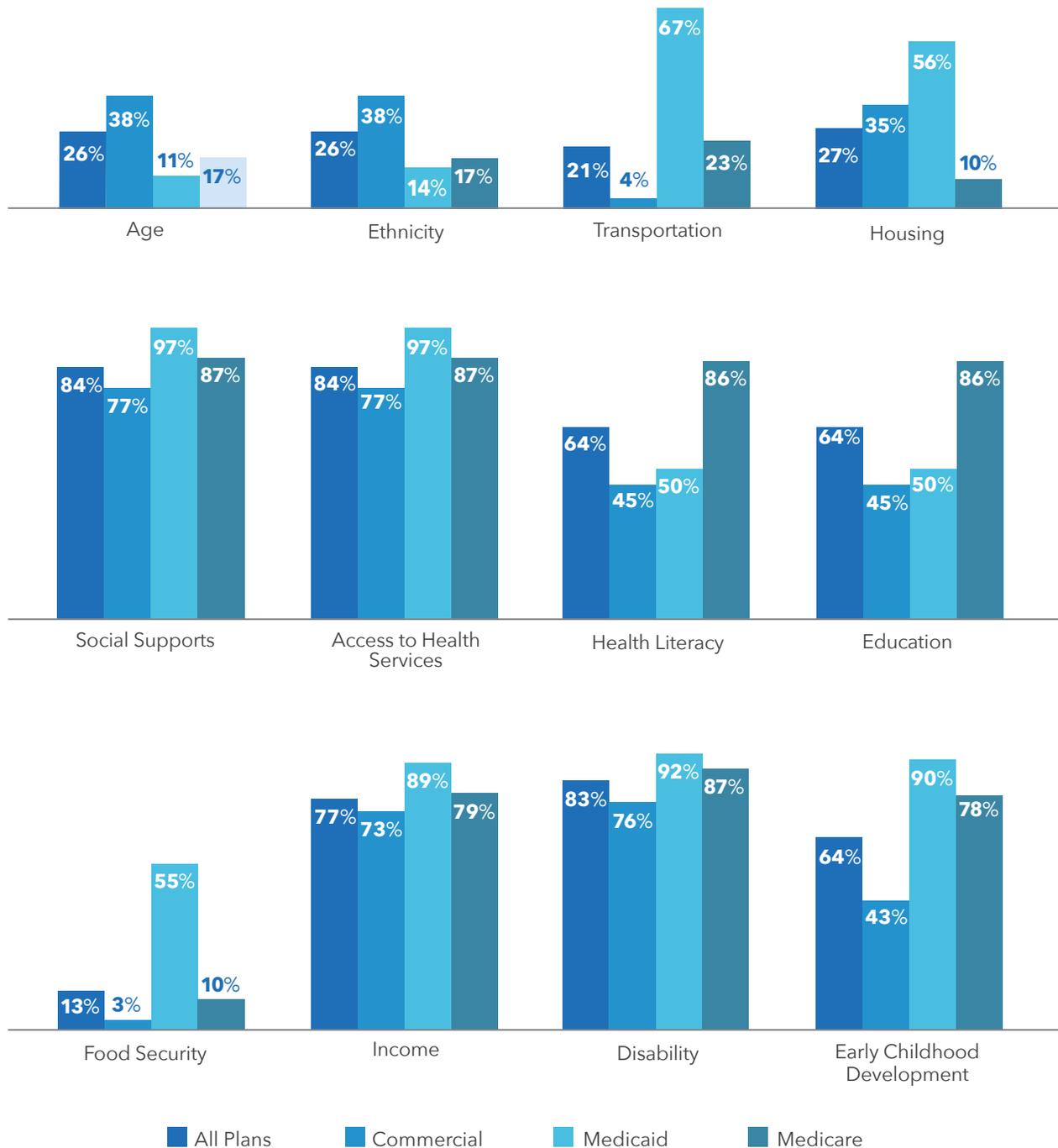
The World Health Organization (WHO) defines social determinants of health (SDoH) as “the conditions in which people are born, grow, live, work and age.” These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.⁴³ There is growing recognition of the impact of lacking social determinants on health outcomes and health care spending, including safe and affordable housing, transportation, and access to nutritional food. Social determinants also impact how and if individuals access health care and the quality of health care services that they receive.⁴⁴

Highlights from a report released in December 2018 by the Center for Health Care Strategies, Inc. outlined how SDoH are being addressed through Medicaid managed care contracts and Section partnerships to address SDoH and payment incentives to advance these projects. The review also found that incentives for healthy behaviors are not typically linked to SDoH.⁴⁵

HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

Figure 24

Utilization of Social Determinants of Health Strategies, by Plan⁵



Developed by OAPI & Lundbeck. OPEN MINDS. (2019). OPEN MINDS Behavioral Health Delivery System, Proprietary Database. Retrieved from OPEN MINDS.

Across the country, states have or will be using Section 1115 Demonstration waivers to help address SDoH. Already, Texas allows Medicaid health plans to cover transportation and activities to promote healthy lifestyles, Massachusetts allows Medicaid ACOs to pay for traditional non-reimbursed services to address health-related social needs, and North Carolina recently approved Section 1115 waivers to include funding to develop enhanced case management pilots that require coordination with community based organizations and social service agencies to address housing, food insecurity, transportation, and interpersonal violence. In addition, Medicaid

Overall, there is a significant difference in the focus on SDoH between commercial, Medicare, and Medicaid plans.

managed care contracts in California and the District of Columbia require the identification of health disparities as well as plans to address them, and Kansas requires that health risk assessments contain questions about domestic violence, housing, and employment.⁴⁵

Health plans are continuing to explore creative ways to address SDoH, one prominent example being the use of ride sharing companies, Uber and Lyft, to help address transportation barriers to care. Uber has launched Uber Health, which provides safe and convenient transportation to medical appointments, and has also built an application that allows for easy ride scheduling, reporting, and billing.⁴⁶ In addition, Lyft has announced ventures with entities such as Allscripts™ to integrate ride scheduling into their electronic health records (EHRs), and has also joined in partnerships with CVS.⁴⁵ In 2017, the Blue Cross Blue Shield (BCBS) Association announced a partnership with Lyft that will enable individuals with BCBS coverage to access the ride sharing service in order to attend medical appointments at no charge.⁴⁷

In addition to addressing transportation barriers to care, health plans are beginning to make significant investments in housing. Recently, Kaiser Permanente announced that it plans to invest up to \$200 million to help address housing stability, homelessness, and other community needs.⁴⁸ Additionally, United Healthcare has invested \$350 million in housing projects in 14 states since 2011.⁴⁹ A brief released by the Association of Health Insurance Plans (AHIP) outlined numerous housing initiatives that are being funded by health plans, including providing short term housing to payer/community organization partnerships, paying for supportive housing programs, and partnering with housing agencies to improve access to affordable housing.⁵⁰ These initiatives are more often seen within Medicaid plans. Overall, there is a significant difference in the focus on SDoH between commercial, Medicare, and Medicaid plans. For example, 35% of commercial payers currently track housing data, 56% of Medicaid payers, and 10% of Medicare.⁵

Managing Long-term Services and Supports

In fiscal year (FY) 2016, the federal government and states spent approximately \$167 billion on Medicaid Managed LTSS (MLTSS).⁵¹ Overall, Medicaid finances 51% of LTSS costs in the U.S.⁵² LTSS include an “array of supportive services needed by people who have limitations in their capacity for self-care because of physical, cognitive, or mental disability or condition.”⁵³ These services and supports include a Home and Community-Based Services (HCBS) waiver, rehabilitative services, and institutional care that is inclusive of nursing facilities and intermediate care facilities. The majority of LTSS user are under the age of 65. A report issued by the Medicaid Innovation Accelerator Program (IAP) highlighted several trends related to LTSS spending. HCBS spending increased by 10% in 2016 compared to 5% annual growth over the previous four years, during which spending on institutional care decreased. In 2016, managed care accounted

HEALTH PLAN POPULATION MANAGEMENT & INNOVATION (cont'd)

for 23% of LTSS expenditures, compared to 7% in 2012, and the population with the highest use of HCBS are individuals with developmental disabilities.⁵¹ 19 states currently operate managed long-term service and support (MLTSS) programs and are increasingly looking to MCOs to ensure that the programs offer high quality and cost-effective services.

In addition to the trends of increased use of HCBS and managed care within LTSS programs, the 2016 CMS Final Rules on Medicaid Managed Care programs will further shape the delivery of MLTSS within the U.S. Key provisions are aimed at improving the quality of services and improving patient protections. Requirements such as state requirements to credential and recredential providers allow individuals to change health plans related to provider disenrollment and enrollment, network adequacy requirements, and requirements around beneficiary support and education. The growing use of MLTSS clearly highlights CMS' commitment to quality and beneficiary rights.

In a brief released by the Center for Health Care Strategies, Inc. (CHCS), an analysis of seven states identified six current trends in MLTSS innovations and LTSS reforms:

1. Increasing Medicare and Medicaid alignment for dually eligible individuals
2. Broadening enrollment to serve individuals with intellectual and developmental disabilities
3. Leveraging housing resources and other social services to keep people in the community
4. Focusing on workforce development and expanding scope of practice
5. Advancing value-based purchasing with LTSS providers
6. Providing ongoing, comprehensive stakeholder engagement⁵²



Considerations

In 2016, the cost of health care within the U.S. was 17.9% of GDP, higher than any other developed country, and will continue to push private and government payers, states, and employers to seek ways to improve quality and decrease cost.^{54,55}

Despite current health care spending, the U.S. has higher mortality rates from common chronic conditions than most developed countries. As our survey of health plans highlights, both commercial and public payers continue to implement payment and service delivery models that promote greater value for health care. Key areas of focus include ensuring access to routine primary care and behavioral health services, leveraging technology and other non-medical supports to better engage individuals in the management of their chronic conditions, integrating treatment of both behavioral health and substance use disorders, increasing the use of value-based reimbursement and benefit design, and building specialty behavioral health networks to address OUDs and the growing percentage of the population with ASDs, all of which are likely to remain key focal areas in the coming years. Additionally, as the connection between social determinants such as housing, food, education, employment, trauma, and poverty have become increasingly clear, community investment and attention to the broader system of care and social supports will provide payers with further opportunity to improve member health outside of the traditional medical and health care systems.



Executive Summary

According to the National Institute of Mental Health (NIMH), in 2016, 44.7 million adults were living with a mental illness in the United States, which is approximately 1 in 5.¹ An estimated 10.4 million adults (4.2%) have a serious mental illness (SMI) and 49.5% of adolescents had any mental disorder, 22.2% of whom had severe impairment.¹ During that time, 43.1% received mental health treatment in the past year.¹ In 2014, 20.2 million adults had a substance use disorder (SUD), including the 1.9 million people with an opioid use disorder (OUD) related to prescription pain pills.²

According to the National Institute of Mental Health (NIMH), in 2016:



During that time, 43.1% received mental health treatment in the past year.

During that time, 2.4 million adults received treatment for SUD—only 7.5% of the SUD population.² This ongoing demand necessitates the ability of commercial and public payers to ensure rapid access to high-quality behavioral health care services. Increased focus on routine screenings for mental illness and substance use in primary care settings is likely to further stretch the current behavioral health system and increase demand for access to timely specialty care. Improved access to health insurance, including Medicaid expansion, will also place a continued demand for greater access on the system. As highlighted in the section above, health plans have employed numerous strategies to expand timely access. In a review of 27 billion private health insurance claims as part of a study on behavioral health and SUD, FAIR Health noted significant increases across behavioral health and SUD claims from 2007 to 2017. For example, amphetamine use, abuse, and dependence claims increased 3,157%, barbiturates by 2,233%, anxiety by 200%, post-traumatic stress disorder (PTSD) by 177%, and major depressive disorder by 172%.

Access to care is measured in several ways, including structural measures, such as having health insurance, or a usual source of care; assessments by consumers of

Continued on next page



Executive Summary (cont'd)

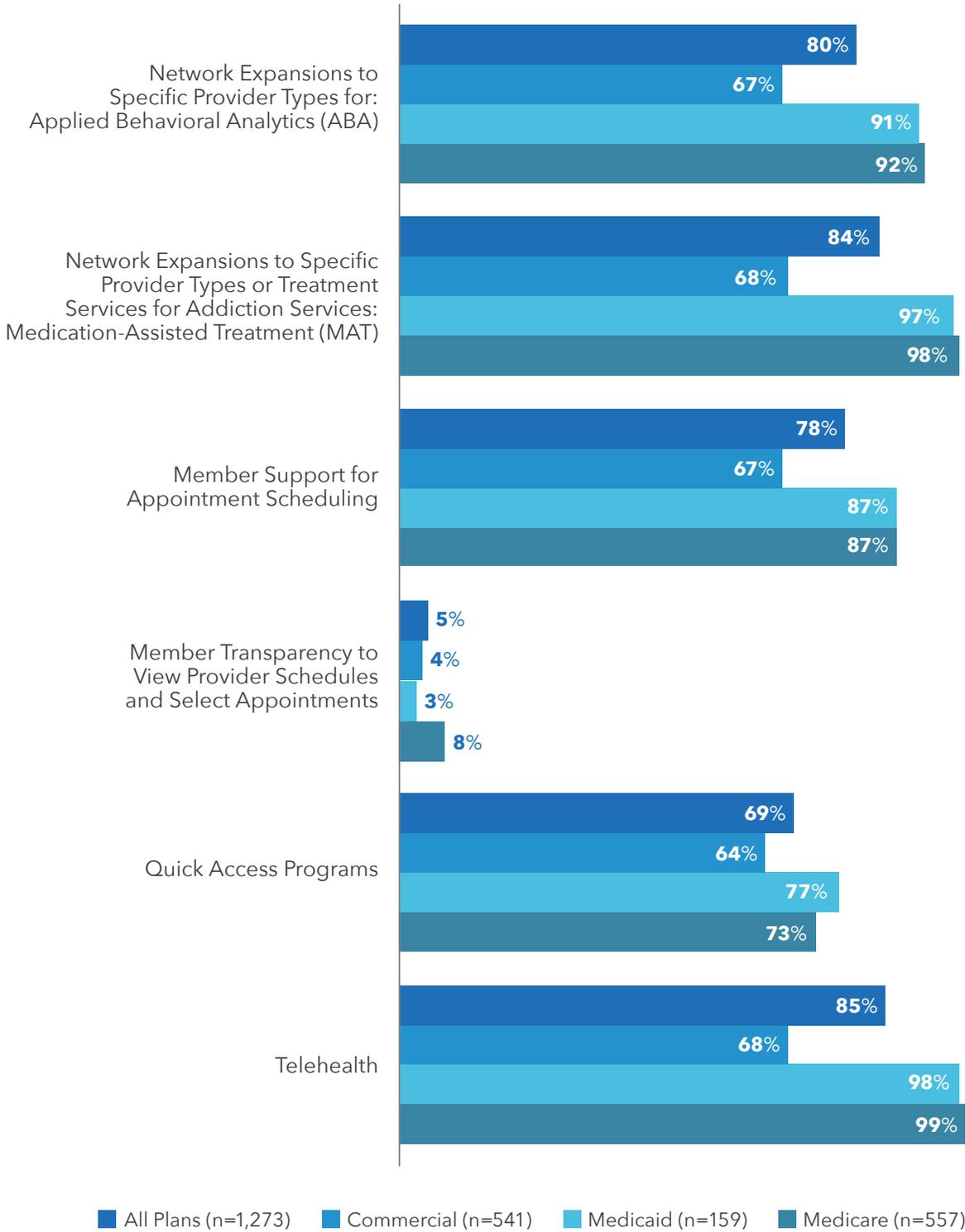
how easily they can get health care services; and utilization measures, including the successful receipt of needed services.⁴ The Centers for Medicare & Medicaid Services (CMS) Final Rule on Medicaid Managed Care requires states to develop time and distance standards for primary and specialty care, including behavioral health, and to assess and certify the adequacy of a managed care plan's provider network both annually and when there is substantial change to the program design. Currently, health plans employ several strategies to assess network adequacy. (See Figure 25 on next page).

The Centers for Medicare & Medicaid Services (CMS) Final Rule on Medicaid Managed Care requires states to develop time and distance standards for primary and specialty care, including behavioral health, and to assess and certify the adequacy of a managed care plan's provider network both annually and when there is substantial change to the program design.

While rapid access programs promote more rapid entry into services, and the psychiatric collaborative care model has the ability to better support the treatment of certain mental health issues within a primary care setting, children, adolescents, and adults with more complex psychiatric conditions will continue to need access to psychiatrist or prescribers with extensive psychiatric training. Therefore, it is important to evaluate the availability of psychiatrist by subspecialty: child and adolescent, geriatric and those with American Society of Addiction Medicine (ASAM) certification. Additionally, as emergency departments throughout the country routinely have individuals awaiting inpatient care occupying beds, understanding psychiatric bed capacity would also provide another view of behavioral health care access. A 2017 study by the National Council of Behavioral Health (NCBH) reported on the current shortage of psychiatrists and psychiatric prescribers as well as the impact of the shortage. Additionally, the country is experiencing a shortage of psychiatric beds.⁶ Lastly, a deeper dive into the availability of research-based opioid treatment is provided below, as both the federal government and health plans are taking actions to improve access to care.

Figure 25

Behavioral Health Access Strategies by Plan Type⁵



Developed by OAPI & Lundbeck. OPEN MINDS. (2019). OPEN MINDS Behavioral Health Delivery System, Proprietary Database. Retrieved from OPEN MINDS.

CONSUMER ACCESS & DELIVERY OF CARE (cont'd)

Consumer Access to Behavioral Health Care

There are 5,042 designated mental health professional shortage areas across the United States, which would require 5,906 psychiatrists.⁷ All 50 states have areas that have provider shortages. Federal regulations stipulate that, for mental health there must be a population to mental health provider ratio of 30,000 to 1 for an area to not be designated as having a shortage of providers, with the ratio lowering to 20,000 to 1 in areas of high need.⁷ As both the demand for psychiatric care and coverage to pay for psychiatric care have increased, 2003 to 2013 saw a 10% decline in the pool of psychiatrists working with the public sector and uninsured populations, and 40% of psychiatrists would no longer accept insurance.⁸ The National Council

“The biggest challenge right now is autism. There is significant variation in utilization and costs. Lots of variability in how services are used.”

—Kathy Mahiue, Aetna

report also highlighted regional shortages of psychiatrists, with 77% of counties categorized as underserved and 55% of states as having a serious shortage of child psychiatrists. In addition, 41% of all psychiatrists are located in the five most populated states with 50% of the country not having adequate coverage to meet the needs of the area.⁹ Washington D.C. and Massachusetts had the greatest number of psychiatrists per 30,000, with Idaho continuing to have the fewest per 30,000 population—which remains consistent with The Inaugural Guide.⁹

As highlighted below, access to psychiatrists and psychiatric prescribers is a universal issue among payers. Another core focus is access to specialty

“There are not enough psychiatrists, or those with prescriptive capacity, and the current providers are aging. Too few are entering into the practice.”

—Kelly Champ, VP Provider Network Strategy, Optum

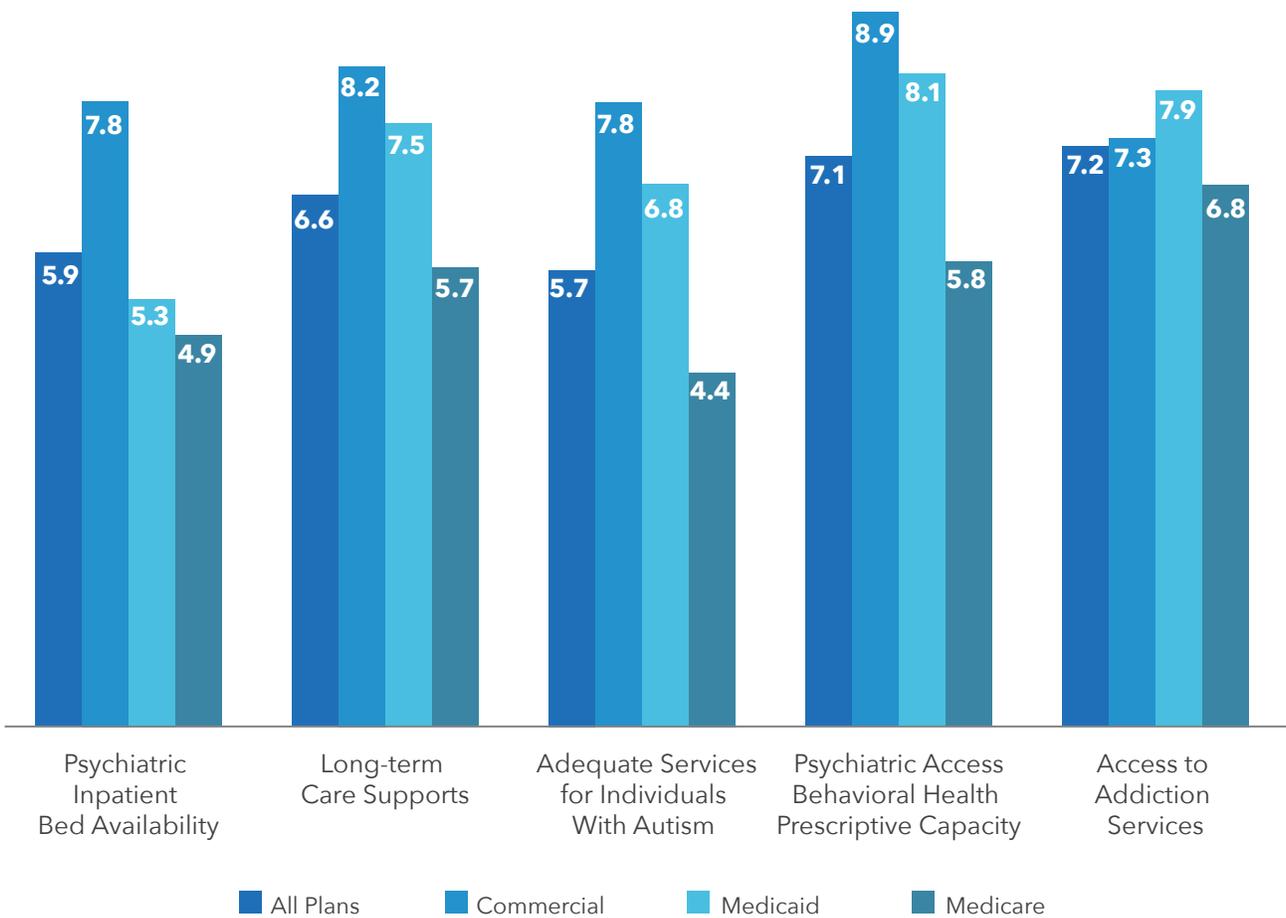
services, particularly evidence-based practice addiction services such as medication assisted treatment (MAT) and high-quality services for children with autism.

As highlighted in Domain III, models of care that integrate behavioral health care into primary care settings and the overall use of telemental health are becoming increasingly important approaches to promote greater access to care. A recent study explored telemental health as a mechanism to improve access to mental health service for female veterans and found that the use of telemental health was perceived to increase access to mental health services. Their findings included a focus on same-gender care and access to providers with specialized training, especially for women in rural areas and those with limiting circumstances, such as childcare, spousal care, and eldercare responsibilities.¹

A recent survey of large employers revealed that employers are also looking to impact access to care, with 96% reporting that they will make telehealth services available in states where it is allowed within the next year. This number is in line with the percentage of health plans already reporting coverage for telehealth services. More than half of the surveyed employers (56%) plan to offer telehealth for behavioral health services, more than double the percentage of those who currently offer such services. The same survey reports that telehealth utilization is on the rise, with nearly 20% of employers experiencing employee utilization rates of 8% or higher.¹¹ Shortages of child mental health professionals

Figure 26

Ratings of Industry Challenges on a 10-Point Scale, by Plan



coupled with the need to expand availability of both opioid use disorder (OUD) and substance use disorders (SUD) treatments continue to be drivers of the expansion of telemental efforts. Increased interest in using technology to extend behavioral health care available to youth can also be seen by the increase of research on this topic. According to Web of Science, there were 145 scientific publications between 2000 and 2014 that addressed child “telemental health,” 56% of which were printed in the past five years.¹²

Despite the growing acceptance of telemental health and widespread coverage by payers,

increased use of telehealth to deliver mental health services, there is an overall low use of utilization for SUD treatment.¹⁴

As of December 2018, there were 42,193 physicians certified to provide buprenorphine treatment to up to 30 individuals, 11,293 certified to provide treatment to up to 100 individuals, and 4,560 to provide treatment to up to 275 individuals.¹⁵ Despite these seemingly large numbers of providers, access is not universal. Geography, affordability, health care coverage, and attitudes regarding MAT remain barriers that individuals must overcome to receive these

Developed by OAPI & Lundbeck. OPEN MINDS. (2019). OPEN MINDS Behavioral Health Delivery System, Proprietary Database. Retrieved from OPEN MINDS.

CONSUMER ACCESS & DELIVERY OF CARE (cont'd)

services. Only one third of specialty addiction treatment programs offer access to the one medication used in the treatment of opioid withdrawal, and only 18% of treatment is funded through private health insurance.^{16,17}

Despite these challenges, there are promising developments and opportunities to improve access to comprehensive OUD treatment, including MAT. In 2017, 16 health insurance companies representing over 248 million individuals showed their commitment to changing the addiction treatment system by agreeing to “identify, promote, and reward” care that aligns with Shatterproof’s National Principles of Care.¹⁸ These principles call for routine screening, treatment of OUD as a chronic illness requiring

Geography, affordability, health care coverage, and attitudes regarding MAT remain barriers that individuals must overcome to receive these services.

person centered care, rapid access to treatment by well qualified treatment professionals, and the removal of barriers to MAT.¹⁸ Additionally, 84% of health plans are actively expanding their MAT networks and are implementing payment strategies to reward use of evidence-based practices and eliminating barriers to care, such as prior authorization process.⁵

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.¹⁹ While some states meet this criterion, 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.



The type of psychiatric beds, either private or state, also affects 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 affect who receives care.⁶ For example, while Iowa has 21.0 private psychiatric beds per 100,000 population, the state has only 9.0 public beds per 100,000 population. Comparatively, Wyoming only has 7.0 private beds per 100,000 population, but 23.0 public beds per 100,000 population.²⁰

The type of psychiatric beds, either private or state, affects access to inpatient care. Differences in the number of those beds per state can affect who receives care.



Considerations

While there is no short-term or quick fix to address the shortage of behavioral healthcare providers and inpatient facilities highlighted above, there are federal, state, and payer initiatives to improve access to care. Institutions for mental disease (IMD) waivers will allow Medicaid eligible individuals with serious mental illness (SMI) and SUD to access inpatient treatment beds that previously were not covered under Medicaid. However, this is likely to create greater need for inpatient bed capacity. Payers may wish to look towards less expensive residential treatment options, such as community crisis facilities, that often rely on county funding which, in some states, is braided within Medicaid fee-for-service (FFS) payments. Models such as collaborative care have shown promising results in addressing the behavioral health needs of individuals with depression, anxiety, and other SMI diagnoses in primary care. These models provide access to evidence informed behavioral health treatment, greatly extend the reach of a psychiatrist as a consultant, and have proven to be cost effective.²¹ New funding for OUD treatment and prevention affords payers the opportunity to expand the use of MAT and implement practice guidelines

that support safer prescribing practices. Promoting Screening, Brief Intervention, Referral and Treatment (SBIRT) within primary care provides another avenue for payers to promote earlier intervention and address treatment needs before higher levels of care become necessary. Lastly, technology continues to hold great promise for extending care and promoting greater individual engagement. Privacy rules and rules within Medicare and some state Medicaid programs limit the flexibility and promise of greater access to care through telemental health and other technology-based care, like text therapy and asynchronous telehealth. Efforts should be made to remove limitations such as requiring a rural or health shortage designation for the use of telehealth within Medicare, removal of requirements of telemental health services to originate from another healthcare facility, which is often a requirement of Medicaid programs, and allow healthcare providers to more easily practice telehealth across state lines. Telemental health is widely supported across all payers, and changes such as those listed above will help to promote this effective, access-improving healthcare model.

Telemental health is widely supported across all payers, and changes such as those listed above will help to promote this effective, access-improving healthcare model.

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ADDITIONAL RESOURCES

- America's Health Insurance Plans (AHIP) is a national advocacy association whose goal it is to improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. (www.ahip.org)
- Center for Health Care Strategies, a national non-profit health policy resource center focused on advancing innovations in healthcare delivery for low-income Americans. (www.chcs.org)
- The Centers for Medicare & Medicaid Innovation (the Innovation Center) supports development and testing of innovative health care payment and service delivery models. (<https://innovation.cms.gov/>)
- Health Care Payment Learning & Action Network is a public-private partnership established to accelerate transition in the healthcare system from a fee-for-services payment model to ones that pay providers for quality care, improved health and lower cost. (<https://hcp-lan.org>)
- The Kaiser Family Foundation is a non-profit organization focusing on national health issues, as well as the U.S. role in global health policy. (www.kff.org)
- Mental Health America is a community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. (<http://www.mentalhealthamerica.net/>)
- MentalHealth.gov provides one-stop access to U.S. government mental health and mental health problems information. MentalHealth.gov explains the basics of mental health, myths and facts, and more. (<https://www.mentalhealth.gov/>)
- The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. (<http://www.nami.org/>)
- The National Association of Medicaid Directors (NAMD) is a bipartisan, non-profit, professional organization representing leaders of state Medicaid agencies across the country. (www.medicaiddirectors.org)
- The National Association of State Mental Health Program Directors (NASMHPD) represents the public mental health service delivery system in all 50 states, 4 territories, and the District of Columbia. It is the only association to represent state mental health commissioners/directors and their agencies. (www.nasmhpd.org)
- The National Institute of Mental Health (NIMH) strives to accelerate the pace of scientific progress by generating research that will have the greatest public health impact and continue to fuel the transformation of mental health care. (www.nimh.nih.gov)
- The National Institute on Drug Abuse (NIDA) performs research regarding causes and consequences of drug use and addiction. Its clinical research findings are used to improve individual and public health. (<https://www.drugabuse.gov/>)
- OPEN MINDS is a market intelligence and management support firm specializing in the sectors of health and human services serving individuals with complex needs. (www.openminds.com)
- PsychU is comprised of a community of health care professionals dedicated to improving the future of mental health care through information, discussion, and collaboration. (www.psychu.org)
- The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. (<https://www.samhsa.gov/>)

