



Behavioral Health + Economics Network



Rebecca Farley, MPH
Vice President, Policy and Advocacy
National Council for Behavioral Health

How did this get started?



- **2010:** Affordable Care Act
- **2013:** Final commercial parity rules
- **2014:** Excellence in Mental Health Act
- **2015:** MACRA
- **2016:** Final Medicaid parity rules
- **2016:** Comprehensive Addiction & Recovery Act
- **2016:** 21st Century Cures Act



Where are we today?

CCBHC Demonstration
strengthens capacity in
the safety net... but
not for all

Growing demand puts
increasing pressure on
the already strained
workforce

Evolving federal policy
environment delegates
substantial flexibility
to states

Cross-sector
collaboration is key to
successful care
delivery & advocacy

Barriers & challenges faced by all

- Financial constraints
- Regulatory barriers
- Workforce challenges
- Health systems partnerships
 - Information exchange between providers
 - Care coordination relationships
- Demonstrating value in a world driven by data

That's where BHECON starts

Built on twin foundations:

- There is power in uniting across policy silos
- Sound policy decisions must rest on solid data



BHECON convened forums in
4 states* in 2016

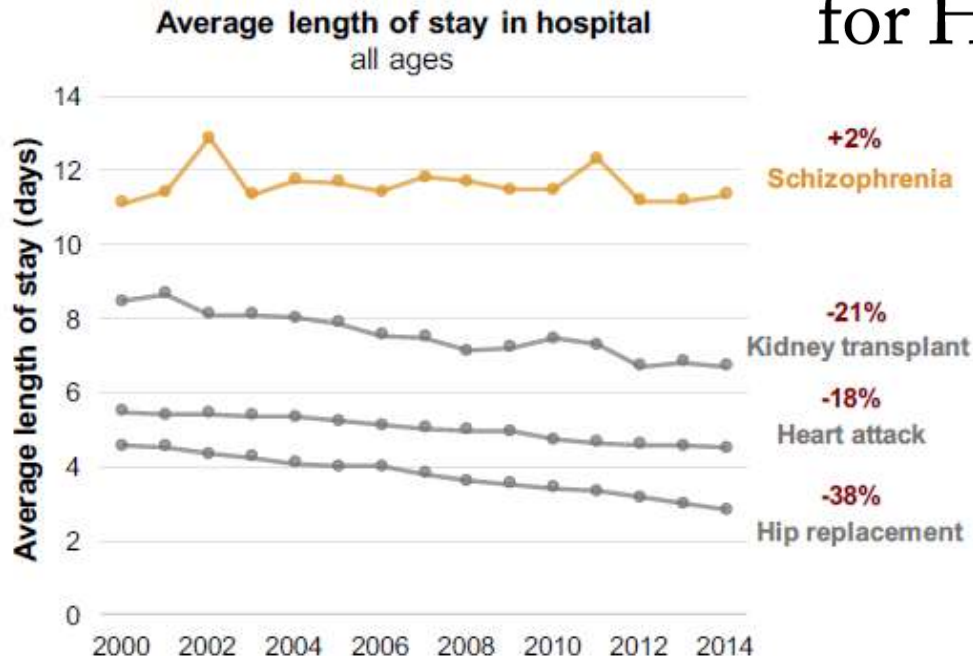


*Activities in Massachusetts coming soon!

BHECON partnered with

USC Schaeffer

Leonard D. Schaeffer Center
for Health Policy & Economics



BHECON Missouri: Workforce, Crisis Intervention

A sampling of the attendees & speakers:

- Missouri Nurses Association
- Technical schools
- Rick Gowdy, Dept. of Mental Health)
- Police chiefs, sheriffs
- Judge Joseph Locascio



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Key takeaway from the 1st panel:
#RightNowICouldUse more psychiatrists
on our staff! (Oh, and LCSWs, LPCs, &
community support staff...)

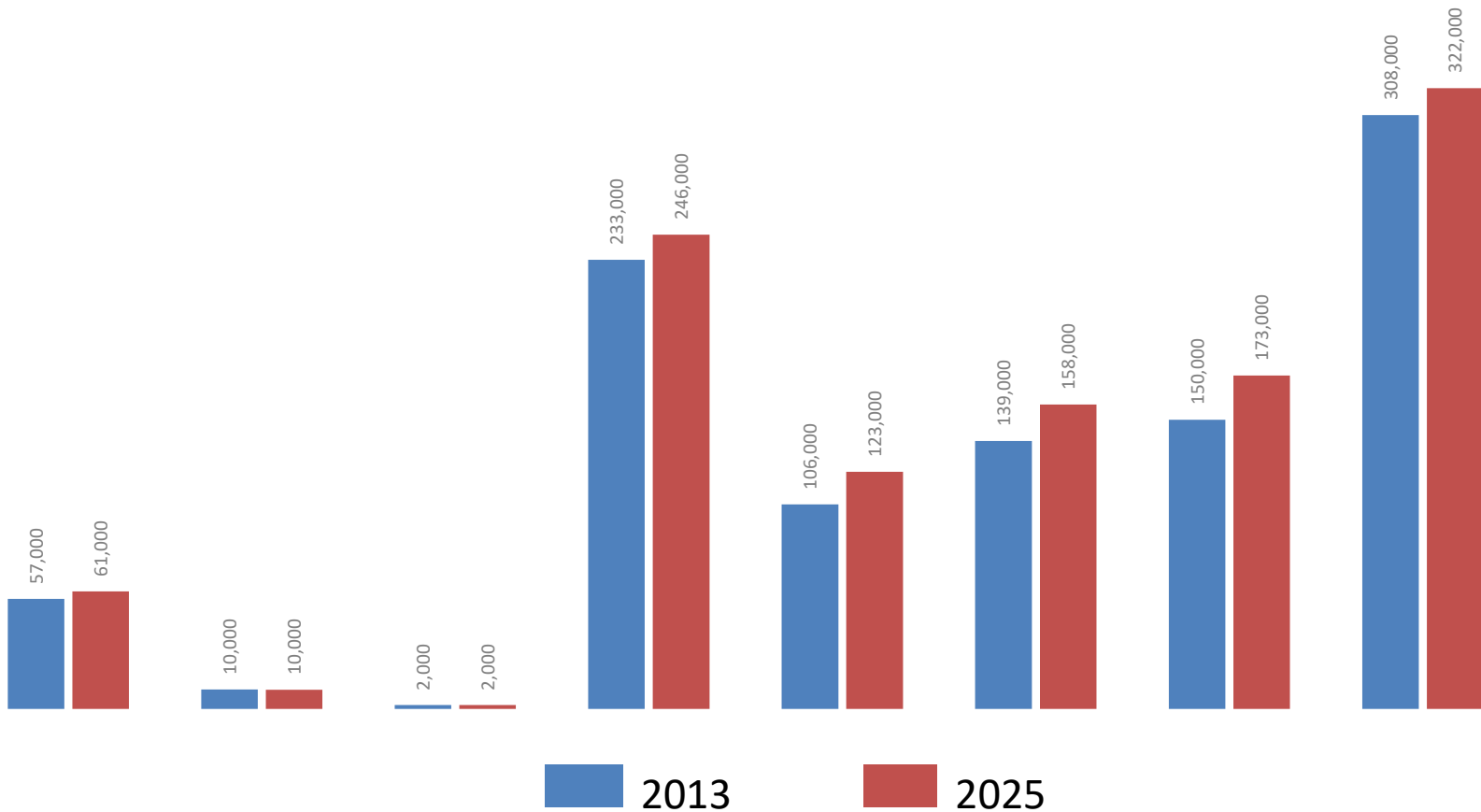


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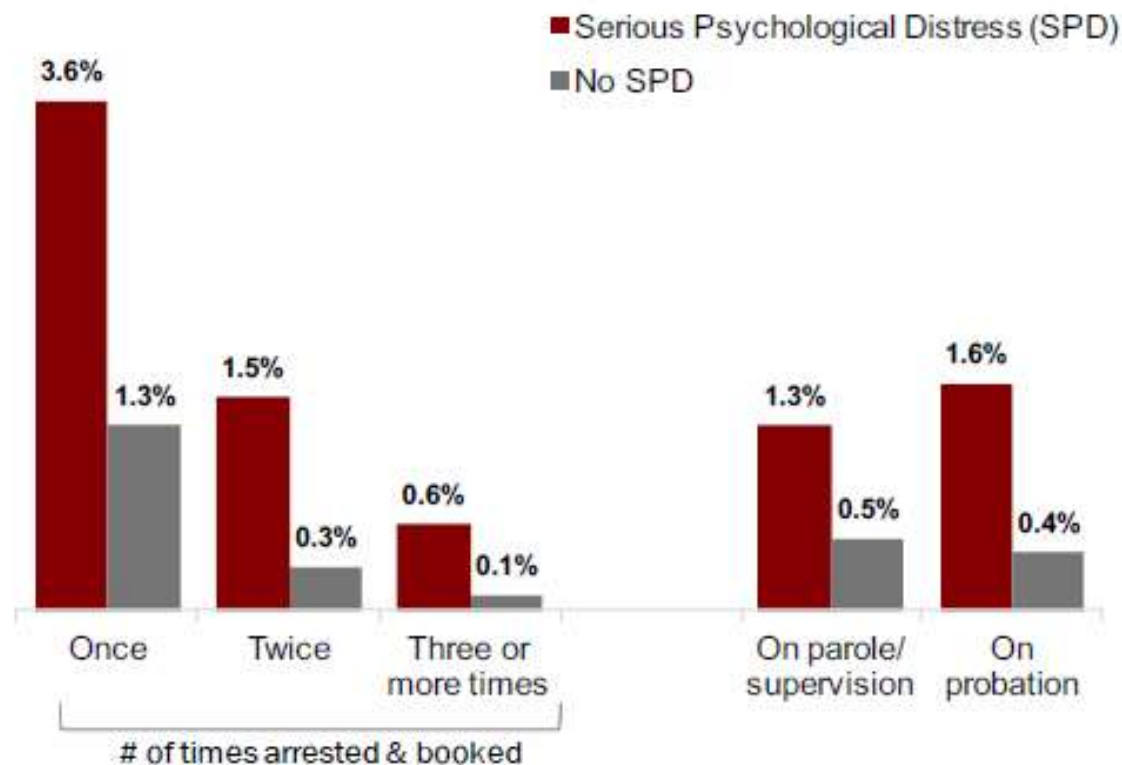
Growth in demand for services will exacerbate workforce shortage

DEMAND FOR BEHAVIORAL HEALTH SERVICES BY PROVIDER TYPE IN THOUSANDS



Contact with Criminal Justice System

UNITED STATES 2015



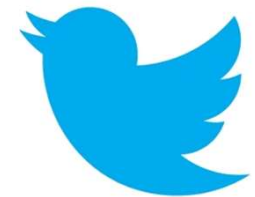
People who experienced Serious Psychological Distress (SPD) are more likely to have been arrested or be on parole or probation in the past year.

Source: National Survey of Drug Use and Health (NSDUH) 2015
Survey does not include current institutionalized population

Draft - subject to change
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Key Takeaways

- Clinics struggle to fill vacancies and retain qualified staff—with consequences for patient care and the bottom line.
- Allowing Advanced Practice Nurses to practice at the top of their license could expand access to mental health care.
- Missouri has prioritized law enforcement officer training and coordination with community mental health liaisons... but more support is needed.



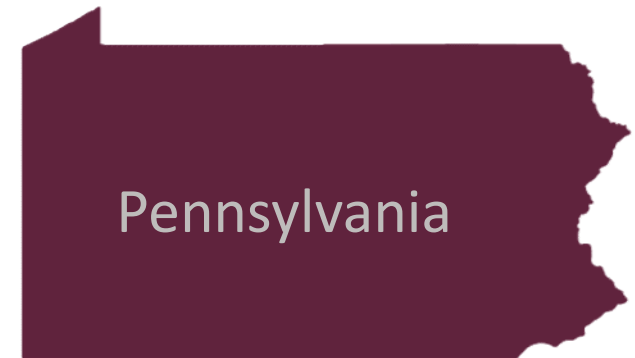
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BHECON Pennsylvania Workforce, Data Reporting

A sampling of the attendees & speakers:

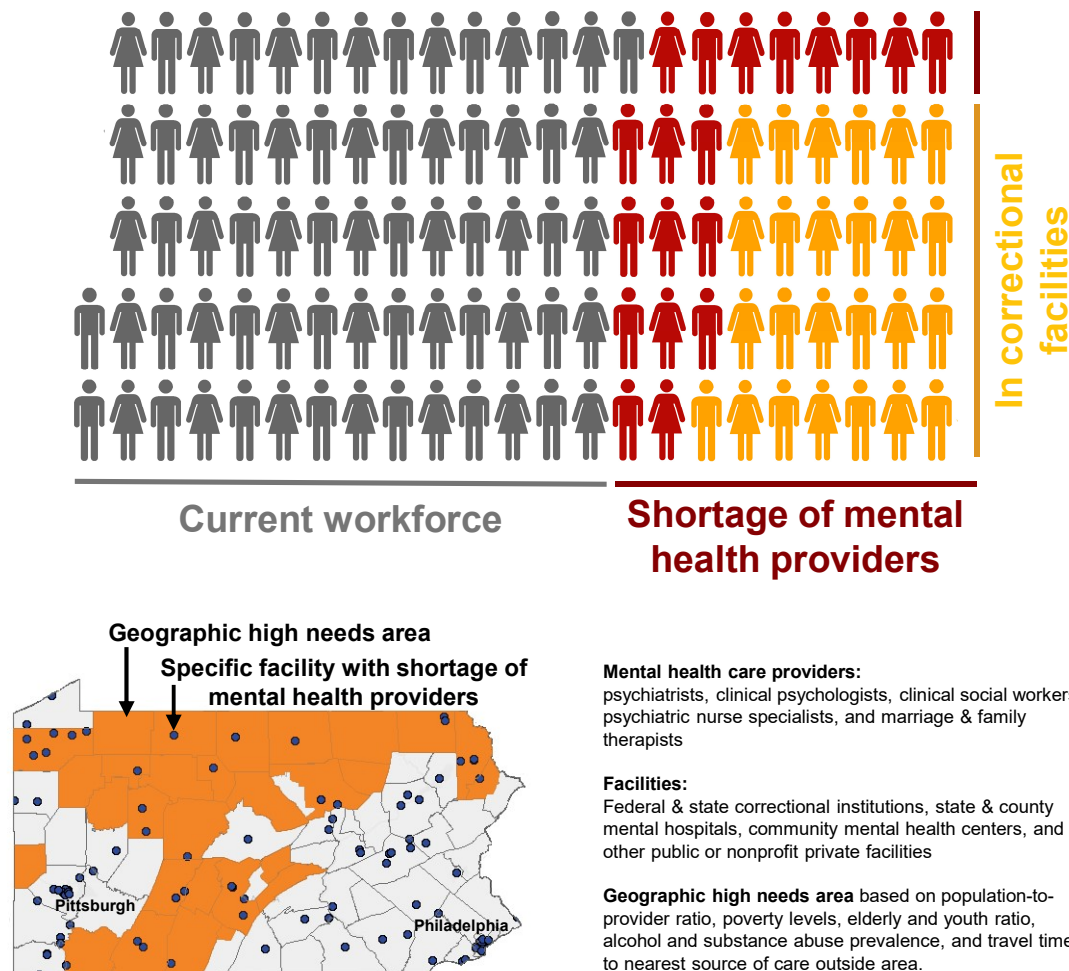
- Lt. Gov. Mike Stack (via video!)
- MCO's
- Brandon Danz, Open Minds
- Secretary John Wetzel, Department of Corrections
- State Representative Mike Schlossberg



Discussion Q's: What opportunities—and challenges—does data/quality reporting present? And what should policymakers do about it?

Shortage of mental health care providers

PENNSYLVANIA 2016



Currently, Pennsylvania has 68 full-time equivalent mental health providers in designated shortage areas. In order to address the shortage issue, 44 more full-time providers are needed in these areas, 25 of whom in correctional facilities. 14% of the total population of Pennsylvania resides in designated shortage areas (1,832,032 people)

Source: Health Professional Shortage Areas (HSPA), HRSA Data Warehouse data as of 7/31/2016

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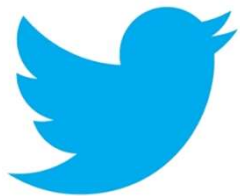
Data gathering: lessons learned

- Identify infrastructure, technology needs
 - For data **reporting** and data **analysis**
- Know what data to gather
- Staff up: hire or train staff on using data analytics for quality improvement
- Sometimes the results don't demonstrate what you want
 - Be flexible in adjusting workflows, practices
 - Or reconsider: does this data accurately capture what I need for decisionmaking?

Key Takeaways

- Providers are using data to improve patient outcomes, reduce waiting times, set performance benchmarks and costs—and want to do more.
- Inadequate behavioral health workforce underlies high incarceration rates for individuals living with a mental illness
- Possible solutions include loan forgiveness, revising outdated regulations, raising reimbursement rates

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Following

#Mentalhealth provider salaries are so low,
“We're competing with grocery stores & fast
food companies for our workforce.” -Noreen
#BHECON



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Jon Evans @InnovaTel_Team sums up
why we must address quality reporting
regs: "There's an opportunity to improve
access and reduce costs."

BHECON Connecticut

Behavioral Health Financing & Advocacy

A sampling of attendees & speakers:

- Craig Obey, Families USA
- NAMI Connecticut
- Dr. Peter Jacoby, Emergency Medicine, St. Mary's Hospital
- Lt. Christopher McKee, Windsor Police Department



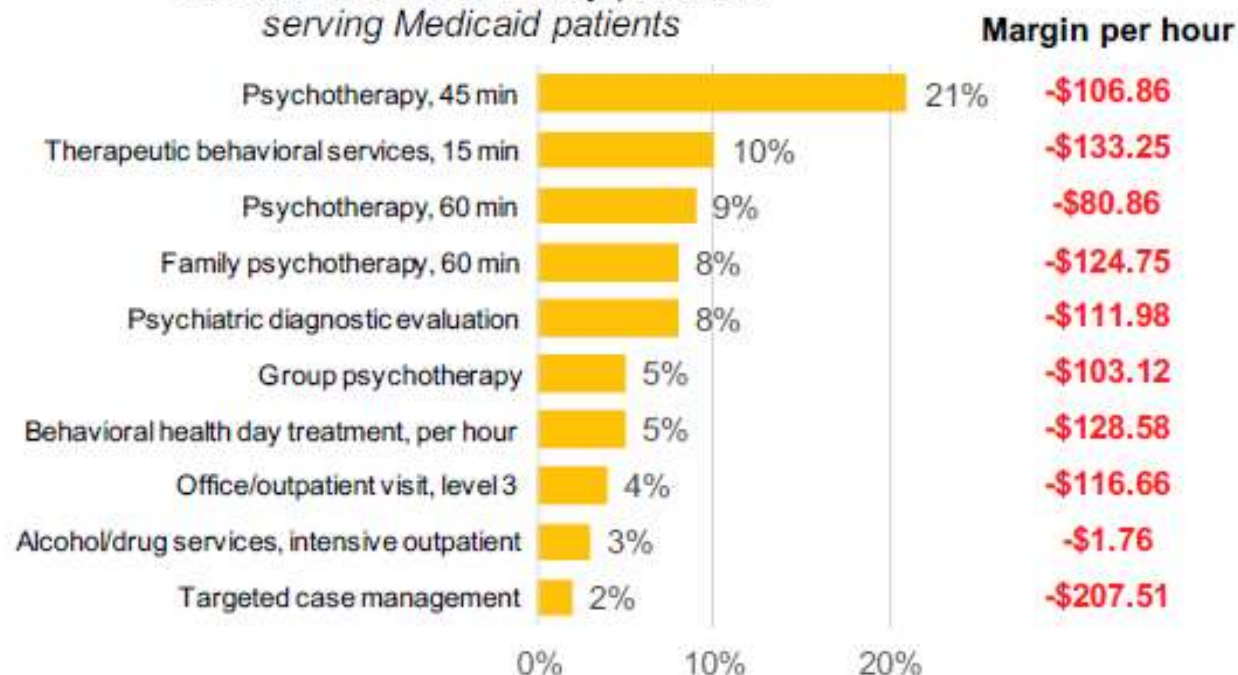
Discussion: How do you create a successful advocacy campaign? How have other organizations created a statewide movement for change?

Medicaid reimbursement rates for mental health services by community providers are low

CONNECTICUT 2014

Top 10 procedures by volume

selection of CT community providers serving Medicaid patients



The 10 most utilized behavioral health services account for 75% of total service hours by community providers.

The service delivery cost for these procedures is higher than the revenue under Medicaid rates, resulting in **negative margins** and providers operating at a loss.

The **annual loss** for these procedures is more than \$27 million for approximately 250,000 service hours.

Source: Prioritizing Community Based Services in CT, CT Community Providers Association, February 2015

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Number of **Connecticut state prison inmates**
previously diagnosed with serious mental illness:

3,542

Overall annual costs:

\$ 149,781,030

(in 2015 US\$)

Overall annual costs based on 2014 average of all state prison inmates in Connecticut

Source: Annual Survey of State Government Finances 2014

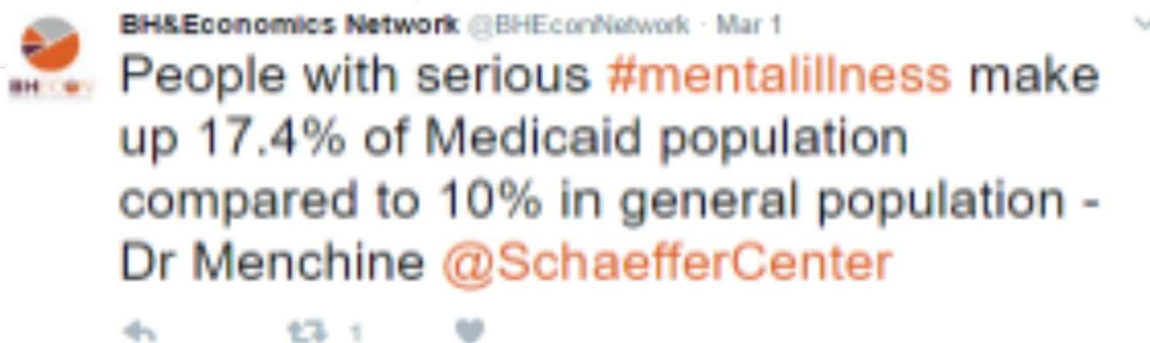
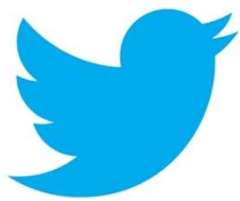
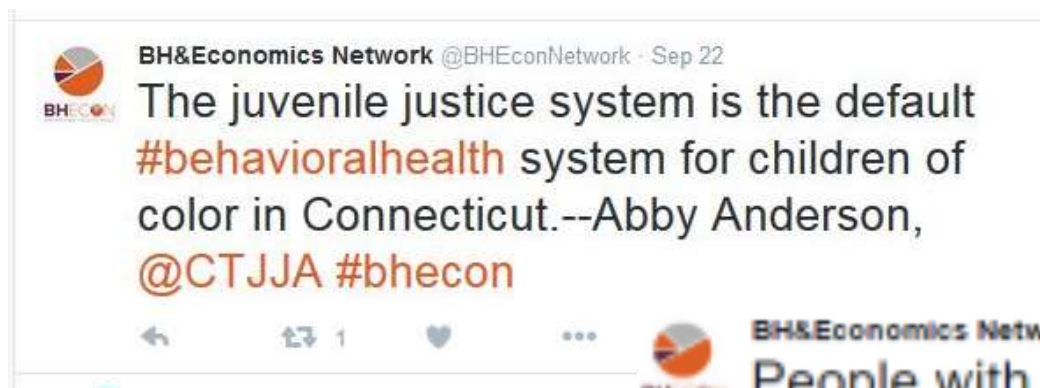
Survey of Inmates in State/Federal Correctional facilities, BJS, 2004

Connecticut Department of Correction website – Incarcerated Population by Status and Gender

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Key Takeaways

- Untreated mental illness is a major cost-driver for the nation's economy and criminal justice system
- Greater investments in behavioral health can drive savings and improve outcomes across social service sectors.
- There are advocacy lessons for the behavioral health community in the movement to end chronic homelessness in CT.



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BHECON Illinois

Behavioral Health Financing & Advocacy

A sampling of attendees & speakers:

- Secretary James Dimas, Dept. of Human Services
- State Rep. Sara Feigenholtz – 12th District
- State Rep. Lou Lang – 16th District
- Vic DiGravio, Association for Behavioral Health
- Kim Yeagle, Missouri Coalition for Community Behavioral Healthcare

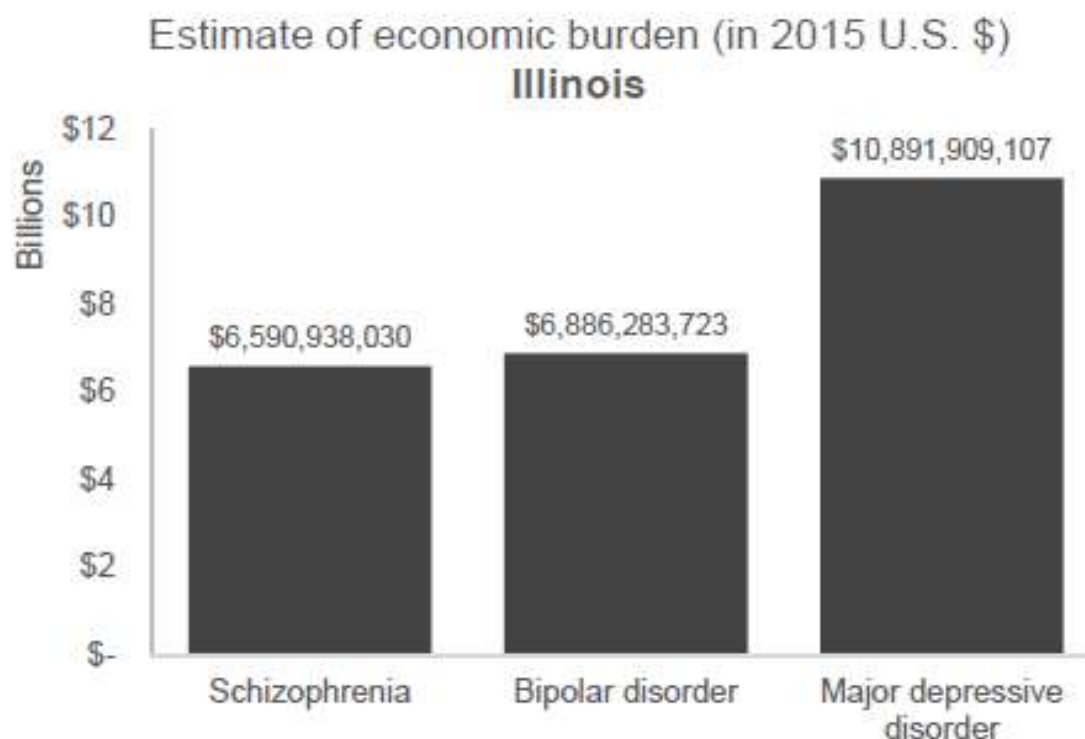


Big Changes for Illinois!

Illinois submitted an 1115 Medicaid Waiver in 2016. Many of the BHECON discussions focused on changes that could be achieved through the waiver.

Economic burden of serious mental illness

Illinois



The economic burden of schizophrenia, bipolar disorder, and major depressive disorder is estimated to be at least 10 billion dollars for each serious mental illness in Illinois.

Due to symptom overlap, diagnoses of mental illnesses are not mutually exclusive, therefore, patients with two or more diagnoses may be represented in multiple categories.
Source: MacEwan JP, Seabury S, et al. Pharmaceutical innovation in the treatment of schizophrenia and mental disorders compared with other diseases. *Innov Clin Neurosci*. 2016 Aug 1;13(7-8):17-25.
Original sources: The Economic Burden of Schizophrenia in the United States. Tokyo, Japan: Otsuka; 2015. Dilsaver S.
An estimate of the minimum economic burden of bipolar I and II disorders in the United States: 2009. *J Affect Disord*. 2011;129(1-3):79-83.
Wyatt R, Henter I. An economic evaluation of manic-depressive illness—1991. *Soc Psychiatry Psychiatr Epidemiol*. 1995;30(5):213-219.
Greenberg P, Fournier A, et al. The economic burden of adults with major depressive disorder in the United States (2005 and 2010). *J Clin Psychiatry*. 2015;76(2):155-162.

1115 Waiver in Illinois

Key initiatives include:

- Behavioral Health and Physical Health Integration.
 - ✓ Development of team-based care partnerships between providers, workforce cross-training to ensure competence in both behavioral and physical health)
- Provision of services in jails pre-release
 - ✓ Including use of medication-assisted treatment

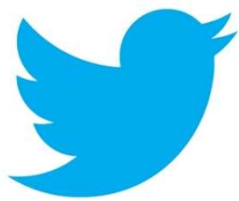
Key Takeaways

- 25% of Illinois Medicaid enrollees have behavioral health needs but account for 56% of costs.
- Illinois' proposed 1115 waiver has promising approaches... but does not address a key driver of lack of access, which is low reimbursement
- House Majority Leader Lou Lang committed to launching a bipartisan legislative mental health task force.



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Key goal of **#Medicaid** transformation in IL: shift resources to community-based **#mentalhealth** care **#bhecon**



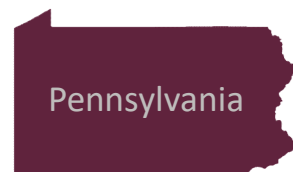
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Illinois' state **#mentalhealth** agency spends \$72 per person compared to avg. \$127 per person among all states. **@SchaefferCenter** **#bhecon**

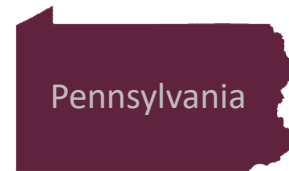
Common themes: workforce & payment

- The behavioral health workforce shortage severely limits patients' access to care and providers' ability to deliver services across all states.
- There's no simple solution: multi-pronged efforts are needed at the state and federal level:
 - Improving reimbursement to support increased salaries (CCBHCs)
 - Loan forgiveness
 - Higher education curricula
 - Telehealth / technology



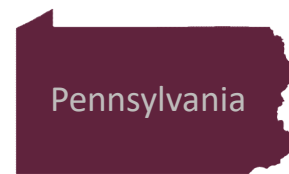
Common themes: crisis intervention, diversion

- Criminal justice system is often the de facto MH care provider
- Cross-sector collaboration is crucial to effective crisis intervention
- States are partnering with law enforcement to offer training (MHFA, CIT) & community mental health liaisons
- Additional investment is needed in front-end diversion as well as re-entry



Common themes: making the case for value

- Integrated care improves outcomes and saves money... but BH providers must make the case to payers, states and other health providers about the value of partnership & investment.
- Providers are beginning to leverage data to make the case for their services.
 - Multitudes of reporting requirements can be a burden and don't always reflect real value of care provided.
 - Providers need help with the costs of IT and data analytics tools.



What's next in 2017?

- Support BHECON states in continued advocacy
- Expand research partnership; translate data into useful advocacy materials
- Build on BHECON momentum by expanding activities to additional states
- Leverage BHECON activities to advance conversations on policy reform on Capitol Hill and in states





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