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Behavioral Health National Landscape, Mental Health Parity & the Nexus of Criminal Justice

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Connecticut Public Health Committee Briefing

Presented by: The National Council for Behavioral Health

National Council for Behavioral Health

The unifying voice of our 2,900 member organizations that are providing mental health and addictions treatment and services to over 10 million adults, children and families in the United States.

We are committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

The National Council introduced **Mental Health First Aid USA** and more than 1 million Americans have been trained.

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Crisis in the safety net: access to care

Only **65%** of people with a serious mental illness receive treatment each year.

Only **10%** of people with an addiction receive treatment.

Where do the others go?

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General Parity Rule

- Plans may not apply any **financial requirement** or **treatment limitation** to MH/SUD benefits in **any classification** that is **more restrictive than** the **predominant** financial requirement or treatment limitation of that type applied to **substantially all** medical/surgical benefits in the same classification.

> **In plain English:** coverage limitations on MH/SUD benefits can't be more restrictive than they are for physical health.

In Medicaid, parity is attached to the individual:

- Enrollees with <u>any part</u> of their benefit provided in Medicaid managed care or Medicaid health plan
- All enrollees in the Medicaid expansion (i.e. Medicaid Alternative Benefit Plans)
- Enrollees in CHIP plans

Parity applies for **<u>individuals</u>** enrolled in MCOs or health plans **<u>EVEN IF</u>** mental health and addiction services are carved out of the managed care plan

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Refresher on treatment limitations

- **Quantitative Treatment Limitations (QTL)** are things that can be measured by numbers
  - E.g. visit caps, length of stay limits, etc.
- **Non-quantitative treatment limitations (NQTLs)** cannot be measured by numbers
  - E.g. methods for determining provider reimbursement rates, medical necessity criteria, formulary design, standards for provider admission to networks, prior authorizations, etc.

Analysis of NQTLs is slightly different from general parity rule:

- Any processes, strategies, evidentiary standards, or other factors used in applying non-quantitative treatment limitations to MH/SUD benefits in a classification must be **comparable to**, and applied **no more stringently than**, those applied to medical/surgical benefits

In plain English: how you determine whether an NQTL is in compliance with parity depends on how you define "comparable."

Remember:

The *standard* must be the same, but not necessarily the *outcome.*

- **Example:**
  A health plan applies concurrent review to all inpatient admissions for primary diagnoses in which a 3-year look-back demonstrates high levels of variation in length of stay. In practice, the application of this standard affects 60% of MH/SUD admissions, but only 30% of medical/surgical admissions.

Study demonstrates major disparities in provider rates

Non-psychiatrists are paid 15%-25% more in-network than psychiatrists for the same service

Median Rates for Medication Visit:

Code	Provider	In-Network
99213	Psychiatrist	$66
	Psych NP	$42
	Non-Psych MD	$76
99214	Psychiatrist	$91
	Psych NP	$75
	Non-Psych MD	$114

Our message: low rates reduce access to care

- Lower rates attract fewer behavioral health providers to participate in-network and are an obstacle to accessing care
- Behavioral health providers are paid much higher out-of-network, incentivizing them to not join the network
- Fewer behavioral health providers in-network force more patients to go out-of-network
- Higher out-of-network deductibles and co-pays are an obstacle to accessing care

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Limits of parity?

- Legislation and litigation have long time horizon
- Litigation and some regulatory reviews require complaints to be filed before action can be taken
- Granularity of analysis means regulatory review body findings often applicable to only one plan
  - **Proactive (i.e. prior to plans being approved for sale) market conduct exams likely have the most potential impact**

What is “comparable?”

Under parity law, determination of whether unequal provider pay is a violation comes down to whether the process for determining MH/SUD rates is deemed “comparable to” that on the physical health side.


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Upcoming federal & state action on parity & provider pay?

Additional federal regulatory action on parity unlikely

- Clarifications on NQTLs have been issued, along with parity roadmap and toolkit
- Feds working with states around enforcement but unlikely to dramatically increase their own enforcement

The Nexus of Behavioral Health & Criminal Justice

The criminal justice system has become the largest de facto mental health and addiction treatment provider in United States, due to an underfunded and overburdened safety net, but prisons and jails are often poorly equipped to address serious mental illness (SMI) or substance use disorder (SUD), leading to increased costs for states and counties.

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Scope of the Problem

- In 2012, jails and prisons housed 10 times as many persons with SMI than state hospitals, highlighting that individuals with SMI are more likely to encounter the justice system than receive behavioral health services. [1]
- Approximately 1 in 25 adults in the U.S., roughly 4%, experiences a SMI in a given year but an average of 22% (more than 1 in 5) of state prison inmates have previously been diagnosed with a SMI.[2]
- In prison, more than 50% of those who were medicated for mental health conditions at admission did not receive pharmacotherapy in prison.[3]

1 Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014). The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf
2 NAMI. Mental Health by the Numbers. Retrieved from: https://www.nami.org/learn-more/mental-health-by-the-numbers
3 Reingle Gonzalez, J. M., & Connell, N. M. (2014). Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity. American Journal of Public Health, 104(12), 2328–2333. http://doi.org/10.2105/AJPH.2014.302043

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Costs Associated with Behavioral Health in the Criminal Justice System

- In 2014, the costs associated with SMI in Connecticut's prisons was $149,781,030.
- Annually in the U.S., housing an inmate with mental illness in jail costs an average of $31,000.[1] Depending on the average costs for the state, a SMI diagnosis can double or triple associated housing costs of an inmate.
  - Community Mental Health services cost only $10,000.

1 Giliberti, M. (2015). Treatment, not jail: It's time to step up. [NAMI] Retrieved from https://www.nami.org/Blogs/From-the-Executive-Director/May-2015/Treatment,-Not-Jail-It%E2%80%99s-Time-to-Step-Up

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Connecticut has Made Significant Strides

- In the U.S. an average of 22% of state prison inmates have previously been diagnosed with a SMI; in Connecticut it's 21% of state prison inmates.
- Connecticut has significantly decreased its prison population, hitting a historic 23-year low in number of individuals incarcerated in 2017.
  - The Second Chance Society program has put focus on reclassifying drug offenses, removing mandatory minimums for non-violent drug possession and increasing re-entry services.
- But, those with SMI are still more likely to be incarcerated for lower level offenses.
  - And individuals with SMI are twice as likely to have a co-occurring substance use disorder.[1]

1 National Institute on Drug Abuse. (2010). Comorbidity: Addiction and Other Mental Illnesses. Retrieved from https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf

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Focus on Substance Use Disorders (SUD) in Prisons

- Inmates are seven times more likely than the general population to have a lifetime instance of SUD.[1]
  - Every dollar invested in SUD treatment with criminal justice-involved clients yields a return of $4 to $7 in reduced crime, criminal justice costs and theft.[2]
- A former inmate's risk of death within the first 2 weeks of release is more than 12 times that of other individuals, with the leading cause of death being a fatal overdose.[3]
- Inmates who receive SUD treatment prior to release are more likely to engage in treatment after their release than inmates who only participate in counseling.[4]

1 The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation. (2014). State Prison Health Care Spending: An examination. Retrieved from http://www.pewtrusts.org/~/media/assets/2014/07/stateprisonhealthcarespendingreport.pdf

2 The National Institute on Drug Abuse. (1999). Principles of Drug Addiction Treatment: A Research-Based Guide. Retrieved from https://www.drugabuse.gov/sites/default/files/podat_1.pdf

3 Binswanger IA, Stern MF, Deyo RA, et al. Release from prison–a high risk of death for former inmates. N Engl J Med. 2007;356(2):157-165. doi:10.1056/NEJMsa064115.

4 Gordon MS, Kinlock TW, Schwartz RP, Fitzgerald TT, O'Grady KE, Vocci FJ. A randomized controlled trial of prison-initiated buprenorphine: prison outcomes and community treatment entry. Drug Alcohol Depend. 2014;142:33-40. doi:10.1016/j.drugalcdep.2014.05.011.

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Prison-based SUD Treatment is a Regional Trend

- Rhode Island was the first state to offer medication assisted treatment to their entire prison population, including transition planning upon release to continue treatment, and overdose rates among recently released inmates dropped from 14% of all overdoses in RI to 5%.
- New Jersey opened the first prison in the U.S., Mid-State Correctional Facility in Fort Dix, designed specifically to treat inmates with SUD last year.
- New York has offered a methadone treatment program at Rikers Island for over 30 years and has seen overall health care cost savings, reduced crime and recidivism, reduced HIV and hepatitis C transmission, and better than average rates of recovery from drug use.
- Massachusetts passed legislation last year expanding addiction treatment in correctional settings.

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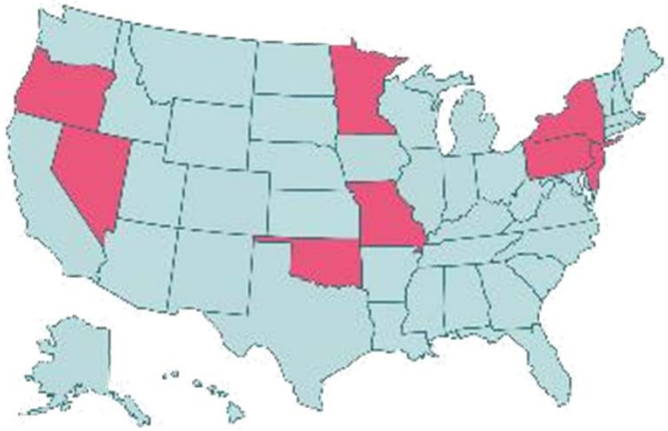
Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs Expand Access to Addiction Care with:

- **Comprehensive, Integrated Care:** CCBHCs are responsible for providing a comprehensive array of mental health and substance use disorder (SUD) services as well as integrated physical health services. SUD services include outpatient services, detoxification, residential programs, and peer support.
- **Evidence-Based Practices:** Supports medication-assisted treatment and other key evidence-based practices for addiction prevention, treatment and recovery.
- **Enhanced Addiction Workforce:** CCBHCs' Medicaid rates will allow clinics to hire new staff such as licensed addiction counselors or peer addiction support specialists.
- **Same-Day Access/Care Outside of Clinic:** With enhanced staffing, clinics will have greater capacity to offer same-day services. CCBHCs can also offer services outside the four walls of their clinic; for example, via mobile crisis teams, home visits, outreach workers and emergency or jail diversion programs.
- **Early Identification of SUDs:** All patients receive an initial assessment related to the patient's use of alcohol, tobacco, and other drugs.

Participating States

- Missouri
- Minnesota
- New Jersey
- New York
- Oregon
- Oklahoma
- Nevada
- Pennsylvania



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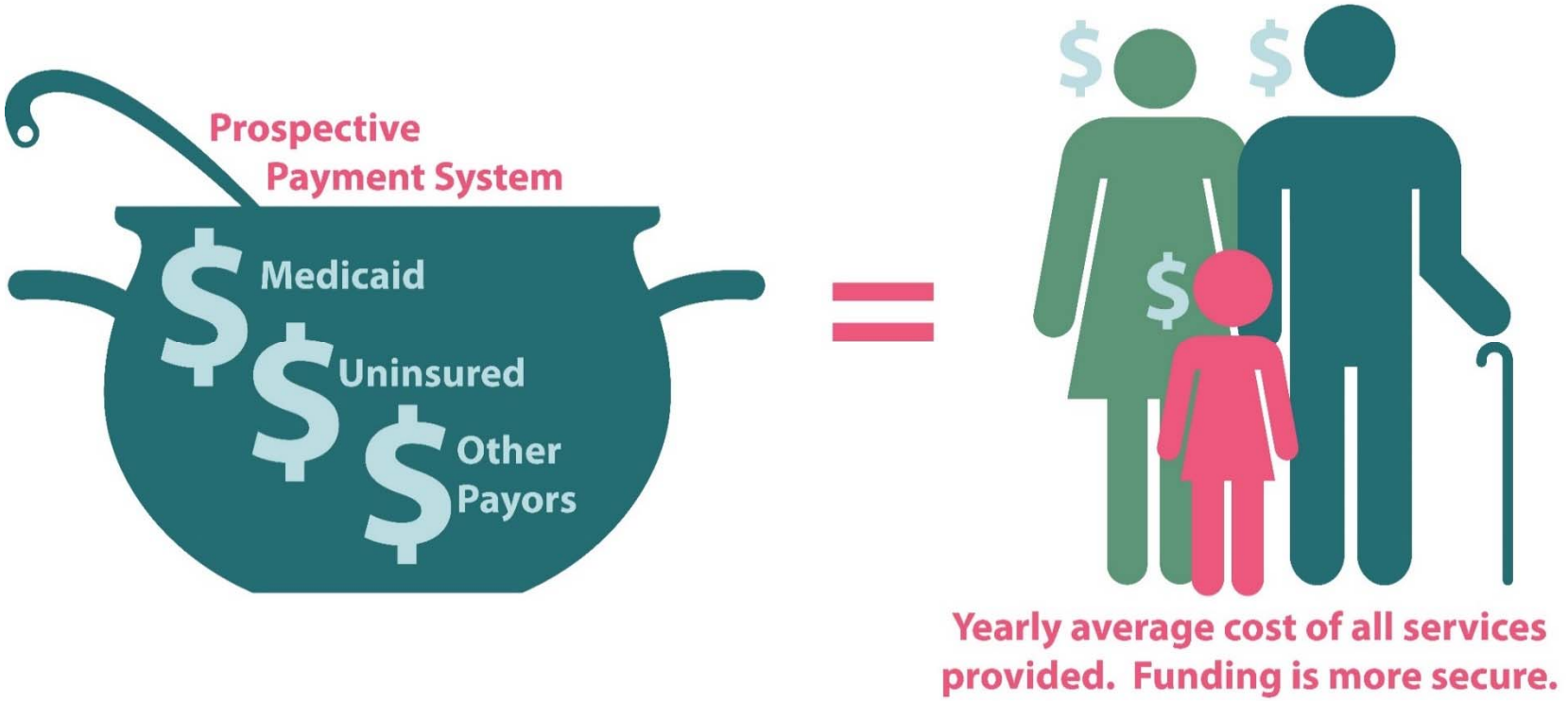
CCBHC Payment: Establishment of a Prospective Payment System



The Behavioral Health + Economics Network, known as BHECON (pronounced “beacon”) unites diverse stakeholders in a series of forums to examine and advance policy reforms to strengthen states’ behavioral health delivery systems.

Led by the National Council for Behavioral Health with our state partners, BHECON participants include individuals and organizations recognized for their commitment to improving lives of people living with serious mental illness and incorporates representatives from the behavioral health, criminal justice, and public safety sectors, along with individuals working in the greater medical field.

BHECON has partnered with academic research institutions to provide data and analysis specific to the topics presented at the forums and has curated national data in support of this effort.

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