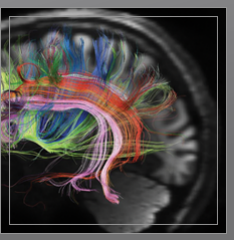


Evidence-Based Behavioral Health Integration

For: **Milbank Memorial Fund Multi-State Collaborative**
January 31, 2019

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National Institute of Mental Health

Disclosures

- Comments may not represent the views of NIMH/NIH/DHHS
- No conflicts
  - We have no financial interests or other relationships with the manufacturers of relevant commercial products, suppliers of commercial services, or commercial supporters.
  - Our presentation will not include any discussion of the unlabeled use of a product or a product under investigational use
- Relevant affiliations
  - University of Washington AIMS Center – Advisor (https://aims.uw.edu/faculty-staff)

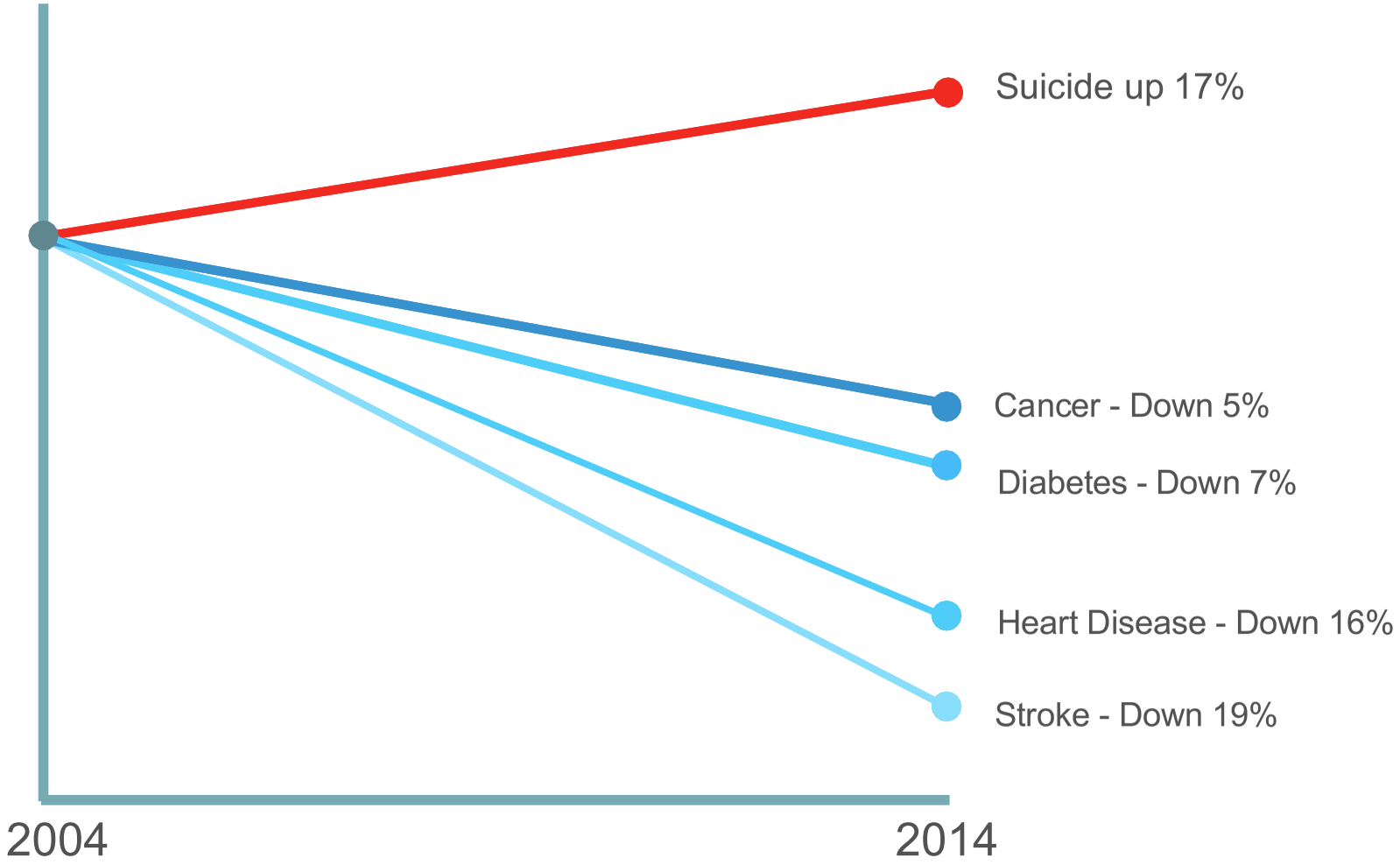
Key Points

- Mental illness and substance use **(behavioral health problems)** are major drivers of disability & costs
- Effective treatments exist, but currently no more than 1 in 4 of people in need receive indicated care
- Not enough specialty providers to address this gap
- Effective integration of behavioral health care with primary care can achieve:
  - Better **access** to care
  - Better health **outcomes**
  - Lower **costs**

Burden of Behavioral Disorders

- **Common**
  - **>1 in 4** Americans struggle with a mental health or substance use problem at some point in their lives
  - No family goes untouched
- **Disabling**
  - Cause nearly **25% of all disability worldwide**
  - Premature mortality, via **suicide & medical comorbidity**
- **Costly**
  - Health care costs
  - Productivity: unemployment, absenteeism, "presenteeism"
  - Social costs: homelessness, criminal justice system

DEATH RATE CHANGES FROM 2004 TO 2014



Percent change in the fraction of total US deaths due to selected medical and behavioral causes: 2004-2014
Adapted from: Wilson, TW; Carneal GU., Harbin HT. Issue Brief: Top 10 causes of death + opioid related deaths in the United States: 2004 - 2014 www.phiinstitut.org

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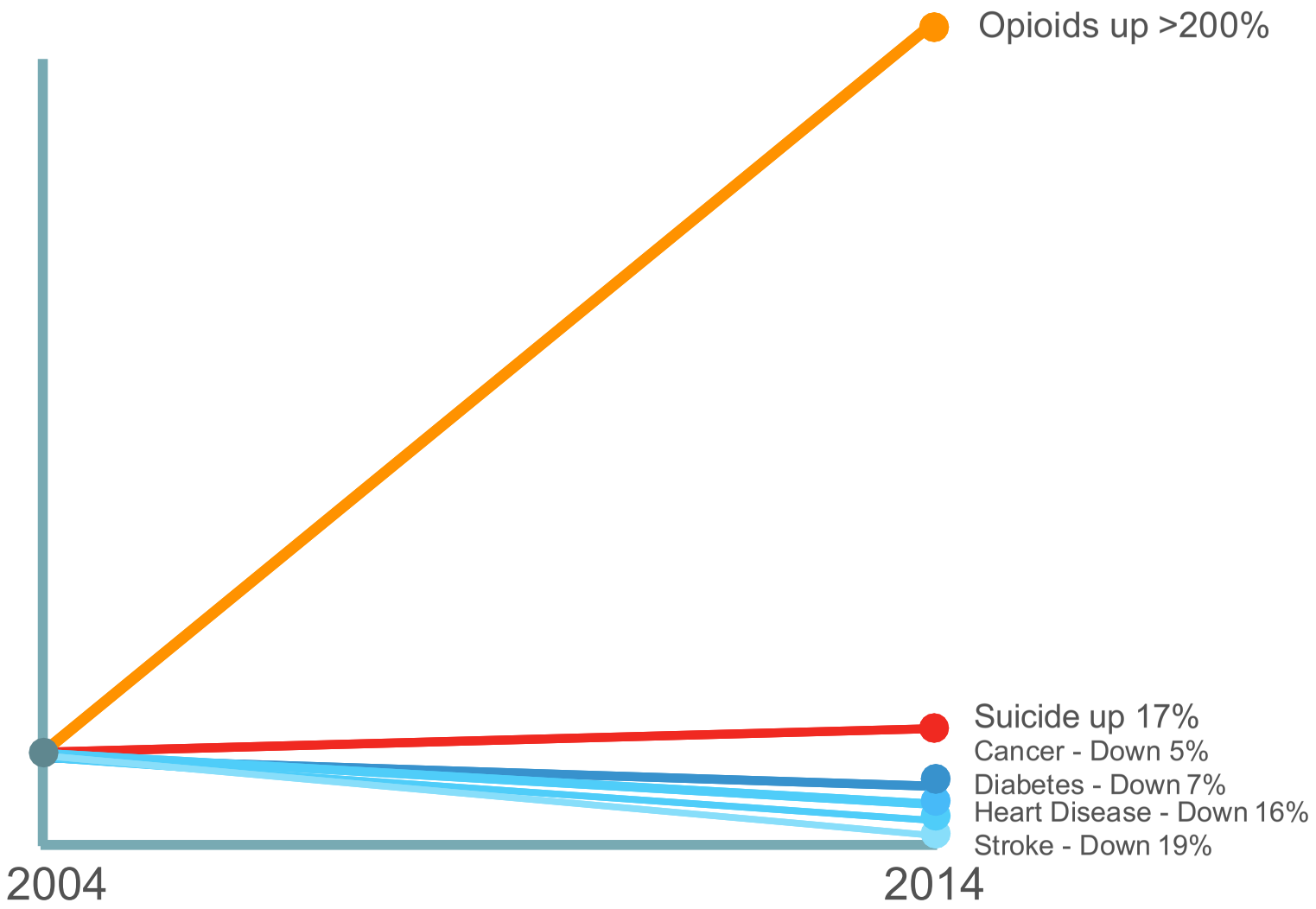

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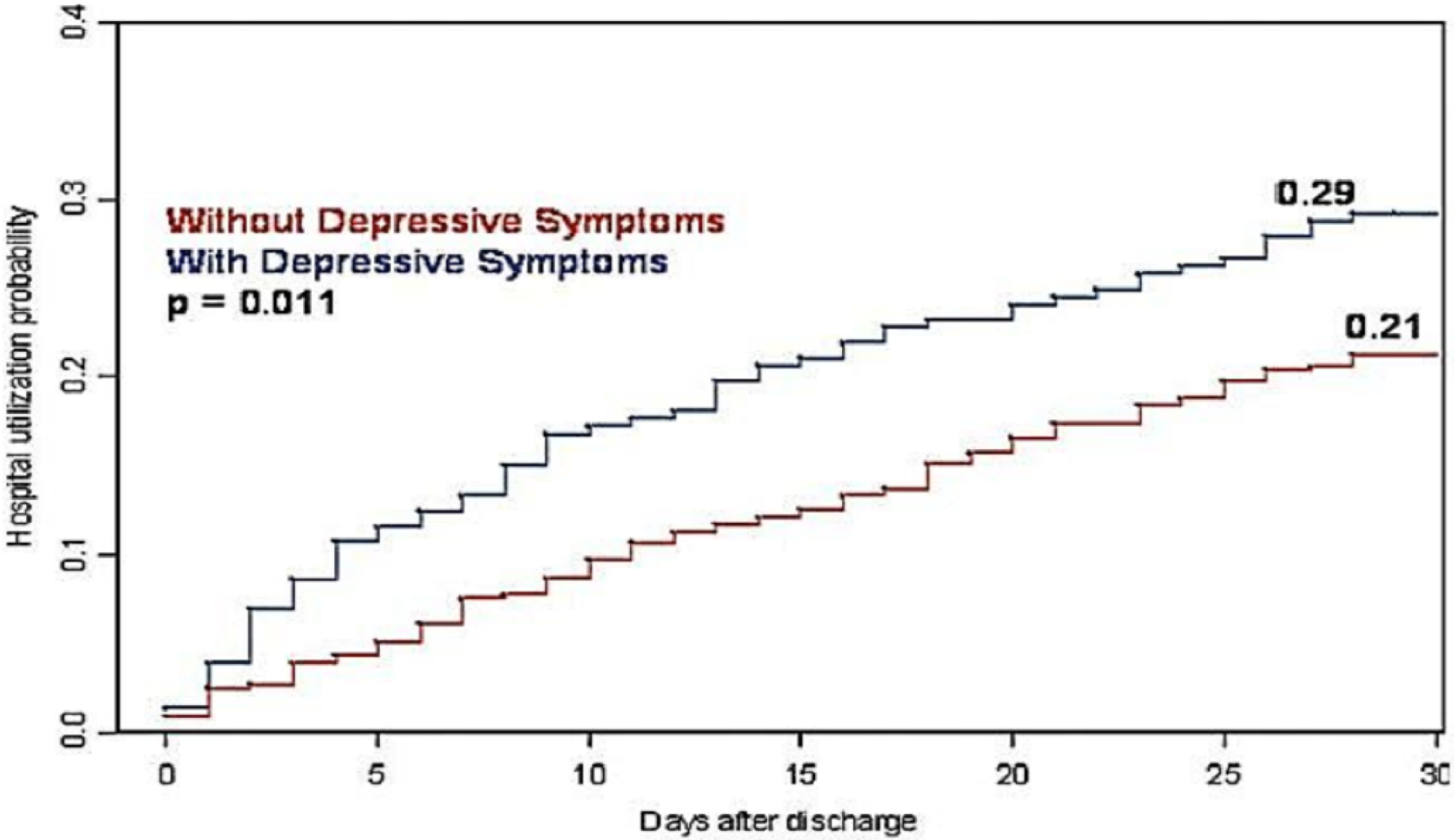
Impact of MHSUD on Medical Costs

POPULATION	% WITH BEHAVIORAL HEALTH DIAGNOSIS	PMPM WIHTOUT BH DIAGNOSIS	PMPM WITH BH DIAGNOSIS	INCREASE IN TOTAL PMPM WITH BH DIAGNOSIS
Commercial	14%	$340	$941	276%
Medicare	9%	$583	$1429	245%
Medicaid	21%	$381	$1301	341%
All Insurers	15%	$397	$1085	273%

Melek S, Norris D, Paulus J: Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Edited by Milliman I. Denver, CO, Prepared for American Psychiatric Association; 204. pp. 1-39.

Depression increases risk of 30-day readmission by nearly 40%



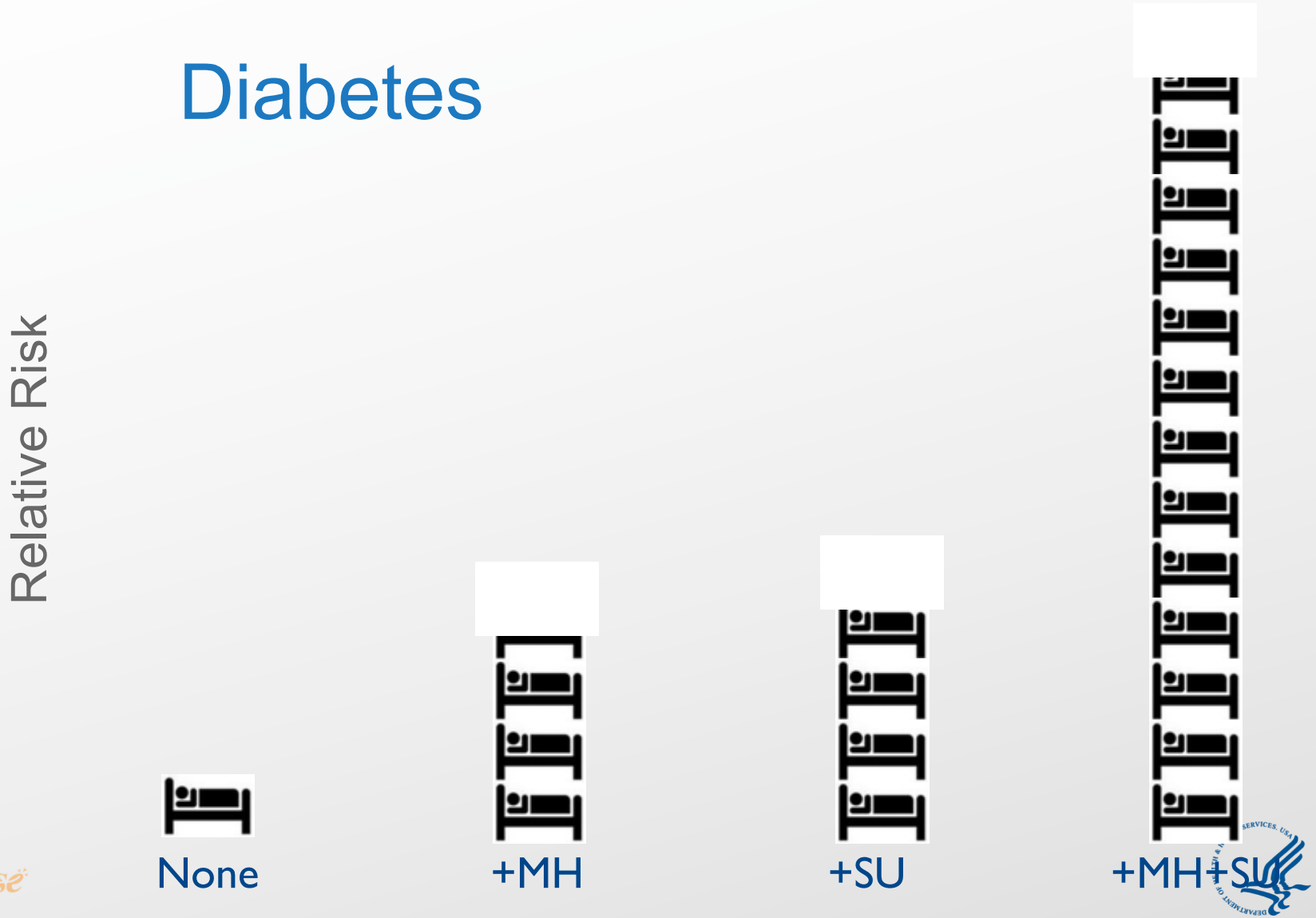
Mitchell et al, J Hosp Med 2010

Slide courtesy of Wayne Katon MD

Relative risk of medical admission with & without MH and SU comorbidity

– *Maryland Medicaid Adults, 2011*

Diabetes



Source: Hilltop Institute, 2012

Fuse

NIH National Institute of Mental Health

Across these top 9 chronic conditions, depression and anxiety go UNDIAGNOSED 85% of the time.

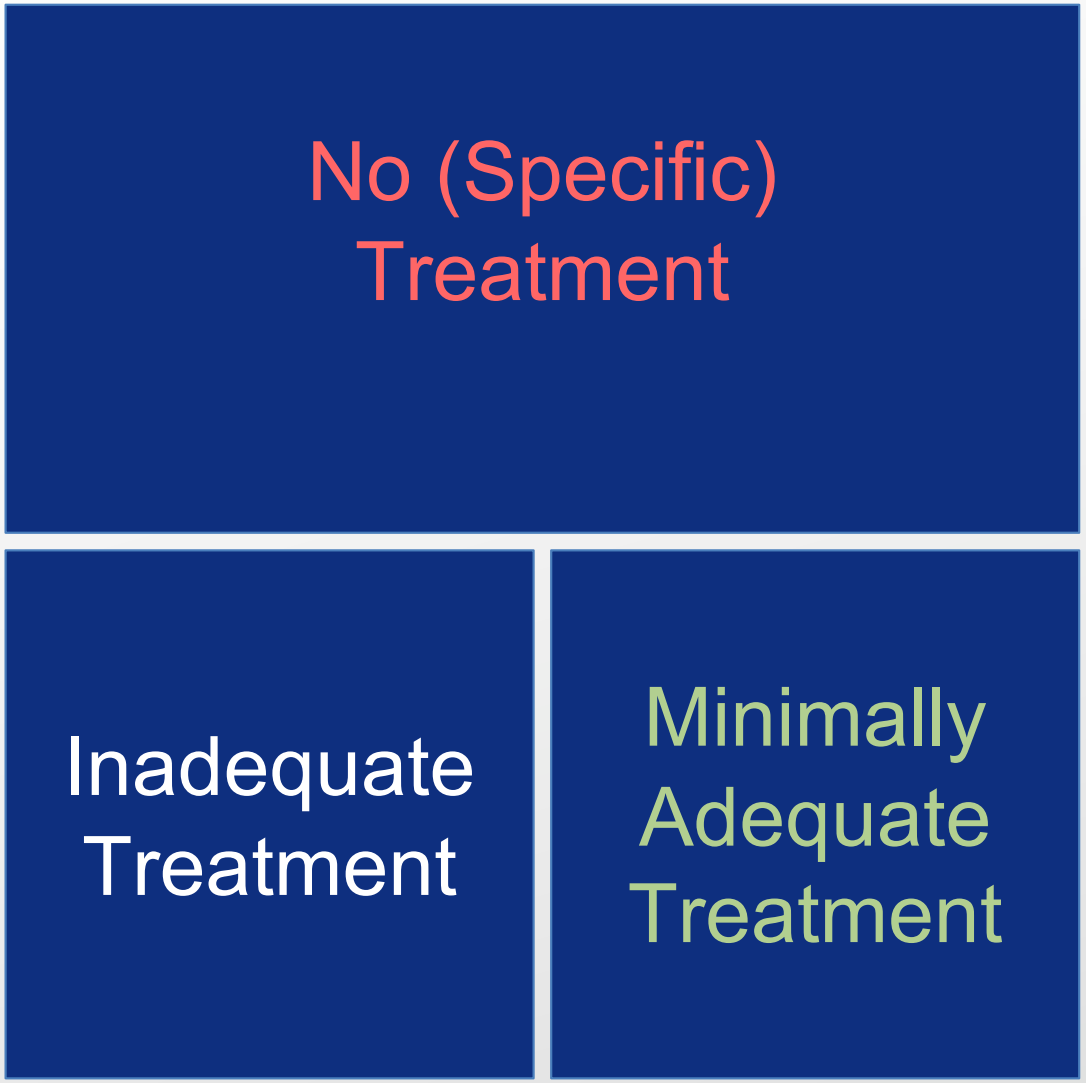
Medical Costs per Disease State					
Chronic Medical Condition	PMPM With Behavioral Condition	PMPM Without Behavioral Condition	% Treated For Depression or Anxiety	Expected Depression or Anxiety Prevalence	% Missed
Arthritis	$871.88	$564.76	7.1%	32.3%	77.9%
Asthma	$861.99	$470.05	6.8%	60.5%	88.8%
Cancer (Malignant)	$1,180.96	$1,018.45	5.7%	39.8%	85.7%
Chronic Pain	$1,210.56	$884.70	5.9%	61.2%	90.4%
Coronary Artery	$1,305.00	$958.34	5.7%	48.2%	88.1%
Diabetes	$1,110	$828.18	5.2%	30.8%	83.2%
Heart Failure	$2,242.85	$1,888.11	7.0%	43.8%	84.1%
Hypertension	$880.33	$588.04	5.5%	30.5%	82.0%
Ischemic Stroke	$1,461.57	$1,254.68	7.7%	52.4%	85.2%

Cost Burdens from unrecognized/undiagnosed/Mental Health Cases.

Source: United Healthcare

Usual Care is Poor

- Half or more of people with mental disorders get NO CARE*
- Of those who receive any care, half receive sub-therapeutic or even contraindicated care*
- ~30 million people receive a prescription for a psychotropic medication in primary care each year; only 25% improve



*Wang PS et al., *Arch Gen Psychiatry*, 2005

How Do We Close the Gap?

- Develop better treatments
- Train & retain more mental health professionals (>50% of US counties don't have a single practicing mental health professional)
- Improve delivery of existing treatments, via integration & measurement-based care

Proactive, Measurement-Based Care

- Screen routinely, & assess positive screens
- If positive assessment, start appropriate treatment
  - Indicated medication at appropriate dosage
  - Indicated psychotherapy
- Assess clinical progress at defined intervals
- If patient isn't improving, adjust treatment
- Expect >=X% of patients to achieve target outcome in defined timeframe

Not All Programs Are Effective

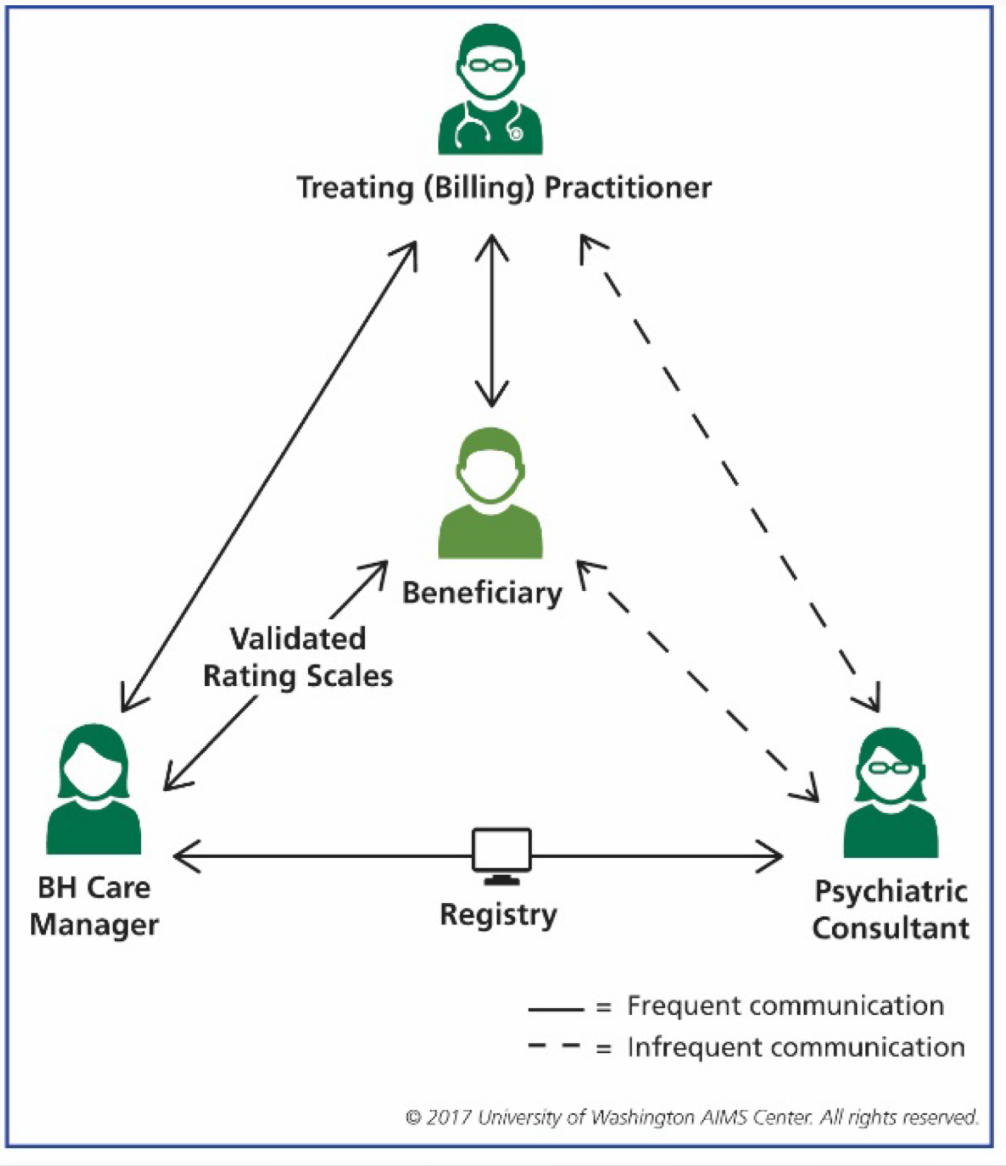
- "Integration" approaches that aren't enough:
  - Screening without adequate treatment
  - Referral to specialty care without close coordination: 50 % fall through the cracks
  - Co-located behavioral health specialists, without effective oversight or evidence-based treatments
  - Treatment without measurement: patients 'fall through the cracks' or stay on ineffective treatment for too long

Collaborative Care – An evidence-based model for treating behavioral health conditions in primary care

EXISTING TREATMENTS

- Medications
- Psychotherapy

DELIVERED VIA:



National Institute of Mental Health

Incentivizing Collaborative Care

- **Payment of core components**
  - Care management (especially via telephone)
  - Psychiatric consultation
  - Payment for Collaborative Care via CPT **99492, 99493, & 99493** *(previously HCPCS G0502/3/4)*
  - Also payment for "general BHI" via CPT **99484** (*G0507*)
- **Measurement / Treatment to target**
  - At minimum:
    - Universal screening via standardized instrument
    - Benchmark for % of cases who remit within 12 months
  - *CMS requires for depression in Medicare ACOs, as of 2015; also part of HEDIS*
- **Pay for Performance**

Payment for Collaborative Care (99492/3/4)

- **Care Team**
  - **Treating (billing) practitioner**
  - **Care manager** – designated individual with behavioral health training; must be available for face-to-face Pt contact
  - **Psychiatric consultant** – medical professional trained in psychiatry & qualified to prescribe full range of medications; can be located remotely
- **Eligible Conditions –** Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services
- **Service Components**
  - (Elements of measurement-based care described earlier)

Questions?

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