NATIONAL HEALTH POLICY
FORUM

FORUM SESSION

Transforming Behavioral Health Practice, Payment, and Policy:

Too Fast, Too Slow, or Just Right?

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The history of mental health and substance use treatment in the United States can be characterized by a number of significant shifts—from care delivered in specialized institutions to community based treatment, from publicly funded direct provision of care to public insurance coverage, from a focus on the seriously mentally ill to a broader view that also incorporates prevention and the needs of those with mild to moderate conditions. Until the creation of the Medicaid, Medicare, and Supplemental Security Income programs and the establishment of community mental health centers in the 1960s, the states were the locus of mental health policy, and the mental health services sector was separate and specialized. Since then, the center of influence has shifted from the specialty mental health and substance use sectors to mainstream programs such as Medicaid.[1] Ten years ago the President's New Freedom Commission on Mental Health concluded that, although effective treatments existed for those living with mental health disorders, the complex, fragmented, and capacity-constrained nature of the U.S. mental health system impeded the delivery of effective care to enable individual recovery.[2] These were not novel conclusions for their time. In 1999, a Surgeon General's report on mental health also called for reforming the mental health system.[3] Diagnosis of and treatment for behavioral health disorders continues to garner significant attention from policymakers, particularly the needs of veterans and military service members, the incarcerated, children, and young adults. Moreover, there has been a growing appreciation that people with a mental health diagnosis often have co-occurring substance use disorders as well as chronic medical conditions like hypertension or diabetes that, when untreated or inadequately treated, often lead to premature death and significant public and private expense.

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Medicaid is the largest source of financing for behavioral health in the United States, covering 26 percent of expenditures, totaling about $35 billion.[4] Medicare plays a much smaller role, financing 7 percent of total expenditures. Medicare's coverage of mental health services is limited and has evolved modestly since the program's inception.[5] The largest federal programs dedicated solely to funding services for those with serious mental illness and substance use disorders are the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block grant, both administered by the Substance Abuse and Mental Health Services Administration. Their appropriations totaled $463 million and $1.8 billion, respectively, in fiscal year 2013.[6] About 21 percent of behavioral health expenditures are covered by state and local sources, and private insurance pays for 24 percent.

Two recent laws—the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010 (ACA)—significantly affect coverage of and financing for behavioral health services. Commonly referred to as "parity," the 2008 law eliminates disparities in benefits, limits, and cost sharing for behavioral health services compared with physical health services for group health plans with 50 or more employees. The ACA also includes a number of provisions that affect people with a mental health or substance use disorder. Modified by a June 2012 Supreme Court decision, the ACA authorizes a 100 percent federal match for three years (phased down to 90 percent thereafter) to states for the expansion of their Medicaid programs to all nonelderly adults with incomes up to 133 percent of the federal poverty level beginning in January 2014. Prior to the ACA, to qualify for Medicaid a person had to meet strict income eligibility standards and be categorically eligible. For those with a serious mental illness, the main route to becoming categorically eligible was through disability status; about 5 percent of Medicaid enrollees qualify due to a disabling mental illness. Medicaid enrollees who qualify through other pathways also have mental health needs and use mental health services.

Recognizing the importance of treating the whole person—it is now known that people with serious mental illness served by the public mental health system die on average 25 years earlier than the general population[7]—and under pressure to find cost-containing and cost-saving approaches, many policymakers, providers, and payers have been looking to the integration of physical, mental health, substance use, and other services used by high-cost enrollees as a

source of savings. The ACA provides a number of tools in this vein; for example, there is the Medicaid health homes option for enrollees who have at least two chronic conditions, or one chronic condition and are at risk for another, or one serious and persistent mental health condition. States receive a 90 percent federal match for health home services during the first two years they have an approved health home State Plan Amendment in effect, in order to provide enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports. In another effort, 15 states have been working with the Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office on demonstration projects "to develop person-centered approaches to coordinate care across primary care, acute care, behavioral health, and long-term supports and services for dual eligible individuals."[8] While a number of integration models are being tested, the IMPACT collaborative care model, pioneered at the University of Washington and now being used by a variety of community health centers and community mental health centers to more effectively treat depression, is one with significant clinical evidence and growing cost-savings evidence that integrates mental health clinicians into the primary care team.[9]

SESSION

This Forum session explored behavioral health treatment policy in the United States, including a discussion of the opportunities and challenges that the ACA and parity laws present for states, insurers, providers, and people with behavioral health conditions. The roles of primary care and specialty behavioral health in integrating care and related policy issues were examined. **Michael Hogan, PhD**, is the former commissioner of mental health for New York and Connecticut and former director of mental health in Ohio. He chaired the President's New Freedom Commission on Mental Health in 2002 and 2003. He provided an overview of the prevalence of behavioral health disorders in the United States, discussed current treatment approaches and key payers, described the public and private delivery systems, and reviewed key ACA provisions and the parity law. **Marc Avery, MD**, is a clinical associate professor in the Division of Integrated Care and Public Health of the Department of Psychiatry and Behavioral Sciences at the University of Washington. He is also associate director for clinical services at the AIMS Center, where he works to develop and test evidence-based models of patient-centered integrated behavioral health care. He talked about the

collaborative care model and his experience in Washington working with community health centers and community mental health centers to provide person-centered integrated mental health care. **Doug Porter** directed the Medicaid programs in Maine, California, and most recently in Washington, where he served as director for over 10 years until becoming a principal with Health Management Associates. He described how states, through their Medicaid programs, and some private plans are responding to new opportunities and requirements to better serve Medicaid expansion populations and existing enrollees with behavioral and physical health needs.

KEY QUESTIONS

- What are the spectrum and prevalence of behavioral health disorders in the United States? What are the characteristics of people with mental health and substance use disorders in terms of gender, race, age, income, and health insurance status? What is known about the co-morbidities of people with mental health and/or substance use disorders? What factors contribute most to the shorter life expectancy of persons with mental illnesses and substance abuse problems?

- How has treatment evolved over the last several decades? What is known about the level of unmet need for services among these populations?

- What roles do public payers like Medicare, Medicaid, the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration play in payment for mental health treatment in the United States?

- How are state Medicaid programs changing their managed care arrangements and care delivery?

- What has been the impact of the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008? How will provisions of the Affordable Care Act affect people with behavioral health disorders?

- Given the expansion of Medicaid in at least half of the states, resulting in more people with health insurance, will there be pressure to reevaluate the role of federal discretionary programs that support the direct provision of services?

- What network adequacy, benefit, and other issues will be important for those living with behavioral health disorders who receive coverage through the health insurance marketplaces?

• What does the research evidence tell us about the various models for integrating behavioral health and physical health services? What policy changes are needed to expand the reach of these evidence-based models?

ENDNOTES

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6. U.S. Department of Health and Human Services, *Fiscal Year 2014: Budget in Brief*, available at www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.

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