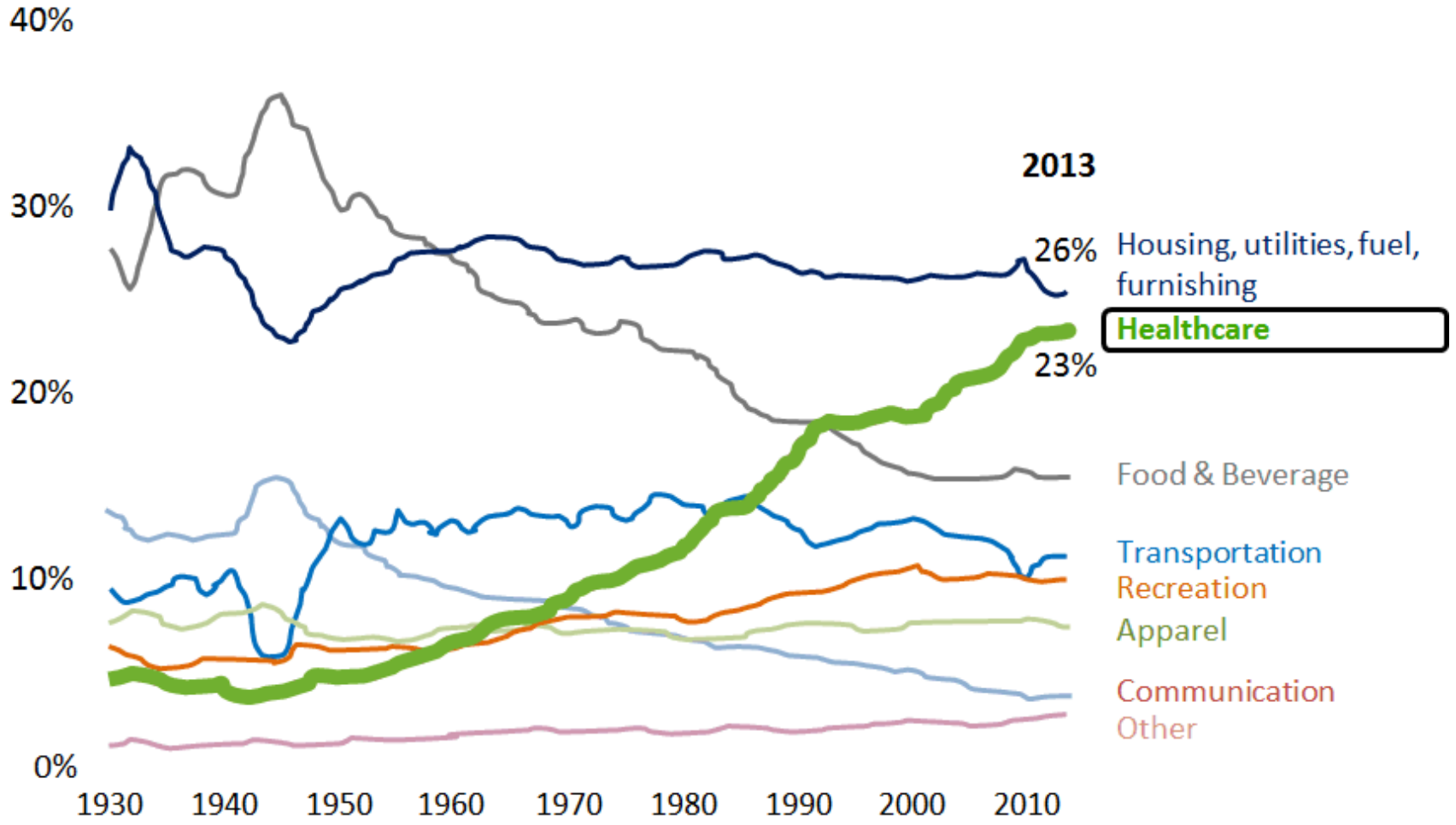
Evolving discussion around mental health claims impact

Sarah Woodley, CEO
BPA Health, Inc

Scott Haas, Vice President
Healthcare Operational Risk Consulting
Wells Fargo Insurance Services USA, Inc

Why we are having this discussion?

Percent of household spending, 1930-2013



Source: BEA

Where do you start the discussion?

Medicaid services

- States have choices in their approach to delivery system design under the Medicaid and CHIP programs. States are increasingly moving to the use of managed care and other integrated care models in serving their Medicaid beneficiaries. On a national basis, more than 70 percent of the Medicaid population is enrolled in some form of managed care.
  - For the most part, Idaho is an "open card" system that has been slow to evolve managed care strategies that have become the norm in most all other states
    - In 2006, the Healthy Connections primary care case management (PCCM) program was initiated and requires mandatory enrollment in 42 of 44 counties
    - Starting September 2013, the state began covering outpatient mental health, substance use disorder, and case management services through a limited benefit capitated managed care program called Idaho Behavioral Health Plan (IBHP)

Where do you start the discussion?

Medicaid services

- ✓ The state is developing:
- ✓ Medical home initiatives:
  - ✓ A multi-payer collaborative;
  - ✓ Pediatric medical homes;
  - ✓ Medicaid Health Homes program, which launched in 21 practices on January 1, 2013, and serves individuals with serious mental illness, diabetes or asthma. Health homes providers must be participating primary providers in the Healthy Connections (PCCM) program.
- ✓ The state contracts directly with primary care physicians to manage care for Medicaid enrollees in the Healthy Connections program.
  - ✓ Primary care providers are paid a monthly per-member case management fee in addition to the regular Medicaid fee-for-service reimbursement.
  - ✓ The state also contracts with three prepaid, limited benefit plans to provide dental, transportation, and behavioral health benefits.

Why do we start the discussion around Medicaid?

- ✓ Idaho Medicaid currently has 230,000 enrollees.
- ✓ Medicaid is the single, largest healthcare plan in Idaho.
- ✓ Medicaid is poised to play an even greater role in healthcare coverage as Medicaid benefits expand to more citizens through the Affordable Care Act.
  - ✓ It is likely all states will eventually expand Medicaid if federal matching funds can be stabilized
    - ✓ Cadillac tax jeopardy – primary purpose is to fund Medicaid expansion
- ✓ Health systems have/are organizing to accept Medicaid, Medicare and commercial risk
  - ✓ Clinically Integrated Networks (CIN)
  - ✓ Direct contracting - alternative payment structures
  - ✓ Population, bundles, and outcome risk/reward based payments
- ✓ Commercial health insurers are slow to evolve from fee for service reimbursement methodology and adoption of true risk based programs

Where do you start the discussion?

Medicaid services

- ✓ The basic point of this overview is the lack of full capitation arrangements between state Medicaid programs and health systems/providers does not incent the provider to patient infrastructure for medical and mental health services to effectively evolve.
  - ✓ Traditional fee-for-service model rewards increased service use, but does not address coordination of care, expanding access to rural areas, or focus on improving patient outcomes.
  - ✓ Idaho has relied on benefit and pricing reductions to sustain the program.
    - ✓ Applicable to both government and commercial health plans

Where do you start the discussion?

Medicaid services

- ✓ Idaho Behavioral Health Plan (IBHP)
  - ✓ Participants who are eligible for the Basic or Enhanced Medicaid Plans are automatically enrolled in the new managed care benefit plan to ensure they have access to behavioral health services if needed.
  - ✓ Optum manages outpatient behavioral health benefits for Idaho Medicaid members.
    - ✓ "Outside in" managed care utilization management program structure
    - ✓ Provides framework for care delivery and documentation
    - ✓ Silo approach that is not necessarily integrated within the primary or specialty care environment to facilitate provider to patient service support
      - ✓ IBHP covers very little for Substance Use Disorder treatment, creating silos within behavioral health services

Where do you start the discussion?

Additional considerations

- ✓ Affordable Care Act
  - ✓ ACA includes mental health and substance use disorder services including behavioral health treatment in the Essential Health Benefits
  - ✓ Young adult coverage up to age 26 exposes plan to the ages of some of the most expensive behavioral health concerns such as need for residential substance use disorder treatment, onset of serious mental illness, and advanced eating disorder
- ✓ Mental Health Parity and Addiction Equity Act
  - ✓ Paired with ACA, adds additional coverage requirement for an essential benefit
- ✓ Credentialing Requirements for State Funded Programs
  - ✓ Idaho requirement have been based on “home-grown” rules and have not relied on national accreditations and certifications making it difficult to ensure consistent levels of quality

Alternatives for self-insured plan sponsors

- How do you structure an optimal management strategy specific to mental health and chemical dependency services that builds upon what Medicaid programs have initiated and health systems and providers are willing to discuss?
  - Will primary care engage in meaningful screening and referral for behavioral health conditions?
  - Will both primary care and behavioral health providers commit to accountable communication regarding patients needs and progress?
  - How can we support behavioral health providers striving toward accreditation/certification and the use of Evidence Based Practices (not just Medically Necessary Care)?

Alternatives for self-insured plan sponsors

- How do you structure an optimal management strategy specific to mental health and chemical dependency services that builds upon what Medicaid programs have initiated and health systems and providers are willing to discuss?
- Doctors are way behind when it comes to identifying and responding to symptoms of depression, according to a new study.
  - The study of 1,000 primary care practices in the U.S., based on national survey data from 2006 to 2013, sought to determine how often doctors are using "best practices" in response to a variety of chronic conditions, including asthma, congestive heart failure, diabetes, and **depression**.
  - The researchers found that the average primary care practice used less than one of the five recommended management practices for depression. The performance of physicians in this regard did not improve during the seven years examined by the study.
  - Less than one on average? That means that none of the recommended practices was consistently used by more than half of the practices.

Alternatives for self-insured plan sponsors

- ✓ What alternatives do employer plan sponsors have when the largest health plan in the state (Medicaid) is bogged down in history, politics and budget constraints at the same time the commercial insurance industry is slow to evolve to meaningful alternative payment models in partnership with health systems and providers?
  - ✓ You have to be willing to change your view of traditional PPO networks which have failed to reduce cost and mitigate trend increases

category	Total Billed	Total Allowed	Medicare 2015Q3 Allowed	Network Discount	Network Allowed Relation to Medicare
Hip	$ 42,925	$ 28,747	$ 19,252	-33.0%	**149.3%**
	$ 119,307	$ 66,745	$ 18,463	-44.1%	**361.5%**
Knee	$ 78,107	$ 35,029	$ 14,563	-55.2%	**240.5%**
	$ 45,987	$ 35,686	$ 15,513	-22.4%	**230.0%**
Spine	$ 131,417	$ 80,908	$ 23,912	-38.4%	**338.4%**
	$ 236,232	$ 134,339	$ 30,296	-43.1%	**443.4%**
Grand Total	**$ 653,974**	**$ 381,454**	**$ 121,999**	-41.7%	**312.7%**

Alternatives for self-insured plan sponsors

- ✓ You have to be willing to change your view of traditional, "outside-in" medical management and wellness programs which have failed to reduce cost, mitigate trend increases and enhance patient quality and outcomes

  "If it is only for a bottom line approach then most management programs may not show a ROI. The member in the end is the one that chooses to or chooses not to do something about their condition." - comment from carrier medical director – March 11, 2016

Alternatives for self-insured plan sponsors

- ✓ You have to be willing to engage in discussions directly with healthcare systems and providers. Health systems and providers are highly motivated to engage in potential direct contracting discussions. Why?
  - ✓ Elimination of middlemen serving self-insured plan sponsors may better represent your own population needs
  - ✓ Reduction of negative impact of Referenced Based Pricing strategies
  - ✓ Collaborative development of Clinically Integrated Network strategies
  - ✓ Step down in plan design in exchange for more favorable, fixed cost contracts

"The growth in health systems accounts receivable attributable to cost shifting now exceeds the amount of uncompensated care prior to the Medicaid expansion." – CFO of large integrated delivery system

Alternatives for self-insured plan sponsors

- ✓ You have to be willing to change the manner in which PBMs charge plan sponsors

  Example of spread pricing impact on commonly prescribed generic drugs used to treat depression

	Optimal $/unit	Common $/unit	30 Unit Rx (Optimal)	30 Unit Rx (Optimal)		30 Unit Rx (Optimal) Annualized	30 Unit Rx (Optimal) Annualized	Variance
DULOXETINE CAP 20MG	$1.20	$4.00	$37.00	$121.00		$444.00	$1,452.00	**$1,008.00**
FLUOXETINE CAP 20MG	$0.03	$0.55	$1.79	$17.50		$21.48	$210.00	**$188.52**
SERTRALINE TAB 25MG	$0.28	$0.80	$9.44	$25.00		$113.28	$300.00	**$186.72**
RISPERIDONE TAB 0.5MG	$0.60	$2.50	$18.93	$76.00		$227.16	$912.00	**$684.84**
30 unit Rx includes $1 dispensing fee								

Consider the impact on members who are in high deductible plan designs on the level of therapy compliance because PBMs artificially inflate the cost of drugs

Dependent cost of mental health

Reporting Period				Nov '14-Oct '15			Nov '13-Oct '14		
Measure Type	Relationship	Age/Gender Band	ICD-9 Diagnostic Category	Paid PMPM	Services/1000	Paid/Service	Paid PMPM	Services/1000	Paid/Service
Benchmark	Dependent								
		15-19 F	Mental Health	$8.79	1,511.8	$70	$8.12	1,438.4	$68
		15-19 M	Mental Health	$6.28	1,062.4	$71	$5.89	1,025.0	$69
		20-24 F	Mental Health	$6.75	1,194.2	$68	$6.48	1,160.4	$67
		20-24 M	Mental Health	$5.14	901.2	$68	$4.94	882.7	$67
		25-29 F	Mental Health	$7.69	1,393.3	$66	$8.11	1,472.7	$66
		25-29 M	Mental Health	$6.44	1,086.3	$71	$5.87	1,016.7	$69
	Summary			$6.28	1,046.2	$72	$6.00	1,025.0	$70

Reporting Period				Nov '14-Oct '15			Nov '13-Oct '14		
Measure Type	Relationship	Age/Gender Band	ICD-9 Diagnostic Category	Paid PMPM	Services/1000	Paid/Service	Paid PMPM	Services/1000	Paid/Service
Benchmark	Dependent								
		15-19 F	All Claims	$76.26	14,643.3	$62.49	$73.56	14,272.5	$61.85
		15-19 M	All Claims	$59.61	10,236.9	$69.88	$58.10	10,061.2	$69.30
		20-24 F	All Claims	$84.56	15,564.9	$65.19	$80.94	15,140.3	$64.15
		20-24 M	All Claims	$58.13	9,285.1	$75.12	$53.74	8,855.2	$72.82
		25-29 F	All Claims	$100.84	16,699.3	$72.46	$102.41	16,832.2	$73.01
		25-29 M	All Claims	$60.59	9,449.1	$76.95	$61.25	9,644.7	$76.21
	Summary			$79.54	14,315.1	$66.68	$78.16	14,175.7	$66.17

Reporting Period				Nov '14-Oct '15			Nov '13-Oct '14		
Measure Type	Relationship	Age/Gender Band	ICD-9 Diagnostic Category	Paid PMPM	Services/1000	Paid/Service	Paid PMPM	Services/1000	Paid/Service
Benchmark	Dependent								
		15-19 F	All Claims	11.5%	10.3%		11.0%	10.1%	
		15-19 M	All Claims	10.5%	10.4%		10.1%	10.2%	
		20-24 F	All Claims	8.0%	7.7%		8.0%	7.7%	
		20-24 M	All Claims	8.8%	9.7%		9.2%	10.0%	
		25-29 F	All Claims	7.6%	8.3%		7.9%	8.7%	
		25-29 M	All Claims	10.6%	11.5%		9.6%	10.5%	
	Summary			7.9%	7.3%		7.7%	7.2%	

Contact information

Scott Haas, CLU, RHU
Wells Fargo Insurance Services USA, Inc.
Healthcare Operational Risk Consulting

1300 SW 5th Avenue, Suite 500
Portland, OR 97201
503-525-5020 Direct Phone
503-867-5757 Cell
Scott.haas@wellsfargo.com

Sarah Woodley
CEO
BPA Health, Inc.

380 E Parkcenter Blvd #300
Boise, ID 83706
208-947-1304 Direct Phone
208-284-8829 Cell
sarah.woodley@bpahealth.com