Integration of Behavioral Health and Medical Care: Medicaid

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Strategy for Delivery System Reform

• More services and dollars under budget or quasi-budget

• Clinical organizations with capacity to manage continuum of care increasingly delegated responsibility for budgets and populations

• Accountability and rewards for performance
  – Savings
  – Quality indicators
High Powered Budget Incentives

• Consolidates funding across service lines; moves accountability towards population focus
• Can reward integration of primary care and specialty behavioral health care
• Can favor prevention and early intervention approaches
  – Especially for clinical preventive services
• Challenges
  – Business case relies on savings subject to meeting quality thresholds
  – Behavioral health quality measures are under-developed
ACA Delivery System Reforms

- Accountable Care Organizations (ACOs)
- Medicaid Health Homes
- Dually Eligibles Integrated Care Demos
- Primary Behavioral Health Care Integration demo (PBHCCI)
- Innovation Center
  - Bundling
- Patient Centered Medical Homes
A Refined View of Integration

- A commitment to patient centered care calls for “meeting people where they are”
- Heightened importance for populations that have heterogeneous needs and face impediments to negotiation of a complex health system
- Implication: bringing general medical care to specialty behavioral health settings is as central as incorporating behavioral health in primary care practices
Integrate Medical Care into Behavioral Health

• People with SPMI frequently suffer from poor general health

• Relative risk of premature mortality for people with SPMI is roughly 4x that of otherwise similar people (Druss 2011)

• Average Medicaid spending on behavioral health for people with schizophrenia = $11,900 plus $5,700 in other medical care compared to $4,000 for average adult beneficiary
What Do We Know About Making Integration Work?

• Primary Care Settings
  – Extensive research focused on depression and anxiety disorders

• Specialty Behavioral Health Settings
  – Limited evidence
  – Promising Models
  – Major investments in demonstrations (ACA)
Impacts of Collaborative Care

• Effectiveness: Meta Analysis (Gilbody et al Arch Int Med 2006)
  – Six month gains ~ 0.25
  – Five year gains ~ 0.15

• Key elements of treatment
  – Medication adherence
  – Credentials and supervision of care managers
Cost-Effectiveness of Collaborative Care

Primary Care Depression

Incremental Cost vs. QALY

QALY = $25,000

QALY = $50,000

QALY = $100,000

Incremental Cost

QALY

$0.00

$500.00

$1,000.00

$1,500.00

$2,000.00

$2,500.00

$3,000.00

$3,500.00

($1,000.00)

($500.00)

$0.00

0.02

0.04

0.06

0.08

0.1

0.12

0.14

QALY

($500.00)
Observations on PBHCI demos

• A clear partnership agreement between agencies is of great import
• Regular meetings and multiple lines of communication are especially important for comprehensive integration
• Flexible hours for Primary Care services
• **Surprise**: colocation appears to matter less than one might have expected
How Do We Encourage Integration?

• Payment Policy
  • Allow billing for multiple services in the same day
  • Link gain sharing to indicators of integration
    • NQF has endorsed several measures of care integration for severe mental disorders

• Technical Assistance
  • Tie TA practices to evidence on effective accountability and organizational designs

• Require flexible hours of operation for CBHC primary care functions
Final Comments

- Learning to date suggests that we can measure and reward activities that drive system towards integration and its benefits
- Measurement of performance and accountability is critical
- Flexible payment systems that get the incentives right and rewards for efficient, high quality integrated care