IMPROVING MENTAL HEALTH AND WELLBEING MAKES $EN$E FOR STATES
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NAMI
National Alliance on Mental Illness

Partnership to Fight Chronic Disease
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Mental Health America

PARTNERSHIP TO FIGHT CHRONIC DISEASE
Today’s Agenda

- What’s the burden of mental illness and behavioral health issues?
- What’s next on the federal policy front?
- What can we expect in the states?
- What’s working now that can serve as models?
- What networks and resources are available to help advocates? (All)
Who is PFCD

The Partnership to Fight Chronic Disease (PFCD) is a global coalition of patient, provider, community, business and labor groups, and health policy experts, committed to raising awareness of the No. 1 cause of death, disability and rising health care costs: chronic disease.

POLICY PRIORITIES

✓ PRIORITIZE prevention & management of chronic conditions

✓ ENCOURAGE innovation in treatment & delivery of care

✓ IMPROVE access to recommended care

✓ PROMOTE health across generations

✓ TRANSLATE knowledge into action
1.1 MILLION American lives could be saved annually through better prevention and treatment of chronic disease.
"We know that mental illness is an important public health problem in itself and is also associated with chronic medical diseases such as cardiovascular disease, diabetes, obesity, and cancer... we need to expand surveillance activities that monitor levels of mental illness in the United States in order to strengthen our prevention efforts."

— Ileana Arias, Ph.D., Principle Deputy Director, Centers for Disease Control and Prevention (CDC)

https://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html
Mental Health in America

Costs and Outcomes of Mental Health and Substance Use Disorders in the US

Nearly 18% of Adults in the United States Reported Having a Mental, Behavioral, or Emotional Disorder in 2015

- **OVERALL 17.9%**
  - Women: 14.3%
  - Men: 21.2%
  - Age 18-25y: 14.0%
  - Age 26-49y: 14.5%
  - Age ≥50y: 19.3%
  - Hispanic: 14.5%
  - White: 15.4%
  - Black: 14.8%
  - NH/OPI*: 14.8%
  - AI/AN**: 21.2%

Nearly 3% of People 12 Years or Older Reported Illicit Drug Addiction or Misuse in 2015

- **OVERALL 2.9%**
  - Female: 2.0%
  - Male: 3.8%
  - Age 12-17y: 2.1%
  - Age 18-25y: 3.4%
  - Age ≥26y: 7.2%
  - Hispanic: 3.0%
  - White: 2.8%
  - Black: 3.5%
  - NH/OPI*: 1.2%
  - AI/AN**: 4.5%

* NH/OPI = Native Hawaiian/Other Pacific Islander  ** AI/AN = American Indian/Alaska Native

Note: Includes marijuana use

Mental Health and Substance Use Disorders Were the Leading Cause of Disease Burden in the US in 2015

*Disability adjusted life years (DALYs) rate per 100,000 population*

- **Mental Health & Substance Use Disorders**: 3,355
- Cancers & Tumors: 3,131
- Cardiovascular Disease: 3,065
- Injuries: 2,419
- Musculoskeletal Disorders: 2,357
- Endocrine (e.g., Diabetes): 1,827
- Nervous System: 1,463
- Chronic Respiratory Diseases: 1,050
- Skin Diseases: 642
- Sense Organ Disease: 624

Costs & Consequences

41% of adults with state-funded coverage, or 15.9 million US adults, live with at least one mental health condition. It’s time to #Fight4Health.

FightChronicDisease.org

MEDICAID ADULTS: STATE AVERAGE PER CAPITA SPENDING BY HEALTH STATUS
Having Multiple Chronic Conditions Dramatically Increases Medical Costs*

TOTAL COST = $3.4T IN MEDICAL + $140.8B IN SOCIETAL COSTS

Societal Costs: Lost productivity (state employees), additional jail time (inmates), & nursing home stays (Medicaid).

Mental health conditions could cost up to $3.5 trillion by 2030

*Though mental health conditions are chronic conditions, for purposes of this graph mental health conditions are shown separately from other chronic conditions. Mental health conditions considered are depression, anxiety, bi-polar, and schizophrenia.
Potential savings in medical and societal costs could amount to $22.8 billion per year, or $342 billion by 2030.

**Potential Savings = LIVES + $**

**Prison Savings**

Savings $397.7 million per year in extended jail time. That's the same as 10,363 fewer years of prison.

**Productivity Costs**

Reducing the $3.6 billion a year in lost productivity among state employees with at least one mental health condition.
Mental health is determined by a range of socioeconomic, biological and environmental factors.

Onset of chronic illness reduces income by 18%.

Lower income populations disproportionately affected.
Federal Policy Landscape

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Trump Administration Initiatives

• Appointment of Elinor McCance-Katz, MD as HHS Assistant Secretary for Mental Health & Substance Abuse

• Convening of the Interdepartmental Serious Mental Illness Coordinating Committee (HHS, HUD, DoL, VA, SSA) – August 31 meeting, NAMI CEO Mary Giliberti is on the outside stakeholder panel

• July 27 public meeting on parity implementation and enforcement and additional parity guidance

• CMS Center for Medicare and Medicaid Innovation (CMMI) RFI on priority setting – deadline November 20
ACA Repeal & Replace
Graham-Cassidy-Heller-Johnson

• Repeal individual and employer mandates
• Combine advanced premium tax credits and cost sharing reduction subsidies into a state block grant
• Create state flexibility to waive major ACA requirements including Essential Health Benefits (EHBs), restrictions on premium ratings based on health status, age, gender, etc.
• Convert the Medicaid program into a “per capita” cap
• Major impact on behavioral health
• Future Senate vote?
Busy Fall in Congress

Must pass legislation includes:

• Children’s Health (CHIP) Reauthorization
• Medicare Extenders Package
  – Medicare Advantage (MA) Special Needs Plans (SNPs)
• FY 2018 spending bills (current funding resolution runs through December 8)
  – $2 billion increase for the NIH at stake
• Debt Limit Extension
Concerns & Priorities for Mental Health Advocates

• Changes to Medicare Part D Low Income Subsidy (LIS) cost sharing as a “pay for” for either CHIP or Medicare Extenders

• Permanent reauthorization for MA Special Needs Plans (SNPs), including:
  – Dual Eligible D-SNPs
  – Chronic Disease C-SNPs
  – Institutional I-SNPs

• Securing a bipartisan budget agreement that:
  – Lifts the current BCA caps on discretionary spending,
  – Avoids sequestration, and
  – Ensures equity for Non-Defense Discretionary (NDD) spending.
Concerns & Priorities for Mental Health Advocates

• Passing HR 3168 for permanent reauthorization for MA Special Needs Plans (SNPs), including:
  – Dual Eligible D-SNPs
  – Chronic Disease C-SNPs
  – Institutional I-SNPs

• House consideration of the Senate passed CHRONIC Act, S 870 (Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care)
  – Permanent reauthorization of all 3 SNPs,
  – Expands CMMI Value-Based Insurance Design
  – Expands supplemental benefits in MA plans, including enhanced disease management,
  – Loosens restrictions on telehealth
  – Eliminates barriers to care coordination for ACOs

Sperling 10/5/17
Concerns & Priorities for Mental Health Advocates

• Opposing changes to Medicare Part D Low Income Subsidy (LIS) cost sharing as a “pay for” for either CHIP or Medicare Extenders

• Securing a bipartisan budget agreement that:
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Other Legislative Priorities

• Behavioral Health Information Technology Act (S 1732 & HR 3331) – Senators Whitehouse & Portman and Representatives Jenkins & Matsui, encourages CMMI to undertake a behavioral health information technology demonstration

• Addressing 42 CFR Part 2 as barrier to care coordination and integration - requirements should be aligned fully with the HIPAA and allow for use and disclosure of patient information for treatment, payment, and health care operations (TPO).
  – Overdose Prevention & Safety Act (HR 3545 – Representatives Tim Murphy & Blumenauer)
  – Protecting Jessica Grubb’s Legacy Act (S 1850 – Senators Manchin & Capito)
Innovations in Mental Health Delivery: What’s Working & How Can You Connect with Advocates in Your Community?

Rebecca Farley David
Primary and Behavioral Health Care Integration (PBHCI)

• Funded by Congress since 2009 ($50 million in FY2017)
• History of strong bipartisan support
• Goals:
  – Advance the adoption of integrated care
  – **Lower participants’ chronic disease risk indicators** (hypertension, obesity, smoking, etc.)
  – Support behavioral health organizations in addressing clients’ physical health needs
  – Foster partnerships between primary and behavioral health care
Who PBHCI Grantees Are

- 25% opted to hire primary care staff directly
- 75% of grantees partnered with a primary care provider

- 213 PBHCI projects
- 8 cohorts of grantees funded by SAMHSA since 2009
- 87,000+ patients enrolled

Grantees span 40 states, including Alaska and Hawaii

The majority of grantees reside in urban areas

Mental Health First Aid®
National Council
For Behavioral Health
Healthy Minds, Strong Communities.
“An African American male patient came to the Center for Mental Health seeking mental health treatment. As the new part of the intake process, each patient is referred to receive primary care services with a complete history and physical. This client met with the nurse practitioner for his physical exam. During his physical exam, it was noted he was having cardiac issues, although he did not report feeling ill. He was quickly referred to the Emergency Room where he was diagnosed with Acute Cardiac Syndrome and was hospitalized. Patient is now receiving treatment and incredibly happy for the intervention.”
Cost savings: an example

• 170 clients enrolled in PBHCI

• After one year in the program, they:
  – Spent 86 fewer nights homeless
  – Had 50 fewer mental health hospitalizations
  – Spent 17 fewer nights in detox
  – Had 17 fewer ER visits

These outcomes resulted in $213,000 saved per month, or $2,500,000 saved in a year.
Tele-behavioral Health

– More than a million telemedicine consultations are estimated to have occurred in the U.S. in 2016 for tele-psychiatry alone

– In 2016, the Department of Veterans Affairs announced the creation of a network of Mental Health Telehealth Resource Centers to provide behavioral health care for veterans

– According to the National Business Group on Health (August 2017):
  • 56% of employers in 2018 plan to offer telehealth for behavioral health services as a covered benefit
  • 96% of employers will make telehealth services available in states where it is allowed next year
Early Intervention
One example: RAISE

• Demonstrated efficacy of Coordinated Specialty Care model (CSC)
  – Medical & non-medical interventions & supports, incl. work w/ family & supported education/employment

• Pockets of excellence in U.S.

• Dissemination challenges:
  – Coverage/payment
  – Transitions to regular care
  – Education/awareness among providers, families, at-risk youth, health care system at large
Ideas from the field

• Assess scope of Medicaid benefit $\rightarrow$ SPA needed?

• Medicaid wraparound for CSC services not covered in commercial insurance? (Illinois)

• Insurance coverage mandate (similar to many states’ mandates for autism, etc)?

• The ACT example: a dedicated funding stream through state budget for finite # of slots? (e.g. Connecticut, others)
Contact with Criminal Justice System

UNITED STATES 2015

People who experienced Serious Psychological Distress (SPD) are more likely to have been arrested or be on parole or probation in the past year.

Source: National Survey of Drug Use and Health (NSDUH) 2015
Survey does not include current institutionalized population

Draft - subject to change
Please do not distribute
After being picked up by law enforcement or referred by a local hospital, clients can stay at the center for up to 23 hours, providing enough time for KC-ATC employees to provide mental health and substance use treatment and develop post-treatment plans, like provider referrals, emergency housing preparation and prescriptions.
CCBHCs are required to coordinate with other sectors such as primary care, law enforcement, hospitals, and other health and social services.

Certified Community Behavioral Health Clinics

- Setting the standard of care for the behavioral health services industry -

Missouri ▲ New Jersey ▲ New York ▲ Oregon ▲ Minnesota ▲ Oklahoma ▲ Nevada ▲ Pennsylvania
Connecting with us in your community

National Council

State Associations

Behavioral Health Centers

Board

Staff

Clients
HILL DAY

OUR VOICES ARE LOUDER TOGETHER

October 2-3, 2017
Washington, D.C.

#HillDay17
Connect with us!

www.thenationalcouncil.org

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What’s happening in the states and what needs to happen

Debbie Plotnick
MHPAEA was just the first step

Passed by Congress on October 3, 2008

Mental Health Parity
States are strengthening parity

States are enacting their own laws

- States that have enacted legislation to strengthen and complement MHPAEA, include: IL, TN, TX, MT
- States with bills pending include: PA, IL (even stronger), CT, MN
- States with coalitions building include: OH, CO, GA, MO, IN
- Start or support a parity law in your state
Medicaid and Behavioral Health

Evolving State Plans

- Redesign that includes recovery supports, NY: peer specialists, innovative crisis services, peer-run respite, housing support
- More than 30 states paying for Peer Services
- Integration innovation, Vermont’s Model of Care
- State waivers that have becoming models for other states, such as Indiana
- Waivers work requirements, multiple states including WI, AK, KY, ME, UT
- Waiver request for drug testing, Wisconsin
- Waiver formulary request change: Massachusetts

Medicaid is the single largest payer for mental health services in the United States and is increasingly playing a larger role in the reimbursement of substance use disorder services.

Medicaid.gov
Mental Health Conditions…

...are the only chronic conditions...

...that as a matter of public policy...

...we wait until Stage 4 to treat, and then often only through incarceration.
75% of the population is female.

8% of the population is native American or American Indian.

7% of the population is Black or African American (non-Hispanic).

11% of the population is Hispanic or Latino.

5% of the population is more than one of the above.

65% of the population is White (non-Hispanic).
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<td>Depression (PHQ-9)</td>
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<td>Anxiety (GAD-7)</td>
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<td>Bipolar (MDQ)</td>
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<td>PTSD (PC-PTSD)</td>
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<td>Youth Screen (PSC-YR)</td>
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<td>Parent Screen (PSC)</td>
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<td>Alcohol and Substance Use Screen (CAGE-AID)</td>
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<td>Psychosis Screen (Ultra-High Risk) (PQ-B)</td>
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<td>Work Health Survey</td>
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<td>Eating Disorder (SWED)</td>
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MHA Screeners by Age 2015-2017

N = 1,691,091

- 34% "11-17"
- 20% "55-64"
- 8% "25-34"
- 4% "35-44"
- 2% "45-54"
- 1% "18-24"
- 1% "65+"
MHA Screener Results 2015-2017

n= 2,339,888

82% Positive Screens
19% Negative Screens
MHA Screeners With Chronic Conditions Who Are Positive For Mental Illness

Source: MHA Online Screening Data, 2016
Integration and Recovery: MHA Peer Support Specialist Certification

Lived Experience

Training by Affiliates and Partners

Credentialing by MHA as a Nationally Certified Peer Specialist to work as a valued member of a clinical care team.
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