Emerging Trends in Behavioral Health and Strategic Outlook for 2017

Prepared for the National Council for Behavioral Health

Avalere Health | An Inovalon Company
January 2017
Agenda

1. Setting the Stage

2. Emerging Trends & Implications for the National Council
   - Medical-Behavioral Health Convergence
   - The Digital Revolution in Behavioral Health
   - Rightward Turn for Health Reform

3. Defining the Path Forward
Setting the Stage
Over the Last Five Years, the National Council Has Experienced Unprecedented Membership Growth

### National Council For Behavioral Health Membership, 2012-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Providers via 100%</th>
<th>Stand-alone Providers</th>
<th>Association/State</th>
<th>Affiliates</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1,645</td>
<td>255</td>
<td>36</td>
<td>50</td>
</tr>
<tr>
<td>2013</td>
<td>1,745</td>
<td>277</td>
<td>52</td>
<td>57</td>
</tr>
<tr>
<td>2014</td>
<td>1,801</td>
<td>286</td>
<td>53</td>
<td>62</td>
</tr>
<tr>
<td>2015</td>
<td>2,091</td>
<td>265</td>
<td>65</td>
<td>86</td>
</tr>
<tr>
<td>2016</td>
<td>2,504</td>
<td>264</td>
<td>62</td>
<td>80</td>
</tr>
</tbody>
</table>

1 National Council for Behavioral Health membership database.
Expanding the Scope of Services to Meet the Needs of a Growing Membership

<table>
<thead>
<tr>
<th>Policy</th>
<th>Consulting</th>
<th>Best Practices</th>
<th>Events and Trainings</th>
</tr>
</thead>
</table>
| • Policy Agenda  
  • Ambassador Network  
  • Advocacy Leadership Awards  
  • Capitol Collector Blog  
  • Hill Day | • Consulting Expertise  
  • Healthcare Practice Improvement  
  • Human Capital Management  
  • MTM Services Consulting | • Mental Health First Aid  
  • SAMHSA-HRSA Center for Integrated Health Solutions  
  • National Behavioral Health Network for Tobacco & Cancer Control | • Annual Conference  
  • Training and Staff Development  
  • Webinars  
  • Online Learning  
  • Social Work Graduate Education  
  • Twitter Chats  
  • Monthly Addiction Committee Calls |
Steady Increase in Need for Behavioral Health Services Underscores the Perennial Challenges Facing the Council

SMI and Non-SMI Among Persons Aged 18 and Older, 2008-2015
in Millions

<table>
<thead>
<tr>
<th>Year</th>
<th>Non-SMI</th>
<th>SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>31.5M</td>
<td>8.3M</td>
</tr>
<tr>
<td>2009</td>
<td>32.8M</td>
<td>8.3M</td>
</tr>
<tr>
<td>2010</td>
<td>32.0M</td>
<td>9.3M</td>
</tr>
<tr>
<td>2011</td>
<td>32.4M</td>
<td>9.0M</td>
</tr>
<tr>
<td>2012</td>
<td>34.0M</td>
<td>9.6M</td>
</tr>
<tr>
<td>2013</td>
<td>33.8M</td>
<td>10.0M</td>
</tr>
<tr>
<td>2014</td>
<td>33.7M</td>
<td>9.8M</td>
</tr>
<tr>
<td>2015</td>
<td>33.7M</td>
<td>9.8M</td>
</tr>
</tbody>
</table>

SMI: Serious Mental Illness
Note: Adults with an SMI were defined as having any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities.
Rise in Opioid-Related Fatalities Bringing Need for Addiction Treatment into Sharp Relief

Number of Deaths from Opioid Drugs, 2004-2015

In Thousands

Note: Opioids can be defined with the following ICD-10 codes: T40.1-T40.4 and T40.6.
Growth in Demand for Behavioral Health Services Will Exacerbate Chronic Workforce Shortages

Demand for Behavioral Health Services by Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>2013</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>57K</td>
<td>61K</td>
</tr>
<tr>
<td>BH Nurse Practitioners</td>
<td>10K</td>
<td>10K</td>
</tr>
<tr>
<td>BH Physician Assistants</td>
<td>2K</td>
<td>2K</td>
</tr>
<tr>
<td>Clinical, Counseling, and School Psychologists</td>
<td>233K</td>
<td>246K</td>
</tr>
<tr>
<td>SA and Behavioral Disorder Counselors</td>
<td>106K</td>
<td>123K</td>
</tr>
<tr>
<td>Mental Health and SA Social Workers</td>
<td>139K</td>
<td>158K</td>
</tr>
<tr>
<td>Mental Health Counselors</td>
<td>150K</td>
<td>173K</td>
</tr>
<tr>
<td>School Counselors</td>
<td>308K</td>
<td>322K</td>
</tr>
</tbody>
</table>

The growing recognition of behavioral health will create additional demand for behavioral health services which will create new opportunities for behavioral health providers

BH: Behavioral Health; SA: Substance Abuse

Game-Changing 2016 Election Will Have Major Impact on Behavioral Health Funding and Coverage

Donald Trump: President-Elect

Tom Price: Nominated for Health and Human Services Secretary

Seema Verma: Nominated for Administrator of the Centers for Medicare and Medicaid Services

Paul Ryan: Speaker of the House of Representatives

Mitch McConnell: Senate Majority Leader
Honing in on the Emerging Trends that the National Council Must Address

1. Medical-Behavioral Health Convergence

2. Digital Revolution in Behavioral Health

3. Rightward Turn for Health Reform
Emerging Trends: Medical-Behavioral Health Convergence
Consolidation of Behavioral Healthcare Services is Steadily Increasing

Total Behavioral Healthcare M&A Transactions

<table>
<thead>
<tr>
<th>Year</th>
<th>Transactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>21</td>
</tr>
<tr>
<td>2011</td>
<td>32</td>
</tr>
<tr>
<td>2012</td>
<td>30</td>
</tr>
<tr>
<td>2013</td>
<td>31</td>
</tr>
<tr>
<td>2014</td>
<td>41</td>
</tr>
<tr>
<td>2015</td>
<td>43</td>
</tr>
<tr>
<td>2016(E)*</td>
<td>57</td>
</tr>
</tbody>
</table>

**Drivers of Consolidation**

- Meeting Growing Demand
- Achieving Operational Efficiencies
- Increasing Contracting Leverage
- Acquiring Complimentary Programs

*2016 M&A activity is a projection based on M&A rates as of July 30, 2016.*

1 Behavioral Healthcare Services Q32016. Capstone Partners. Date Accessed: Nov. 21, 2016. Available at: link;
For-Profit Behavioral Health Providers Steadily Gaining Ground

THE NUMBER OF PATIENTS TREATED BY FOR-PROFIT FACILITIES INCREASED BY 53 PERCENT BETWEEN 2003 AND 2013

Facility Operators by Owner Type

### Investors Focus on Specific Behavioral Health Services

**68 PERCENT OF ACQUISITIONS FROM 2012 TO 2015 TARGETED INPATIENT BEHAVIORAL HEALTH CENTERS**

<table>
<thead>
<tr>
<th>Acquisitions</th>
<th>Investments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Behavioral Health/Psychiatric Services</strong></td>
<td><strong>Residential Mental and Behavioral Treatment Services</strong></td>
</tr>
<tr>
<td>In December 2015, Acadia Healthcare Company, Inc. acquired Medical Management Options, Inc.</td>
<td>In May 2013, Bregal Partners invested in US Community Behavioral</td>
</tr>
<tr>
<td><strong>Substance Abuse and Addiction Treatment Services</strong></td>
<td><strong>Outpatient Behavioral Health Services</strong></td>
</tr>
<tr>
<td><strong>Transitional Programming Services</strong></td>
<td><strong>Eating Disorder Recovery Services</strong></td>
</tr>
<tr>
<td>In November 2015, Wellspring Capital Management LLC acquired AdvoServ. Inc.</td>
<td>In January 2013, Lee Equity Partners invested in Eating Recovery Center</td>
</tr>
</tbody>
</table>

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“In markets across the country, investors are cherry picking profitable services, so now there is the need to be big enough to compete.”

– National Council Member Interviewee

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Health Systems Are Making Large Investments in Behavioral Health as They Shift Their Focus From Volume to Value

**Continuum of Value-Based Payment Models**

- **Volume (FFS):** FFS payments tied to cost and quality performance.
- **Episodic Bundles:** Fixed payment for all/most services by related providers attendant to time-delimited episodes of care.
- **Shared Savings:** FFS-based, but possibility of earning shared savings if total cost of care kept below benchmark for defined population.
- **Capitation:** Fixed payment amount per patient for defined services rendered over set period.
- **Value:**

**Incentives for Health System Investment in Behavioral Health**

- Reduce ED overcrowding
- Improve bed availability
- Reduce inpatient LOS
- Prevent unnecessary readmissions
- Improve clinical outcomes and reduce total cost of care for complex, chronically ill patient populations

**Abbreviations:**
- FFS: Fee-for-Service
- ED: Emergency Department
- LOS: Length of Stay
New Opportunities Emerging as the Line Between Physical and Behavioral Health Blurs

**Behavioral Health**
- Consolidation of Behavioral Health Providers
- For-Profit Expansion into Niche Behavioral Health Services

**Medical Care**
- Steady Expansion of Value-Based Payment Models
- Increased Clinical Integration across the Continuum

ACA; Affordable Care Acr, ACO: Accountable Care Organization; PCP: Primary Care Physician; BH: Behavioral Health
### Case Study / Carolinas HealthCare System Addresses Behavioral Health Using Various Strategies

**Health System Overview**

- **Location:** North and South Carolina, Georgia
- **Hospitals:** 39 campuses
- **Care Locations:** > 940
- **Network and Affiliate Employees:** > 62,000

### Bed Capacity

**Challenge**
NC has one of the lowest per-capita psychiatric bed ratios in the U.S.

**Solution**
A new 66-bed inpatient hospital with three units. Each team includes 3 therapists, a pharmacist, internist, and peer specialist.

### ED Outreach

**Challenge**
NC has 2x national rate of psychiatric patients in EDs; statewide ALOS is 40 hours

**Solution**
Virtual behavioral health teams deployed to 25 EDs; contract with transportation company instead of using law enforcement.

### BH Integration

**Challenge**
How to reach patients before a crisis point when barriers and acuity are low

**Solution**
Integrated behavioral health into 50 primary care offices, serving over 8,000 patients in with virtual team over 2-year period

### Mental Health First Aid

**Challenge**
Stigma/discrimination against mental illness results in fewer people accessing care

**Solution**
Eight-hour course on how to recognize and manage a psychiatric crisis; trained over 7,000 individuals (e.g., teachers, clergy)

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ED: Emergency Department; ALOS: Average Length of Stay; BH: Behavioral Health

2 Santopietro, J. The Hidden Value of Behavioral Health. AJNC. Date Accessed: Nov. 22, 2016/ Available at: [link](#).
# Pockets of Innovation in Hospital-Led Integration of Primary Care and Behavioral Health

## PCP-Behavioral Health Integration Models

### University of Texas Medical Branch’s Integrated Program for At-Risk Teens

**Program:** UTMB created a program to improve access to mental health services for kids in school; providers are staffed by the hospital  
**Location:** Teen health centers in Galveston, TX schools  
**Services:**  
- Center staff triage patients to determine best needs (e.g., psychiatrist, psychologist, social worker)  
- Telepsychiatry services offered to children  
- On-site therapist to offer support as issues arise  
**Results:**  
- Increase in school attendance

### Nassau University Medical Center’s Integrated Primary Care Program

**Program:** NUHealth integrated a primary care program into an outpatient MHC  
**Location:** Outpatient MHC  
**Services:**  
- PCP works out of the clinic four hours/week to give patients annual physicals, vaccinations, etc.  
- On-site nurse helps deliver primary care services  
**Results:**  
- Providers have access to online charts with a patient’s physical and behavioral health information  
- Increased communication between PCPs and MHC

### University of Washington’s Behavioral Health Integration Program

**Program:** Behavioral healthcare managers and psychiatric consultants are embedded in 14 clinics and are part of care team  
**Location:** Primary care clinics  
**Services:**  
- PCPs conduct BH screening and determine if specialist is needed  
- PCPs help with warm handoffs to BH providers  
**Results:**  
- A single, comprehensive treatment plan for patients  
- Integrated EHR system  
- Continuous communication between PCPs and BH providers for each patient

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PCP: Primary Care Physician; BH: Behavioral Health; MHC: Mental Health Clinic; EHR: Electronic Health Record

Health Systems Are Looking for Partners with a Well-Defined Value Proposition and Differentiated Capabilities

ALTHOUGH HEALTH SYSTEMS ARE INVESTING IN THEIR OWN NETWORKS, THEY WILL NOT BE ABLE TO RE-CREATE THE ENTIRE BEHAVIORAL HEALTH ECOSYSTEM

“We recognize the need to engage with existing behavioral health providers, but we need to know what unique capabilities they bring to the table.”
– National Council Member Interviewee
ACOs Taking Root in Most Markets across the U.S.

84 PERCENT OF ACOS REPORT HAVING FINANCIAL ACCOUNTABILITY FOR BEHAVIORAL HEALTH AS A PART OF THEIR SHARED SAVINGS CONTRACT

Estimated ACO Penetration by Hospital Referral Region

ACO: Accountable Care Organization
Despite Accountability for Behavioral Health, Few ACOs Have Engaged Mental Health and Addiction Service Providers

“The reality is that most ACOs are still in their nascent stages, and few of them are assuming significant financial risk.”
– National Council Member Interviewee

ACO: Accountable Care Organization
Case Study / Montefiore ACO Invests in Behavioral Health and Achieves Significant Savings

Montefiore

Montefiore ACO
• ACO Type: Pioneer ACO
• Location: New York
• PY 1 Results (2012): $14.0M
• PY 2 Results (2013): $13.1M
• PY 3 Results (2014): $8.4M
• PY 4 Results (2015): $0

Innovative Interventions
• ED case management
• Post-discharge calls
• Expand PCMH
• SNF initiative
• Care guidance
• House calls
• Integrated medical and behavioral health care management
• Clinical pathways

Patient Centered Health Home
• Model: Team-based care using the Collaborative Care Initiative Model
• Approach: Care management to provide patient support and help patient's behavioral health needs
• Approach: PHQ-9 administered at every encounter to measure symptoms and psychiatrist used as a consultant
• Approach: Patient registry to track outcomes
• Results: Based on a pilot sample, 46 percent of patients with depression had a clinically significant five point reduction in PHQ9 scores and 22 percent decrease in visits to PCPs

Behavioral Health Synergy Team
• Activity: Developed a care management synergy team to manage complex patients (e.g., depression and diabetes)
  o Psychiatrist reviews cases with synergy team and coaches PCPs. Will provide on-site treatment for complex patients
  o RN completes baseline assessment and helps with scheduling appointments, community referrals, etc.
• Results: Mean PHQ9 scores reduced by 32 percent (15.3 to 10.4)

“We need nimble behavioral healthcare providers. Some will have to jump into risk arrangements.”
– National Council Member Interviewee

ACO: Accountable Care Organization; RN: Registered Nurse; BH: Behavioral Health; ED: Emergency Department; PY: Performance Year; PCMH: Patient Centered Medical Home; PCP: Primary Care Physician; SNF: Skilled Nursing Facility
1 Chung, H. and Schwartz, B. The Montefiore ACO and Behavioral Health Integration: A Work in Progress. Date Accessed: Nov. 23, 2016. Available at: link;
2 Montefiore Accountable Care Organization. Montefiore. Date Accessed: Nov. 23, 2016. Available at: link;
3 Chung, H. Behavioral Health Integration and Health Reform: Are We at the Tipping Point? Date Accessed: Nov. 23, 2016. Available at: link.
Hennepin Health

Hennepin ACO

- **ACO Type:** Medicaid ACO
- **Location:** Minnesota
- **Partners:**
  - Human Services and Public Health Department
  - Hennepin County Medical Center
  - Metropolitan Health Plan
  - NorthPoint Health and Wellness Center (FQHC)
- **Population:** 12,000 Medicaid beneficiaries, ages 21-64, low-income, childless adults
  - 68 percent with mental illness
  - 81 percent with chemical dependency
- **Financial Model:** PMPM capitated payment to cover all Medicaid costs; providers reimbursed through FFS from Hennepin Health
- **ACO Features:**
  - Proactive risk-identification
  - Care Coordination for high-risk patients
  - Multi-disciplinary teams

**Care Model**

- **Low-Risk Patients:** No documented physical or behavioral health issues and no hospitalization within past year
  - Care delivered in primary care clinics with a focus on health maintenance and disease prevention. Social service needs are addressed via social workers in clinics and partner organizations
- **Intermediate-Risk Patients:** Require ongoing management of chronic conditions and behavioral health conditions
  - Receive disease management support from care coordination team and access to social workers
- **High-Risk Patients:** Multiple hospitalizations and significant physical and behavioral health conditions
  - Primary coordinator assigned to each patient and patients with several behavioral health hospitalizations or a history of substance dependency will receive a licensed alcohol and drug counselor or other behavioral health specialists

**Team Members and Partnerships**

- **Members:** Care coordinator, pharmacist, behavioral health staff member*, clinical social worker, community health worker, housing or social service navigator, etc.
- **Partnerships:** Partners with nonprofits and social services agencies with a particular focus on secure housing and substance abuse treatment
- **Results:** 18 percent decrease in psychiatric ED visits

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Despite Some Successful Cases, Several Challenges Remain to Effectively Integrate Behavioral Health into ACOs

## Hurdles to Greater ACO-Behavioral Health Integration

### Lack of Existing Relationships

- One-third of ACOs have no formal relationship with BH providers
- Some ACOs believe behavioral health is better addressed at the practice level and not the ACO level
- Some ACOs do not consider BH a priority and will therefore leave these efforts to the community (i.e., provider resistance)

### Financial Incentives Not Always Aligned

- Different payment models for medical and behavioral health services result in some cases in countervailing incentives for tighter integration
- BH providers may not have the financial risk management capabilities necessary to enter into gainsharing arrangements with ACOs and other risk-bearing medical providers

### Data Integration Challenges

- Limited HIT infrastructure and integration challenges resulting in fragmented, incomplete data for ACOs and BH partners
- BH providers may not have analytic capabilities to compliment ACO analytics
- Privacy and data sharing restrictions limits effectiveness of EHR and care coordination efforts

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ACO: Accountable Care Organization; BH: Behavioral Health; ROI: Return on Investment; EHR: Electronic Health Record; HIT: Health Information Technology

Primary Care and Behavioral Health Integration Will Begin to Blur the Lines of Provider Responsibilities

STRATIFYING PROVIDER RESPONSIBILITY BY PATIENT ACUITY WILL RESULT IN THE DELIVERY OF EFFICIENT AND EFFECTIVE CARE

BH Providers Integrating Primary Care
- In the future, mental health clinics managing high-acuity patients will offer primary care services (e.g., measure blood pressure) as part of health home model
- Sustainability is the key issue given lack of consistent funding

PCPs Integrating Behavioral Health
- Some PCPs will integrate more behavioral health services into their practices
- Behavioral health services may be provided within the practice, in a co-located setting, or have a virtual link to the PCP
Medical-Behavioral Health Convergence: Strategic Priorities for the National Council (1 of 2)

● Support Members in Defining Their Unique Value Proposition

Guide National Council members, particularly independent providers, in defining the specific value and unique role(s) they play as the behavioral health landscape shifts, value-based payment models continue to evolve, and new providers (e.g., health systems, for-profit providers) emerge.

● Assist Members in Navigating the M&A Terrain

The National Council should help members determine the optimal scale for their operations and help them understand the opportunities and challenges associated with M&A models as well as partnership and affiliation options.

● Provide Effective Models for Engagement with Health Systems

Increased health system involvement will require behavioral health providers to understand their role, their value proposition, and how to link health systems to the community; the National Council should educate members on how to define the value they can deliver to health systems and effective models for clinical collaboration.
Medical-Behavioral Health Convergence: Strategic Priorities for the National Council (2 of 2)

- **Identify Areas of Alignment with Hospitals and Health Systems on the Policy Front**

  *The National Council should forge stronger partnerships with health systems and their associations (e.g., AAMC, AHA) to advocate on areas of mutual interest, including expanding funding for behavioral health services and ensuring access to mental health and addiction treatment.*

- **Clarify the Opportunities for Engaging with ACOs**

  *Moving beyond the conceptual discussion of ACOs and the future of value-based care, National Council members need market-specific guidance for partnering with ACOs; the Council should compile best practices from the handful of ACOs that are actively working with behavioral health providers.*

ACO: Accountable Care Organization; AAMC: Association of American Medical Colleges; AHA: American Hospital Association
Emerging Trends: Digital Revolution in Behavioral Health
## Behavioral Healthcare Delivery Will Continue to Shift in the Coming Years

<table>
<thead>
<tr>
<th>Standard Approach</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evaluation performed by clinician based on interview design tools</td>
<td>Outpatient counseling and psychotherapy addressed separately from patient’s physical health needs</td>
<td>Apart from phone calls and intermittent emails, clinicians typically have limited engagement with patients outside of office visits and therapy sessions</td>
</tr>
<tr>
<td></td>
<td>Diagnosis refined based on continued in-person engagement with patient</td>
<td>Medications prescribed based on assessment and diagnosis of patient with regular follow-up visits and review of treatment regimen</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emerging Modalities</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Predictive analytics employed to identify patients with potential for a behavioral health issue</td>
<td>Telepsychiatry visits bring medicine to patients, improving access to care, particularly for those in remote areas</td>
<td>Mobile applications enable patients to engage with a tool designed to attend to their individual behavioral health needs in real time</td>
</tr>
<tr>
<td></td>
<td>Analytics allows for tailored approach to an individual’s unique needs and facilitates earlier interventions</td>
<td>Integration of behavioral and physical health with a focus on mental health first aid</td>
<td>Online peer groups provide support and reduce isolation for patients</td>
</tr>
</tbody>
</table>
Enabling Deeper Insights into Behavioral Health Needs

**Mentrics, Powered by IBM’s Watson**

- In April 2016, ODH (a behavioral health analytics firm) and IBM Watson Health launch Mentrics, a management platform built for managed care organizations handling behavioral health benefits.
- Platform aggregates data from behavioral, physical medical services and prescription claims into a single platform.
- Mentrics assigns a behavioral health risk score for each individual providing actionable insights that alert care coordinators in real time to treatment gaps.

Leveraging Analytics to Guide Care Management Strategies

Analytics-Driven Preventive Care

**Catasys OnTrak Model**
- Humana claims data analyzed to identify “at risk” individuals for medical and psychiatric complications and a history of SUD
- Patients segmented into different care management models based on risk level

**RESULTS:**
- **16%** Reduction in ED visits
- **67%** Fewer inpatient hospitalizations
- **46%** Reduction in costs

**At-Risk Interventions**
- 3 coaching calls/month
- Routine physician visits
- Psychosocial visits employing motivational enhancement therapy and cognitive behavioral therapy

**Low-Risk Management**
- Continual monitoring of individuals’ claims data
- Physician visits
- Routine review of patient status

ED: Emergency Department
Deep Brain Stimulation (DBS): DBS was originally used to treat Parkinson’s disease and has been shown to be useful in the treatment of persistent depression; Although DBS remains a rarely-used procedure for depression, researchers continue to explore its clinical efficacy for severe mental health issues.

Non-invasive Neuromodulation: These devices are gaining clinical significance in the behavioral health space, particularly for drug-resistant depression; Similar to DBS, use beyond research setting is limited, but poised to gain broader acceptance with promising results.

Implantable Medication Dispensation: Long-acting surgically implanted devices can be used along with counseling and other behavioral therapies to treat a range of conditions including opioid-addiction.

Ketamine Clinics: Ketamine, originally used as anesthesia is now being offered as an infusion in cutting edge outpatient treatment clinics to rapidly treat mood disorders and chronic pain conditions.

“The fact that DBS and other interventional models haven’t caught on yet does not mean that we will be immune from disruptive treatment modalities.” - National Council Member Interviewee
Telehealth Encompasses a Wide Variety of Services

MOBILE HEALTH INNOVATIONS SET TO TRANSFORM HOW WE TREAT AND ENGAGE PATIENTS WITH MENTAL HEALTH AND SUBSTANCE ABUSE ISSUES

Telehealth

- Remote delivery of care through video consults
- Store-and-forward data and images to remote providers

Telemedicine

- Use of technologies to monitor patients remotely
- “Smart” scales, blood pressure cuffs etc. collect and report data to clinicians

Remote Monitoring

- Ever-expanding array of health applications designed to monitor and engage patients
- Weight, vital signs trackers now commonplace

Mobile Health
Online Therapy and Mobile Applications Are Transforming Telepsychiatry and Creating Remote Monitoring Opportunities

7 Cups Connects People in Need of Mental Health Support with Trained Listeners

- Free, anonymous, and confidential online text chat with trained listeners, accessible online therapists, and counselors
- Forum allows users to connect with listeners through secure networks instantly
- Users can select listeners based on life experience or affiliation
- Users can remain anonymous to ensure confidentiality
- $37.50/week, or $150 for the whole month of unlimited contact with an individual therapist

1. 7 Cups.. Accessed: Jan. 10, 2016. Available at: [link]
In Recent Years Mental Health Smartphone Applications Have Emerged to Engage Consumers

Mental Health Applications by Condition

- Mood Disorders, 44%
- PTSD and Other Anxiety Disorders, 43%
- Schizophrenia, 13%

Mental Health Applications by Treatment Type

- Cognitive Behavioral Therapy, 44%
- Symptom Tracking, 28%
- Cognitive Remediation, 5%
- Cognitive Training, 9%
- Mindfulness, 12%
- DBT, 2%

DBT: Dialectical brain therapy; PTSD: Post-Traumatic Stress Disorder
Proliferation of Mobile Apps to Support Patients, Caregivers, and Providers in the Substance Use and Recovery Space

<table>
<thead>
<tr>
<th>i(nar)CAN</th>
<th>Sober Grid</th>
<th>Ascent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>•</strong> FDA sponsored competition to create a mobile app to help opioid abusers</td>
<td><strong>•</strong> Free location-based app allowing users to connect with other individuals nearby (giving approximate distance) who are in recovery</td>
<td><strong>•</strong> For $35/month, app provides 24/7 support from trained peer-recovery coaches to help SUD-recovering individuals avoid relapse</td>
</tr>
<tr>
<td><strong>•</strong> i(nar)CAN allows users to create a network profile of first responders and naloxone carriers who can assist during an overdose</td>
<td><strong>•</strong> App provides information, skills, and practice exercises designed to encourage users to challenge thought patterns that contribute to depression</td>
<td><strong>•</strong> Users have access to a network of other individuals in recovery via a community messaging section</td>
</tr>
<tr>
<td><strong>•</strong> The network connects the user with nearest person or organization carrying the drug to receive immediate assistance</td>
<td><strong>•</strong> Users can remain anonymous</td>
<td><strong>•</strong> Users receive an individualized, customized plan and have access to recovery videos and can track their own recovery</td>
</tr>
</tbody>
</table>

“Many of the apps out there won’t pan out, but there are a handful that could transform how we care for our patients.”
- National Council Member Interviewee

Digital Revolution in Behavioral Health: Strategic Priorities for the National Council

● Develop a Clearinghouse on Mobile Health Technologies
  Create a comprehensive resource on “low-touch” interventions and mobile applications with detailed information on the clinical efficacy and cost-effectiveness and their optimal application of emerging technologies

● Serve as the Nexus between Providers and Innovators
  Support collaboration between providers and technology firms in defining patients’ unmet needs, developing new technologies and implementing them

● Promote Flexibility in Payment Models to Spur Adoption
  The Council can demonstrate adequate reimbursement for telepsychiatry, mHealth apps, and other technologies will lead to better outcomes through enhanced diagnosis, treatment, and engagement with patients

● Double Down on Advocacy for HIT Funding for Behavioral Health
  The Council should join with other provider organizations to support incentives for health IT adoption and integration across care settings
Emerging Trends: Rightward Turn for Health Reform
While Many Prominent ACA Provisions May Be Repealed, Some Policies Are Likely to Remain

<table>
<thead>
<tr>
<th>Likely to Be Repealed</th>
<th>Likely to Remain Intact</th>
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<tbody>
<tr>
<td><strong>Mandates:</strong></td>
<td><strong>Select Market Rules:</strong></td>
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<tr>
<td>Penalties associated with the individual and employer mandates*</td>
<td>Prohibition on pre-existing condition exclusions, dependent coverage until age 26</td>
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<td><strong>Financial Assistance:</strong></td>
<td>Medical Loss Ratio (MLR)</td>
</tr>
<tr>
<td>Premium tax credits and cost sharing subsidies*</td>
<td><strong>Drug-Related Provisions:</strong></td>
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<tr>
<td><strong>Tax-Related Provisions:</strong></td>
<td>Medicaid drug rebates, biosimilars, 340B, and Part D coverage gap provisions</td>
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<tr>
<td>Cadillac tax, medical device tax, health insurance tax, pharmaceutical company tax*</td>
<td><strong>Provider Provisions:</strong></td>
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<tr>
<td>Small business tax credit*</td>
<td>Some payment and delivery reforms (MSSP, hospital acquired condition penalties, readmissions penalties)</td>
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<tr>
<td>Medicare tax increase for high-income individuals*</td>
<td>Changes to Medicare provider rates (e.g., market basket reductions)</td>
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<tr>
<td><strong>DSH Cuts:</strong></td>
<td><strong>Medicare Advantage Reform:</strong></td>
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<tr>
<td>Reductions to DSH payments*</td>
<td>Changes to Medicare Advantage payments</td>
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<tr>
<td><strong>Other:</strong></td>
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<tr>
<td>Prevention and Public Health Fund*</td>
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**ACA Provisions Likely to Be Debated in 2017**

- Medicaid expansion*
- Independent Payment Advisory Board (IPAB)**
- Center for Medicare & Medicaid Innovation (CMMI)
- Essential Health Benefits (EHB) requirements***
- Select market reforms (e.g., guaranteed issue)
- Preventive services coverage requirement

*Provisions that were repealed in the 2015 reconciliation bill.
**IPAB was not repealed in the 2015 reconciliation bill based on the ruling of Senate Parliamentarian.
***The 2015 reconciliation bill repealed the requirement for Medicaid benchmark plans to offer minimum EHB after 2017.

MSSP: Medicare Shared Savings Program; DSH: Disproportionate Share Hospital; ACA: Affordable Care Act
Republicans Propose Block Grant or Per Capita Alternative Funding Approaches in Medicaid

<table>
<thead>
<tr>
<th>Block Grant Approach</th>
<th>Per Capita Cap Approach</th>
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<tbody>
<tr>
<td>The federal government would provide each state with one funding amount across all Medicaid populations</td>
<td>The federal government would provide each state with a per beneficiary funding amount (“cap”). One funding amount could be applied across Medicaid populations or funding amounts could vary for different beneficiary categories (e.g., aged, blind and disabled, children, and adults)</td>
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</table>

**Key Questions / Considerations**

- **Baseline Funding Levels:**
  - The baseline year or figures from which the block grant or per capita cap amounts are calculated
  - Whether the funding amounts will be set based on national or state-specific figures

- **State-Level Impact:**
  - Differential impact of funding reforms on states, based on state-specific program and demographic characteristics (e.g., enrollee composition, existing FMAP)

- **Funding Changes over Time:**
  - The formula-defined growth rate of block grant amounts or per capita cap amounts
  - The extent to which these approaches account for changes in Medicaid enrollment

- **Services Included in Payment Rate:**
  - The exemption or carve out of any covered products or services from block grants or capitated amounts
  - Whether funding amounts account for the introduction of new products or services

Proposed alternative Medicaid funding approaches are typically designed to achieve savings, which could place pressure on stakeholders, including plans and providers. These reforms are often paired with additional flexibility for states.

FMAP: Federal Medical Assistance Percentage
Federal Rules Outline State Flexibility Within the Medicaid Program, Which Could Be Expanded

Under current rules:

**CMS Sets Guidelines Requiring States to:**
- Implement programs statewide
- Provide comparable benefits to comparable enrollees*
- Ensure freedom of choice of provider
- Cover mandatory services
- Cover mandatory populations

**States Have Flexibility to Set:**
- Eligibility standards
- Benefits package
- Payment rates
- Program administration
- Provider certification

Block grant and per capita cap proposals in Medicaid typically allow for greater state flexibility in exchange for capping program funding. Federal guidelines and rules around program design, cost sharing, and coverage of mandatory services could be made more flexible under one of these structures.

Notably, 1115 Waivers give the administration significant authority to grant flexibility to states.

*Under the ACA, the benefit package for newly-eligible beneficiaries may be different from that available to previously-eligible individuals.
CMS: Centers for Medicare & Medicaid Services
**ACA Repeal: What’s at Stake for Behavioral Health**

<table>
<thead>
<tr>
<th>Mental Health Parity Equity Expansions</th>
<th>Preventive Care</th>
<th>Essential Health Benefits (EHBs)</th>
<th>Medicaid Expansion</th>
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<tbody>
<tr>
<td>• Since 2014, MHPAEA was extended beyond large group plans to all individual and small-group plans and Medicaid</td>
<td>• All non-grandfathered plans must cover depression and alcohol misuse screening for adults and adolescents and behavioral assessments for children</td>
<td>• Since 2014, Small-group and individual health plans have been required to cover 10 EHBs with no lifetime limits including mental health and addiction treatment and Rx drugs to treat behavioral health conditions</td>
<td>• Increased the number of low-income Americans with access to behavioral health care and positively impacted state budgets for expansion states.</td>
</tr>
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</table>
21st Century Cures Presents Some Bright Spots for Behavioral Health

• General requirements for states to use at least 10 percent of their mental health block grants on early intervention for psychosis, providing a team of specialists to provide psychotherapy, medication, education and support for patients’ families

• $1B in grants to states to fight Opioid Addiction

• Serious Mental Health Support:
  - $5 million grant program to provide assertive community treatment - a team of professionals on call 24 hours a day.
  - Expansion of a grant program for assisted outpatient treatment providing court-ordered care for people with serious mental illness who might otherwise not seek help.

• $10M in grants to increase workforce shortages of psychologists and psychiatrists

A future Congress must appropriate the funds authorized in the 21st Century Cures Act

Support Constructive Approaches to ACA “Repeal and Replace”

As the need to develop a viable replacement takes shape, the National Council can protect key provisions for behavioral health patients and their providers (e.g., preexisting conditions ban, essential health benefits, preventive services) while supporting alternatives to Medicaid expansion and the Exchanges that ensure access to vital mental health and addiction services.

Illuminate the Implications of Medicaid Reform for Our Members

Although major Medicaid reform is not a near-term reality, National Council members must account for the financial impact of block grant and per capita models; the Council should strenuously advocate against these models, but it is essential that members start developing contingency plans regarding their Medicaid funding.
Engage with State-Level Innovators on Medicaid Reform

As the federal government provides states with greater flexibility for Medicaid, the National Council can partner with progressive states in developing new benefits packages and models for delivering mental health and addiction treatment to Medicaid beneficiaries; these models should be touted as alternatives to a “slash and burn” approach to revamping Medicaid behavioral health services.

Position the Council as a Leader in Patient-Centered, Value-Based Innovation in Behavioral Healthcare

Despite deep misgivings regarding “Obamacare,” Republican policymakers support efforts to extract greater value out of Medicare and Medicaid spending and empower consumers in selecting their care; the Council should demonstrate its commitment to greater care integration, improved transparency, and quality-based payment models and actively engage with CMMI and other entities to advance value-based behavioral health care.
Defining the Path Forward
Emerging Trends Redefining Treatment Modalities and Care Settings for Behavioral Health

- **Who Will We Be Treating?**
  - SMI population will continue to grow, but *less acute, underserved patient populations* (e.g., anxiety, moderate depression) requiring focus and support
  - **Opioid epidemic** also requiring intensive focus

- **How Will We Treat Them?**
  - **Telehealth and mobile technologies** creating new opportunities for treatment and strengthening patient engagement
  - **New interventional modalities** (e.g., medication-dispensing implants) reshaping treatment model

- **Where Will We Treat Them?**
  - **Traditional medical providers** emerging as vital parts of behavioral healthcare ecosystems
  - With mobile technologies, providers engaging with patients outside of clinical settings

SMI: Serious Mental Illness
## Near-Term Priorities for the National Council

<table>
<thead>
<tr>
<th>Policy</th>
<th>Consulting</th>
<th>Best Practices</th>
<th>Events and Trainings</th>
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<tbody>
<tr>
<td>• Promote constructive approaches to ACA replacement</td>
<td>• Provide strategic guidance for navigating M&amp;A terrain</td>
<td>• Develop best practice resource guide for engaging with health systems and ACOs</td>
<td>• Support tech innovation through more joint provider-technology firm forums</td>
</tr>
<tr>
<td>• Partner with hospitals (and associations) on BH funding and access advocacy</td>
<td>• Support BH providers in defining their value proposition for health systems</td>
<td>• Create “one-stop” clearinghouse for innovations in mobile technology</td>
<td>• Engage with innovative state policymakers on Medicaid reform</td>
</tr>
<tr>
<td>• Advocate for sustainable payment models for telehealth</td>
<td>• Assist members in assessing financial implications of Medicare reform</td>
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BH: Behavioral Health; ACA: Affordable Care Act; ACO: Accountable Care Organization
Long-Term View: How Can the National Council Continue to Fulfill its Mission over the Next Decade?

The Enduring Mission

- Act as the **unifying voice** for community mental health and addictions treatment organizations
- **Ensure access to comprehensive, high-quality care** that affords every opportunity for recovery and full participation in community life

**Key Strategic Questions:**

- **Long-Term Vision** – What role(s) will the National Council need to play to fulfill our mission? What services, capabilities will we need to develop to remain vital? What offerings should we downscale / discontinue?

- **Membership Size and Scope** – How big do we need to be? What segments of the behavioral health ecosystem need our support?

- **Measures of Success** – How will we define success? What benchmarks, milestones do we need to hit over the next 3, 5, and 10 years?

- **Our Leadership** – How do we ensure strong leadership to ensure we’re meeting our mission and realizing our long-term vision?