Unmanaged Behavioral Health Puts Your Company At Risk

Presented by:

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Integrated Behavioral Health

Behavioral Health Management Webinar Overview

- History of BH management
- Prevalence of behavioral health conditions in U.S.
- Current critical elements for health plans and providers
- Recommendations to improve quality, reduce costs, and benefit employer operations

History of BH Management

- 1970's
  - Unmanaged, paid through medical plan, often as "medical" claim, charges or % of charges paid
- 1980's
  - Application of Utilization Review relative to increased hospital costs. Symptom checklists and nurse reviewers visiting hospitals. Substance abuse capped at 28 days. Outpatient continued paid without review. Hospital costs continued to increase.
- 1990's
  - Treatment of mental health and substance abuse as specialty conditions, under category of behavioral health. Rapid development of companies designed to "carve out" BH benefits and manage care and costs, with specialty networks, clinical case managers, and prior authorization.

History of BH Management

- 2000's
  - Promotion of best practices for specific BH conditions. "Discussion" of integration of BH and medical management for co-morbid patients. Concern about costs of specialty management and movement of "carve in" BH to medical carrier operations. Parity regulations complicated management of BH benefits. Management of outpatient services often discontinued. EAP and wellness services increased but independently.
- 2013
  - Federal regulations create multiple options/structures for managing and delivering care to commercial, Medicare, and Medicaid populations. Exchanges, accountable care organizations, management services organizations, state based cooperatives, etc. are being developed, with little experience available. Rewards and penalties are being tied to financial, clinical performance, and patient satisfaction.

Prevalence of Behavioral Health Conditions in the U.S.

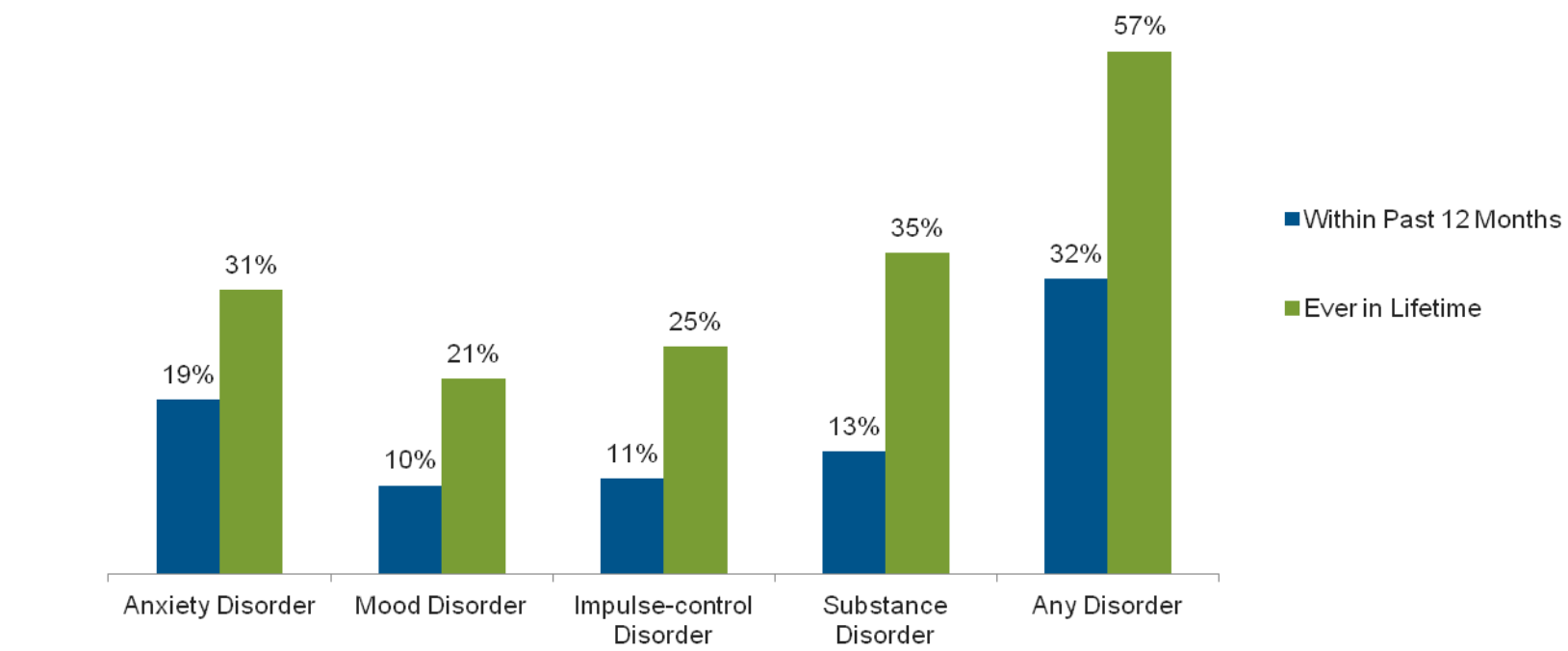
"The current system does not accurately track the prevalence, costs and treatment options for mental health as it does for medical conditions such as diabetes, heart disease, and cancer.

Primary care physicians see behavioral health issues in chronic diseases, disability, and workplace absences, but often file claims under medical diagnoses such as fatigue, insomnia, or headaches.

More fully reported behavioral conditions would promote more resources and increased search for evidence-based options."

Source: Dr. Christopher Crow, Mental Health: The Elephant in the Room, Behavioral Health, 01/15/2013

Behavioral health conditions are prevalent among adults in the U.S.



Note: Anxiety disorder includes panic disorder, agoraphobia, specific phobia, social phobia, generalized anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder, and adult separation anxiety disorder. Impulse-control disorder includes oppositional defiant disorder, conduct disorder, attention deficit/hyperactivity disorder, and intermittent explosive disorder. Substance disorder includes alcohol abuse, drug abuse, and nicotine dependence.

Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

Prevalence of Behavioral Health Conditions in the U.S.

Major Depressive Disorder

- **12 month prevalence: 6.7% of adult population. 30% of these (2.0% of adult population) are classified as "severe."**
- **Only 51.7% are receiving treatment**
- **38.0% of those receiving treatment are receiving minimally adequate treatment (19.6% of those with the disorder)**

Source: Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005, Jun;62(6):617-27

Prevalence of Behavioral Health Conditions in the U.S.

Any Mood Disorder

- **12 month prevalence: 9.5% of adult population**
- **45% of these cases are classified as severe (4.3% of the adult population**
- **50.9% of those with the disorder are receiving treatment**
- **38.5% of those receiving treatment are receiving minimally adequate treatment (19.6% of those with the disorder)**

Includes MDD, Dysthymic Disorder, and/or bipolar disorder

Source: Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005, Jun;62(6):617-27

Prevalence of Behavioral Health Conditions in the U.S.

Any Anxiety Disorder Among Adults Per 10,000

- **12 month prevalence: 18.1% of adult population – 1810**
- **22.8% of these cases (4.1% of adult population) are classified as "severe." – 412**
- **12 month healthcare use: 36.9% of those with the disorder are receiving treatment. – 667**
- **34.3% of those receiving treatment are receiving minimally adequate treatment (12.7% of those with the disorder). – 228**

Includes PTSD, OCD, specific phobias, stress reactions, etc.

Source: Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005, Jun;62(6):617-27

BH Impact on Illness, Disability, and Death

Burden of Disorders within the Neuropsychiatric Category

- Total burden of disability measured in Disability-Adjusted Life Years (DALYs)
- Number of years life lost plus the number of years lived in disability = DALY

Source: World Health Organization Data

BH Impact on Illness, Disability, and Death

DALYs for Neuropsychiatric Disorders

- Total Neuropsychiatric Disorders – 28.47
  - Unipolar Depression – 10.30
  - Alcohol Use – 4.08
  - Alzheimer's/Dementia – 3.01
  - Drug use – 2.44
  - Schizophrenia – 1.16
  - Bipolar Disorder – 1.16
  - Migraine – 1.10
  - Panic Disorder - .61

Percent of Total DALY's across U.S. & Canada

Source: World Health Organization Data

BH Impact on Illness, Disability, and Death

Leading Individual Disease/Disorder Contributors - Percent of Total DALY's in U.S. & Canada

1. Unipolar Depression – 10.3
2. Ischemic Heart Disease – 6.76
3. Alcohol Use Disorders – 4.06
4. COPD – 3.65
5. Trachea/Bronchus/Lung Cancer – 3.07
6. Hearing Loss – 3.07
7. Alzheimer's/Dementia – 3.01
8. Cerebrovascular Disease – 2.96

Source: World Health Organization Data

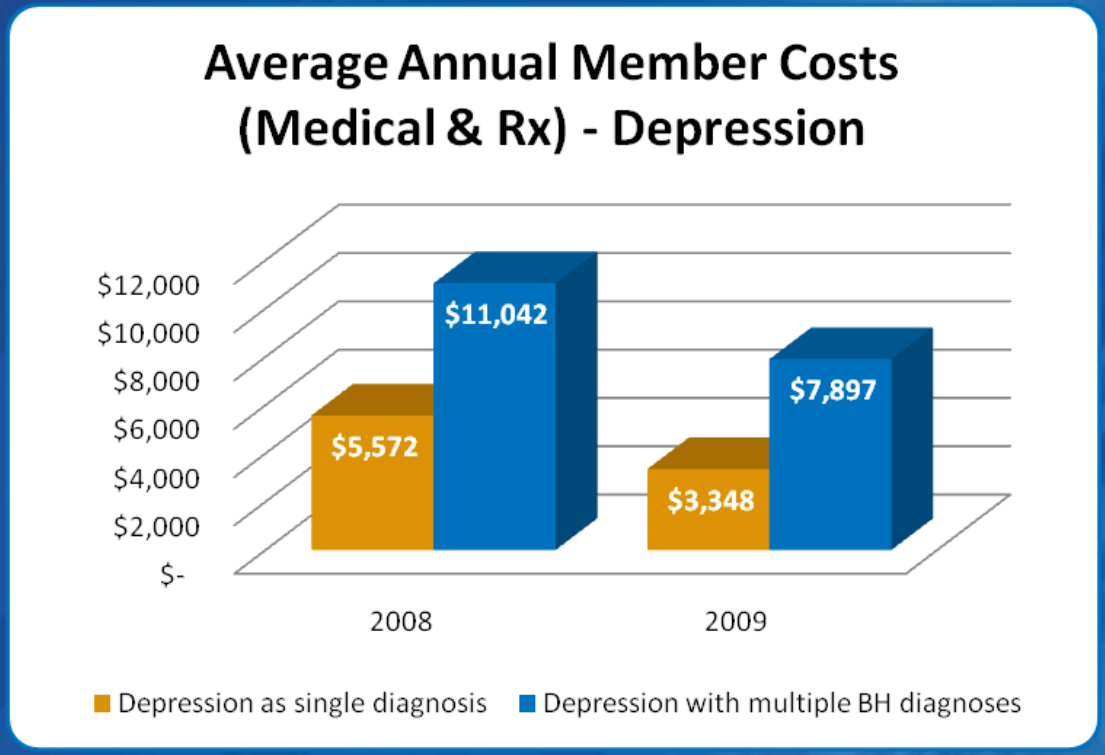
Five Most Costly Medical Conditions

Total Expenditures (in $ billions) for the Five Most Costly Medical Conditions in 2006

- **Heart Conditions – 78.0 (19.7 million persons)**
- **Trauma-related – 68.1 (34.9 million persons)**
- **Cancer – 57.5 (11.1 million persons)**
- **Mental Disorders – 57.5 (36.2 million persons)**
- **Asthma – 51.3 (48.5 million persons)**

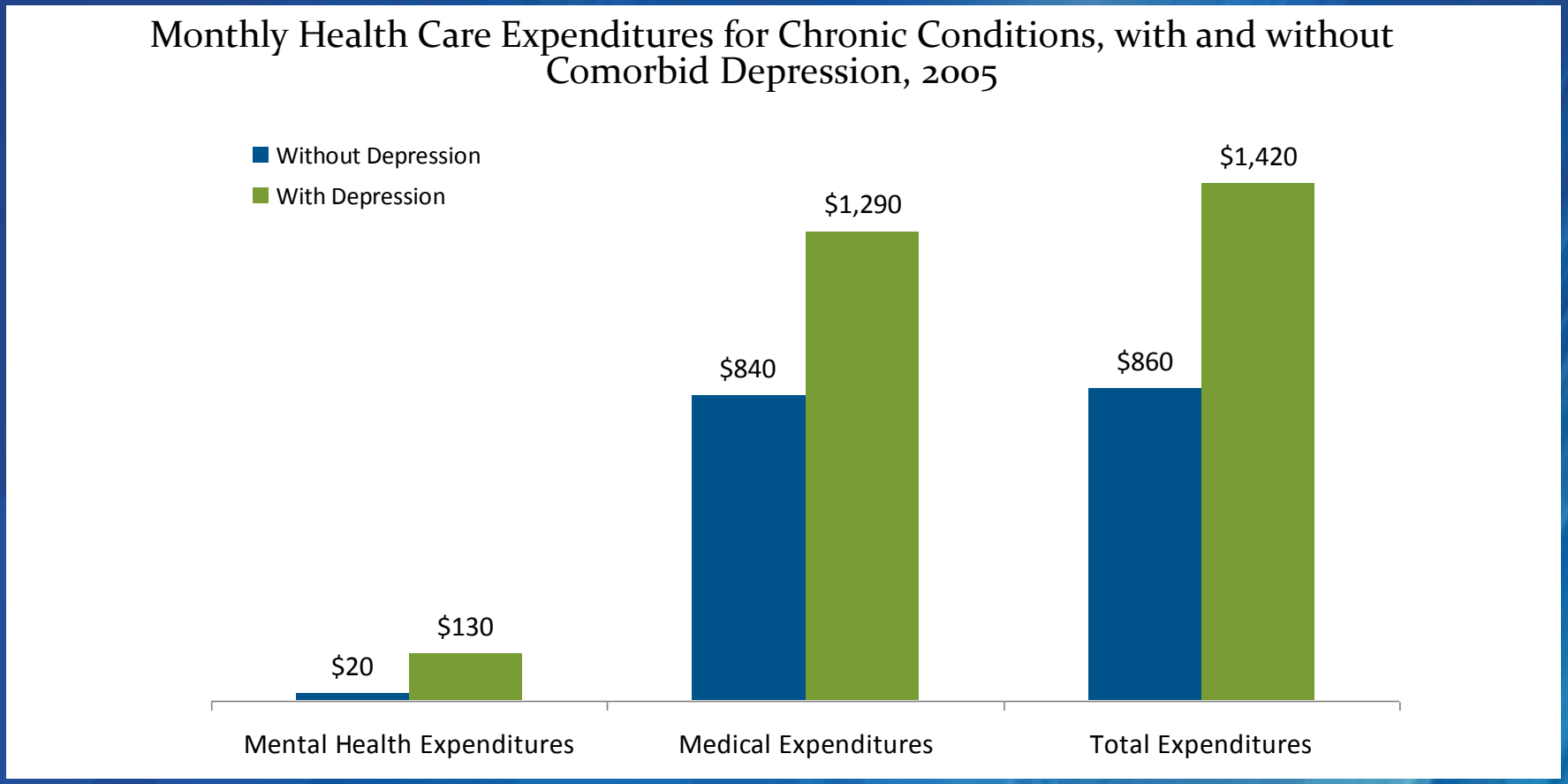
Source: Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey

Behavioral Health Diagnosed Member Cost



Depression Analysis - Non Adjusted	2008				2009			
	Count	Medical	Rx	Total	Medical	Rx	Total
Depression as single diagnosis	1664	$ 4,522	$ 1,050	$ 5,572	$ 2,535	$ 813	$ 3,348
Depression with multiple BH diagnoses	937	$ 9,594	$ 1,448	$ 11,042	$ 6,777	$ 1,120	$ 7,897

The presence of a mental health disorder raises treatment costs for chronic medical conditions.



Source: Melek, S., and Norris, D. (2008). *Chronic Conditions and Comorbid Psychological Disorders*. Cited in: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

Cost Impact of comorbid depression & anxiety on patients with chronic medical conditions

Milliman found:

- **Many individuals with chronic medical conditions and co-occurring depression or anxiety are never diagnosed or treated for their psychiatric conditions**

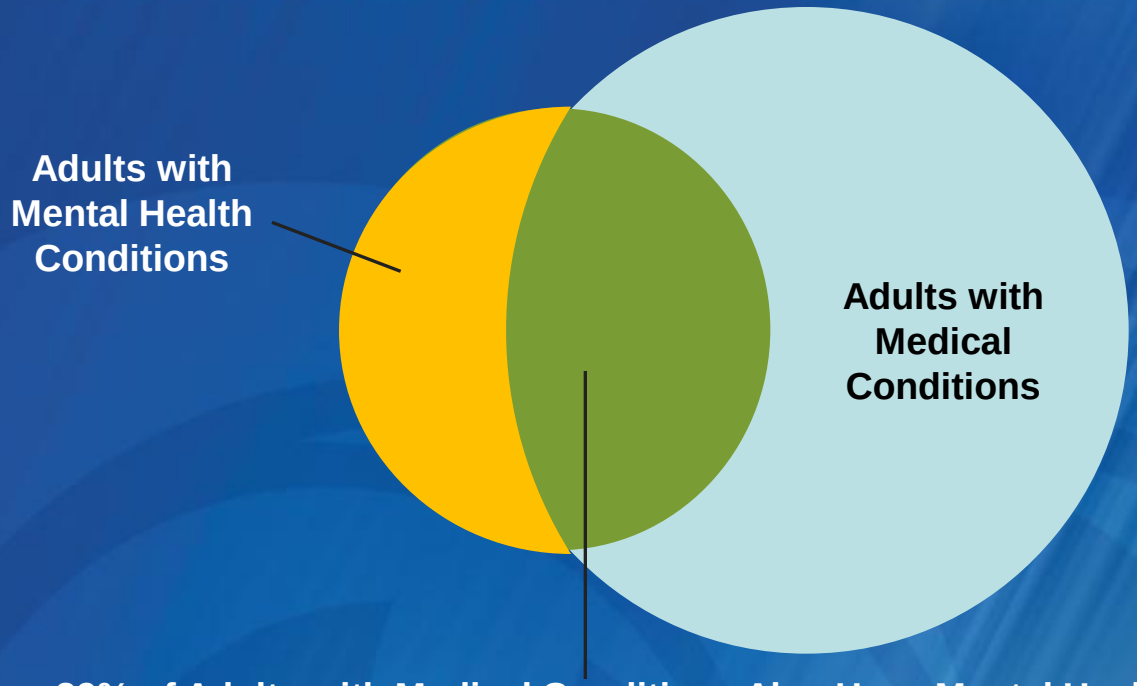
- **Comorbid depression results in elevated total healthcare costs, averaging $505 per comorbid member per month across all chronic medical conditions**

- **10% reduction in excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare programs would result in $5.4 million of healthcare savings could be achieved per 100,000 members**

Source: Melek S, Norris D. Chronic conditions and comorbid psychological disorders. Milliman Research Report, July 2008

Individuals with behavioral health conditions frequently have co-occurring physical health conditions

Percentage of Adults with Mental Health Conditions and/or Medical Conditions, 2001-2003



29% of Adults with Medical Conditions Also Have Mental Health Conditions
68% of Adults with Mental Health Conditions Also Have Medical Conditions

Source: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

Comorbid Data
Medical Impactable Conditions

Alcohol, or depression, and/or anxiety are present, as behavioral comorbid conditions in the following medical impactable conditions:

• All cardiac diseases	42.8% behavioral comorbidity
• Diabetes	35.9% behavioral comorbidity
• Hypertension	39.3% behavioral comorbidity
• Asthma and COPD	37.8% behavioral comorbidity
• Obesity	47.2% behavioral comorbidity
• Hyperlipidemia	37.2% behavioral comorbidity
• Back and Neck disorders	38.9% behavioral comorbidity

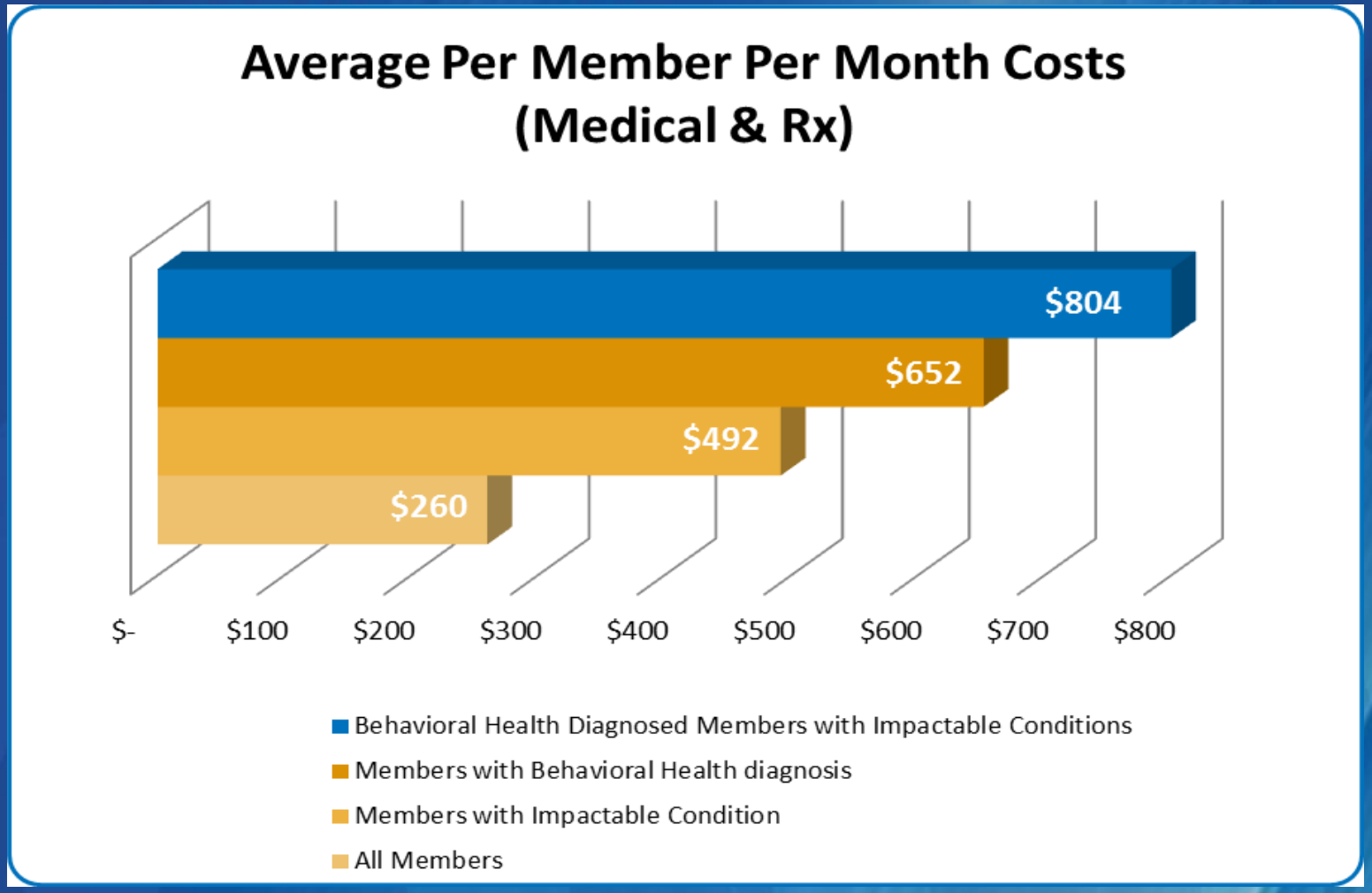
Impact of Co-morbid Depression/ Anxiety on Physical Health Costs

Excess PMPY costs from:

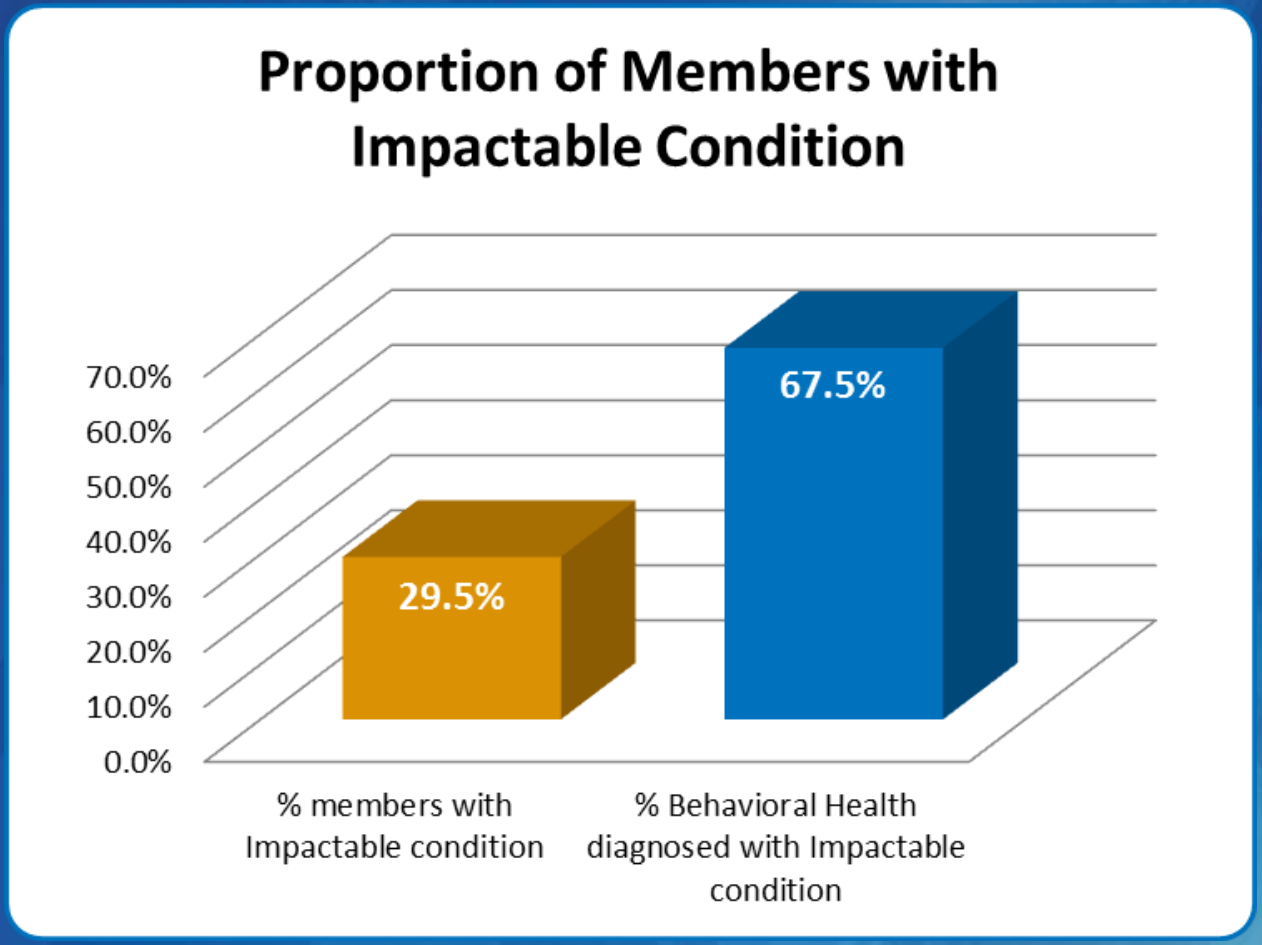
- **Asthma** 135%
- **Diabetes** 89%
- **COPD** 102%
- **All Cancers** 80%
- **CHF** 59%
- **CAD** 54%

Source: Mental Health Parity, Segal/Sibson, 2009

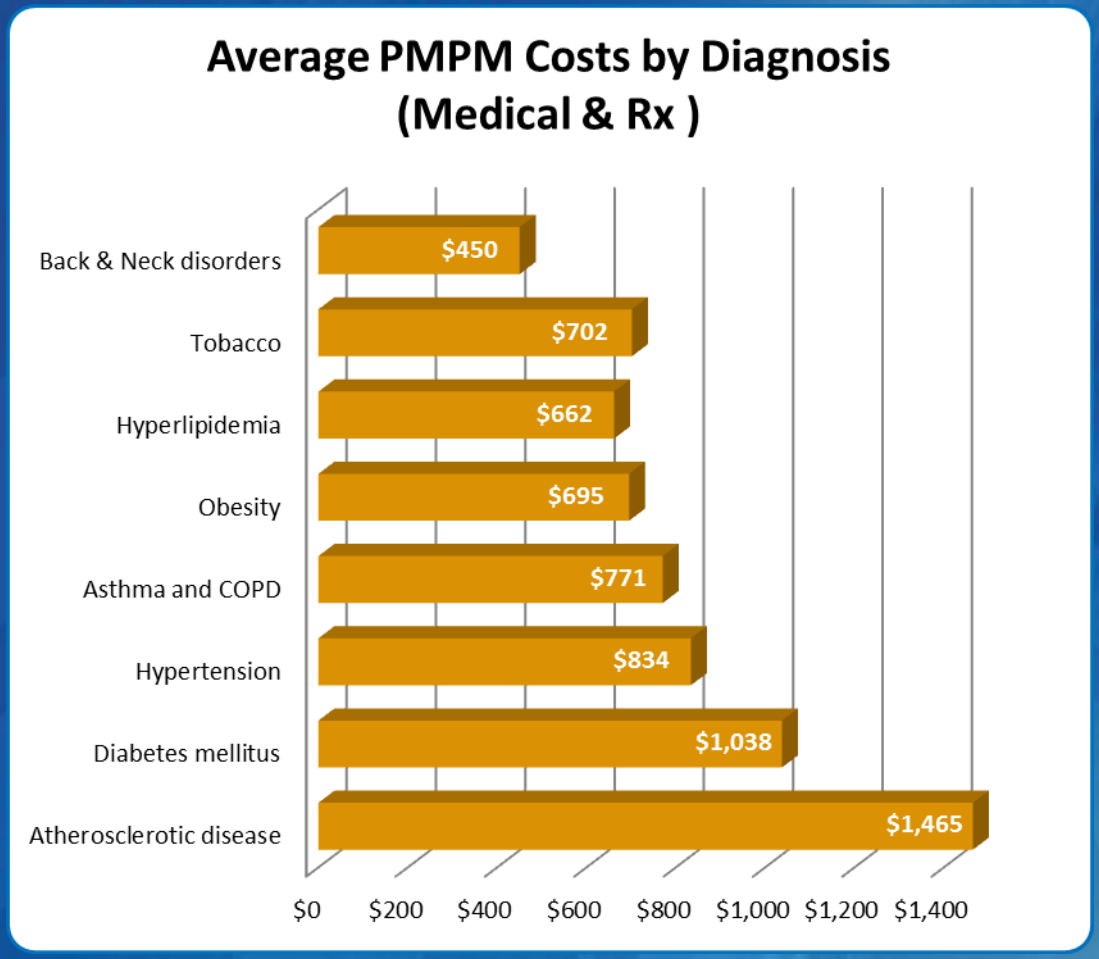
Effect of Costs on Members



Prevalence Behavioral Health Co-morbidity

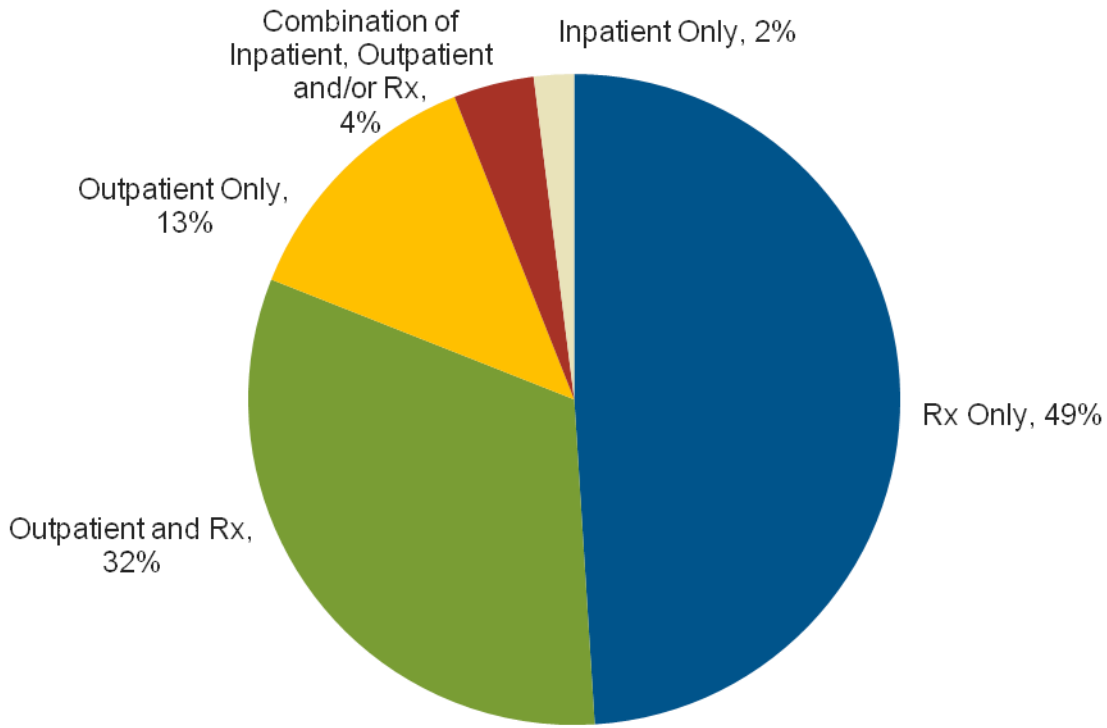


Impactable *Diagnosed Member Cost*



Treatment for behavioral health problems is most frequently delivered on an outpatient basis

Types of Mental Health Services Used in Past Year, Among Adults Receiving Treatment, 2009

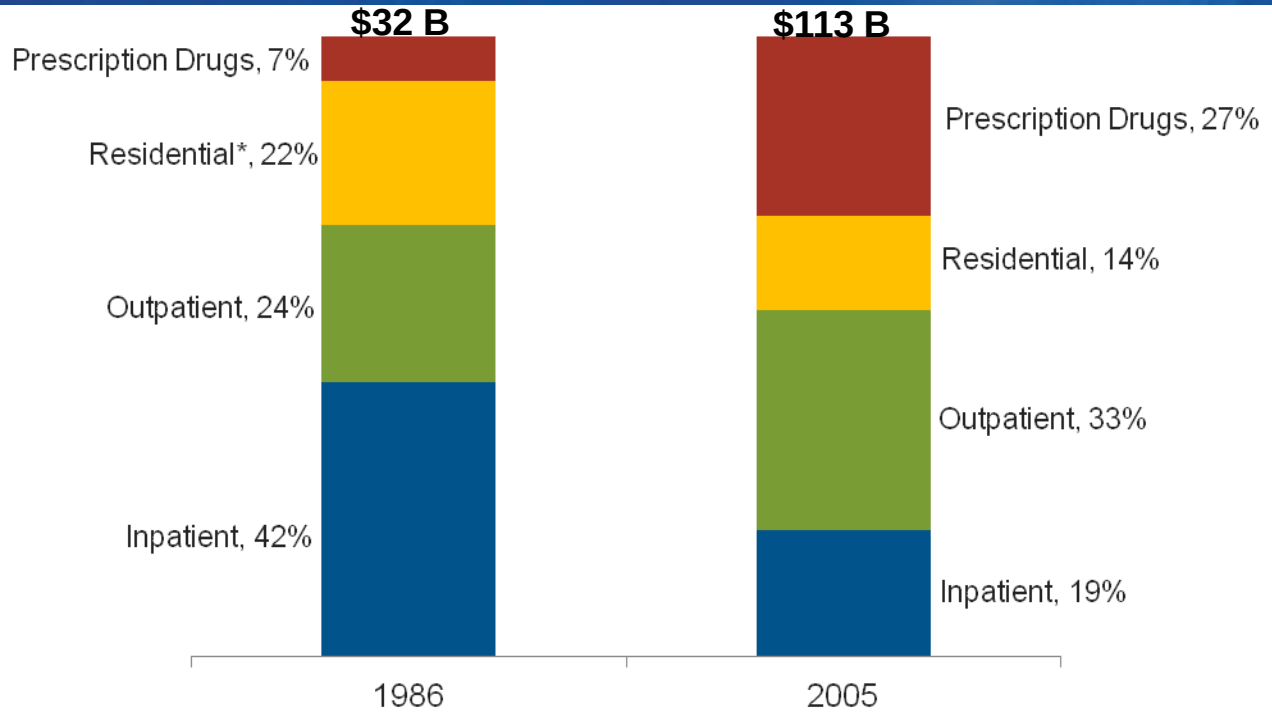


Note: Excludes treatment for substance abuse disorders.

Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

Increased utilization of Rx drugs & decreased reliance on inpatient services has shifted spending over time

Distribution of Mental Health Expenditures by Type of Service, 1986 and 2005



Note: Excludes spending on insurance administration. Data not adjusted for inflation.
*** Residential treatment includes spending in nursing home units of hospitals or in nursing homes affiliated with hospitals.**

Source: Substance Abuse and Mental Health Services Administration. (2011) . National Expenditures for Mental Health Services & Substance Abuse Treatment 1986 – 2005. Washington, DC. As cited in Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

Coordination of care can reduce costs for individuals with behavioral health conditions

Total Costs at 1 and 2 Years for Patients with Serious and Persistent Mental Illnesses Receiving a Medical Care Management Intervention vs. Usual Care

Source: Druss, B.G., et al. (2011). Budget Impact and Sustainability of Medical Care Management for Persons with Serious Mental Illness. *American Journal of Psychiatry*, AiA, 1-8.

Critical Elements for Health Plans and Providers

- **Medical, behavioral health, EAP, Wellness, and disability cases administered and treated in "Silos"**
- **Care not coordinated nor integrated**
- **Parity matched behavioral health quantitative services to medical plan, increasing costs**
- **Management of qualitative treatment elements reduced to most costly conditions/settings**

Critical Elements for Health Plans and Providers

- 35 + million new persons added to insured groups
- Insufficient numbers and locations of psychiatrists, psychologists, and specialty behavioral health nurse practitioners
- EAP services being expanded to provide “treatment”
- Plans and providers moving into various arrangements for delivering and paying for treatment – return to “risk”
- Government and consumers including more specific performance criteria, i.e. improved population health, more positive patient experiences, and slowing increases in healthcare costs

Critical Elements for Health Plans and Providers

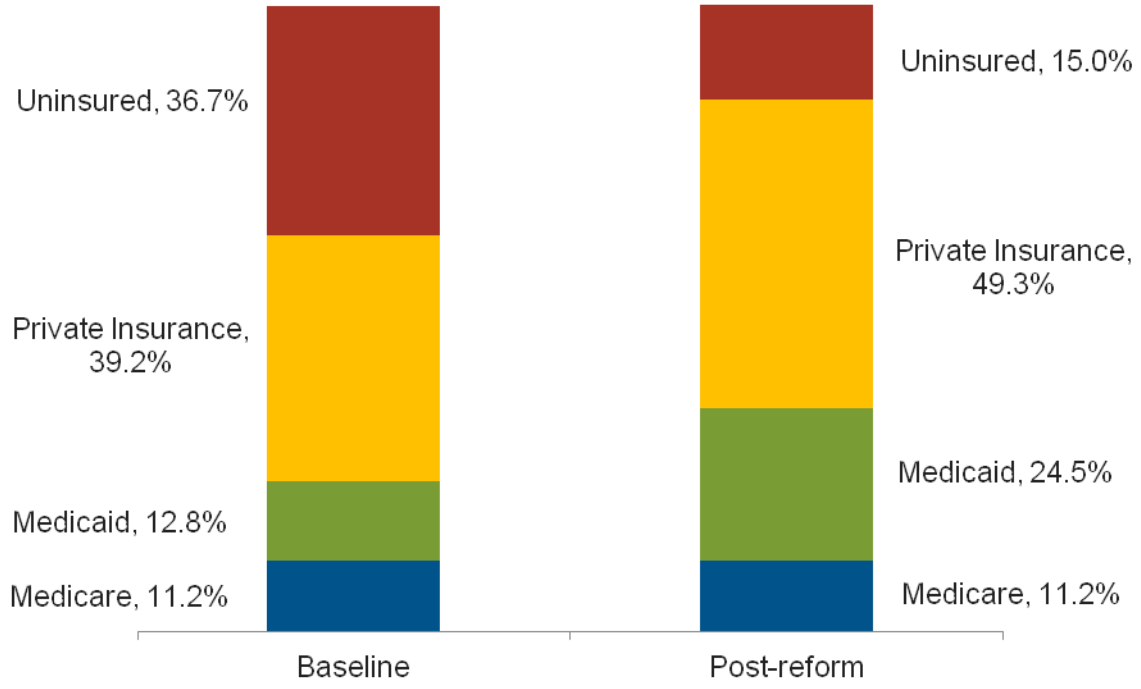
- **Impact of addition of Evaluation and Management codes for psychiatrists and psychologists**

- **DSM-5 revisions may lead to:**
  - **unnecessary prescriptions,**
  - **increased categories for reimbursement**
  - **Increased requests for accommodations**

Source: Sally Satel , M.D. “Why the fuss over the DSM-5?” American Enterprise Institute, May 2013

Uninsured adults with mental health needs will gain coverage under health reform

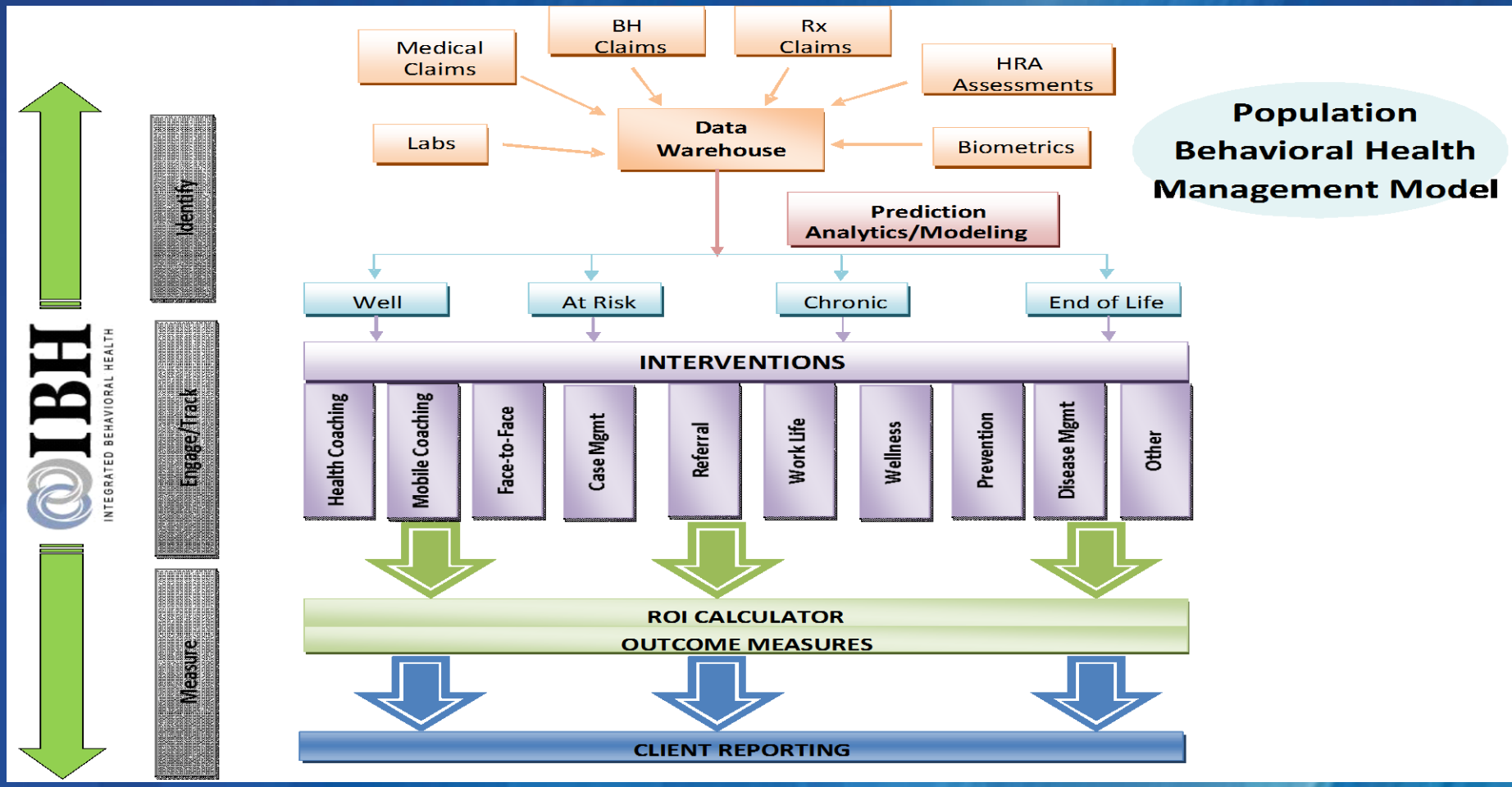
Simulated Change in Coverage After Reform Among Adults with Probable Depression or Serious Psychological Distress



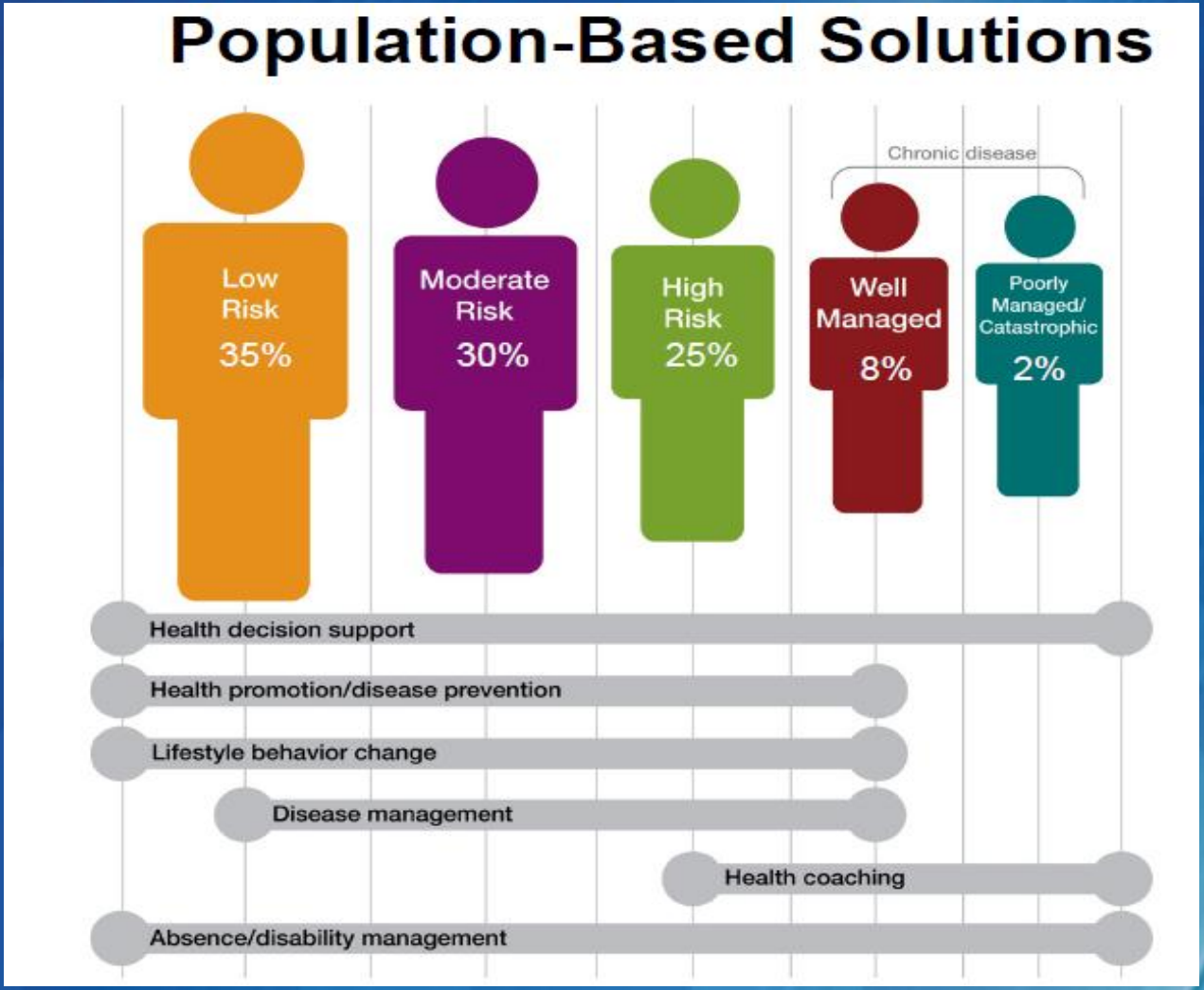
Note: Based on data for adults ages 18-64 in the 2004-2006 Medical Expenditure Panel Surveys.

Source: Garfield, R., et al. (2011). The Impact of National Health Care Reform on Adults With Severe Mental Disorders. *American Journal of Psychiatry*, 168(5): 486-494.

Sample Elements for Managing Behavioral Health and Comorbid Conditions in Employer Health Plan



Behavioral Health Management



Questions for Employers Regarding Health Plan or BH Vendor

Employer questions:

1. **Do employees have ready access to BH information through educational and referral programs?**

2. **Do employees receive a diagnosis from appropriate clinician screening for depression and anxiety? Substance abuse? Medical illnesses? Family or work issues?**

3. **Is treatment managed balancing medication and counseling/psychotherapy?**

4. **Are PCP's encouraged to routinely screen for and treat depression, and oriented as to when to refer to psychiatrist, psychologist, nurse practitioner, and/or EAP?**

Questions for Employers Regarding Health Plan or BH Vendor

Employer questions:

5. **Does the BH vendor (carrier or carve out) integrate services with EAP, medical providers, disease management or disability program?**

6. **Is the PBM able to provide claim data for analysis of psychiatric medications? Monitor for appropriateness and adherence? Provide information to employees?**

7. **Does the PBM monitor and assist patients regarding psychotrophic medications and interface with BH vendors?**

8. **Can the EAP conduct awareness program for depression, stress/anxiety and substance abuse?**

Questions for Employers Regarding Health Plan or BH Vendor

Employer questions:

8. **Are managers trained to recognize employee BH and personal/workplace issues and to make referrals to EAP?**

9. **Is a drug free workplace program in place?**

10. **Can comorbid and chronic conditions be identified and serviced in a BH/medical /EAP integrated manner? Is disease management available for these and serious BH conditions?**

Recommendations to Improve Quality, Reduce Costs, and Benefit Employer Operations

1. **Increase internal marketing** of EAP services

2. **Implement** screening programs for depression, stress, substance abuse.

3. **Increase delivery** of specific employee information about conditions, issues, treatment services, and self-management (hardcopy, internal print pieces, internet, on-site options)

4. **Request** BH vendor to obtain data for medical, BH, pharmacy, disability claims.

Recommendations to Improve Quality, Reduce Costs, and Benefit Employer Operations

5. **Apply analytics to identify patients treated by non-specialists, with multiple or inappropriate psychotropic medications**

6. **Patients with comorbid conditions and no BH specialty intervention or assistance**

7. **Patients being treated in BH services, with comorbid conditions but no coordination or integration with medical providers**

8. ***Patients continuing with disability claims complicated by BH conditions.***

Recommendations to Improve Quality, Reduce Costs, and Benefit Employer Operations

10. **Review** condition management process for severe BH conditions and chronic comorbid conditions (major depression, bipolar disorder, eating disorders, severe anxiety, COPD, cardiac conditions, Gastrointestinal conditions, chronic pain, diabetes)

11. **Coordinate** and integrate EAP services with Wellness, BH, medical and disability services.

12. **Establish** method of receiving and analyzing key performance criteria for plan manager and providers