Treating Mental Health & Substance Use Disorders

Monday, Aug. 7, 2017. 1:30 pm-3:00 pm
Convention Center 157 ABC
Session Line Up

- Moderator - Representative Diane Franklin, Missouri

- Speakers
  - Cynthia Reilly, Pew Charitable Trusts, Washington, D.C.
  - David Seltz, Massachusetts Health Policy Commission

- Panelists
  - Debbie Plotnick, Mental Health America, Virginia
  - Brendan Abel, Massachusetts Medical Society
  - Ken Duckworth, Blue Cross Blue Shield of Massachusetts
  - Senator Daniel W. Thatcher, Utah
  - Representative Steve Eliason, Utah
1) Reduce the inappropriate use of prescription opioids while ensuring that patients with medical needs have access to pain control, and

2) Expand access to effective treatment for substance use disorders, including medication-assisted treatment.
Presentation Outline

• Overview of Opioid Use Disorders (OUD)

• Evidence-Based Treatment

• Barriers and Solutions to Improve Treatment Access
NEARLY 21 MILLION PEOPLE SUFFER FROM A SUBSTANCE USE DISORDER.
ONLY 1/10 RECEIVES TREATMENT.

Opioid use disorder...

- is a complex disease that results in chemical and physiologic changes to the brain
- must be treated like any other chronic, relapsing condition
Medication-Assisted Treatment (MAT) is Effective

FDA-approved drugs + Behavioral therapy

Medication-assisted treatment increases adherence and reduces:

- Illicit opioid use
- Overdose risk and fatalities
- Health care utilization
- Criminal activity

Mattick RP et al., 2009;3:CD002209; Comer SD et al. JAMA Psych. 2006;63:210-8; Fudala PJ et al., NEJM. 2003;10:949-58;
Medications for Opioid Use Disorder

Behavioral Therapies for OUD

• Goals
  – Modify underlying behaviors that lead to misuse
  – Support medication adherence

• Example cognitive behavioral therapies
  – Individual or group counseling
  – Family therapy
  – Mutual help programs
Guidelines from the American Society of Addiction Medicine (ASAM)

Recommend coverage for:

- FDA-approved drugs
- Counseling and long-term recovery supports

Guidelines address:

- Disease severity
- Setting of care

ASAM Criteria Use Disease Severity to Determine Treatment Needs

- **.5** Early Intervention
- **1** Outpatient Treatment
- **2** Intensive Outpatient and Partial Hospitalization
- **3** Residential/Inpatient Treatment
- **4** Medically-Managed Intensive Inpatient Treatment

In practice, many public and private payers fail to cover all of the care recommended by the ASAM guidelines.
Medicaid Programs in 19 States Do Not Cover All Drugs for Opioid Use Disorder

Colleen M. Grogan et al., “Survey Highlights Differences In Medicaid Coverage For Substance Use Disorder Treatment And Opioid Use Disorder Medications,” Health Affairs 35, no. 12 (2016), http://content.healthaffairs.org/content/35/12/2289.full.
Residential Treatment is Often Not Covered by Medicaid

Source: Colleen M. Grogan et al., “Survey Highlights Differences In Medicaid Coverage For Substance Use Disorder Treatment And Opioid Use Disorder Medications,” Health Affairs 35, no. 12 (2016), http://content.healthaffairs.org/content/35/12/2289.full.

ASAM Levels of Care Coverage
☐ All Levels Covered
❑ Missing One or More Levels
How Does Parity Relate to Treatment Coverage?

• Parity laws requires that an insurer’s coverage for substance use disorders be comparable to—or at parity with—general medical care.

• Parity laws and regulations aim to eliminate restrictions that are more strict than those applied to physical conditions.

• Coverage limitations may indicate, but are not necessarily parity violations.
Stakeholders Involved in Ensuring Treatment Access and Parity
Consumers

Federal Agencies

States

Insurance Providers

Providers

Consumers

Know their rights and raise questions and concerns
Engage in treatment efforts and provide comprehensive care consistent with evidence-based guidelines.
Provide coverage for SUD care consistent with parity requirements
States

Federal Agencies

States

Insurance Providers

Providers

Consumers

Provide primary oversight of parity implementation
Various federal agencies have oversight of parity but have delegated primary enforcement authority to the states.
Barriers to an Effective Treatment System

- Coverage Gaps
- Treatment Infrastructure
- Funding
The GOAL is...

an effective treatment system that provides **timely access** to **comprehensive** and evidence-based care.
Summary

• Opioid use disorder is a chronic disease

• A comprehensive and evidence-based treatment approach is needed

• Medication-assisted treatment is effective, but barriers exist

• Access to effective treatment requires input from patients, clinicians, insurers, and state and federal policymakers
Don’t miss out!

Visit Booth #545 in the exhibit hall to learn about The Pew Charitable Trusts’ work in all 50 states and meet our policy experts.

pewtrusts.org/NCSL
AGENDA

- About the HPC
- HPC promotion of access to behavioral health services
  - Research
  - Investments
  - Provider certification programs
  - Office of Patient Protection
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Chapter 224 of the Acts of 2012 established the HPC and a target for reducing health care spending growth in Massachusetts.

Chapter 224 of the Acts of 2012

An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation.

GOAL

Reduce total health care spending growth to meet the Health Care Cost Growth Benchmark, which is set by the HPC and tied to the state’s overall economic growth.

VISION

A transparent and innovative healthcare system that is accountable for producing better health and better care at a lower cost for the people of the Commonwealth.
The HPC, in collaboration with others, promotes and monitors priority policy outcomes that contribute to the goal and vision of Chapter 224.

Strengthen market functioning and system transparency

in which payers and providers openly compete, providers are supported and equitably rewarded for providing high-quality and affordable services, and health system performance is transparent in order to implement reforms and evaluate performance over time.

Promoting an efficient, high-quality system with aligned incentives

that reduces spending and improves health by delivering coordinated, patient-centered and efficient health care that accounts for patients’ behavioral, social, and medical needs through the support of aligned incentives between providers, employers and consumers.

The two policy priorities reinforce each other toward the ultimate goal of reducing spending growth.
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Examples of Behavioral Health Integration (BHI) Research to Date

Reporting in 2013 Cost Trends Report on cost of care for comorbid Behavioral Health (BH) condition and at least one other chronic health condition.

Monitoring the number of opioid related Emergency Department (ED) visits, hospital admissions, and births presenting with Neonatal Abstinence Syndrome to inform policy and investments.

Reporting on supply of providers offering pharmacologic assisted opioid use disorder treatment.

Monitoring opioid related hospital utilization (admissions and ED visits) to inform investments in and reforms to the current care delivery system and payment systems could improve the efficiency with which Opioid Use Disorder (OUD) is treated in the Commonwealth.

Monitoring BH related ED visits and related ED boarding (spending 12 or more hours in the ED).
Patients with behavioral health and chronic conditions have significantly higher medical expenditures

Medical expenditures per patient (excludes drug spending)*

Average patient with neither comorbidity

Behavioral health† comorbidity

Chronic condition‡ comorbidity

Both comorbidities

COMMERCIAL

1x

1.6x

2.1x

4.2x

1x

2.2x

2.8x

7.0x

MATERIAL

* The sample for analysis was limited to patients who had continuous enrollment from 1/1/2010 – 12/31/2011 and costs of at least $1 in each year. Figures do not capture pharmacy costs, payments outside the claims system, Medicare cost-sharing, or end-of-life care for patients who died in 2010 or 2011.

† Behavioral health comorbidity includes child psychology, severe and persistent mental illness, mental health, psychiatry, and substance abuse

‡ Chronic condition includes arthritis, epilepsy, glaucoma, hemophilia, sickle-cell anemia, heart disease, HIV/AIDS, hyperlipidemia, hypertension, multiple sclerosis, renal, asthma, and diabetes

Source: All-Payer Claims Database; HPC analysis
Higher spending for people with behavioral health conditions is concentrated in inpatient and ED spending

**SPENDING BY CATEGORY OF SERVICE FOR PATIENTS WITH AND WITHOUT BEHAVIORAL HEALTH CONDITIONS**

Claims-based medical expenditures* by category of service†, for people with and without behavioral health (BH) conditions‡, 2011

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>COMMERCIAL</th>
<th>MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spending per person per category</td>
<td>% difference between people with and without BH conditions</td>
</tr>
<tr>
<td>ED</td>
<td>$291 $122</td>
<td>+140%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$2,245 $1,000</td>
<td>+125%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$326 $515</td>
<td>+80%</td>
</tr>
<tr>
<td>Long-Term Care and Home Health</td>
<td>$66 $17</td>
<td>+279%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>$782 $524</td>
<td>+49%</td>
</tr>
<tr>
<td>Professional†</td>
<td>$3,003 $1,444</td>
<td>+108%</td>
</tr>
</tbody>
</table>

* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).
† For detailed definitions of categories of service, see CHIA and HPC publication, "Massachusetts Commercial Medicare Spending: Findings from the All-Payer Claims Database." Lab/x-ray category includes professional services associated with laboratory and imaging.
‡ Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software.

SOURCE: All-Payer Claims Database; HPC analysis
Focus on impact of opioid epidemic on hospitals across the Commonwealth

Number of Opioid-Related Hospital Discharges

Rate of Change in Opioid-Related Hospital Discharges

<table>
<thead>
<tr>
<th>Years</th>
<th>Heroin-related</th>
<th>Other opioids</th>
<th>All opioid-related</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012</td>
<td>22%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>2012-2013</td>
<td>35%</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>2013-2014</td>
<td>44%</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>2014-2015</td>
<td>50%</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>2011-2015</td>
<td>256%</td>
<td>50%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Source: HPC analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and Emergency Department Databases, 2011 and 2015
Opioid related hospital utilization is increasing almost uniformly across the state

Data can be found at
Source: HPC analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and Emergency Department Databases, 2011 and 2015
Behavioral health patients are increasingly more likely to have an extended length of stay in the ED

Percent of ED visits with a length of stay of more than 12 hours, by primary diagnosis type, 2011-2015

Notes:
ED= emergency department; BH=behavioral health. BH ED visits identified using NYU Billings algorithm and include any discharge with a primary mental health, substance abuse, or alcohol-related diagnosis code. Length of stay is calculated as the difference between the point of registration and the point of admission or discharge.
Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2015
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HPC Investment Programs

HPC’s care delivery transformation investments advance our vision of accountable care:

A health care system that efficiently delivers on the triple aim of better care for individuals, better health for populations, and lower cost through continual improvement through the support of alternative payments.

CHART Phase 2

Community Hospital Acceleration, Revitalization, and Transformation
$60 million invested • 25 competitively selected projects • 24 months
→ Investments in certain community hospitals¹ to enhance the delivery of efficient, effective care

HCII

Health Care Innovation Investments Program
$11+ million invested • 20 competitively selected projects • 3 pathways
→ Targeted Cost Challenge Investments (TCCI)
→ Telemedicine Pilot Initiative
→ Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions

¹ CHART hospital eligibility, as determined by Chapter 224 of the Acts of 2012, excludes acute care hospitals or health systems with for-profit status, excludes major acute care teaching hospitals, and excludes hospitals whose relative prices are determined to be above the statewide median relative price.

+ CHART Phase 2 awardees
▲ HCII awardees (inclusive of Telemedicine Pilot partners)
Patient story: Before CHART engagement

A middle-aged woman with a long and complicated history of substance abuse presented to the ED on a monthly basis. On one occasion, when she arrived to the ED seeking detox treatment, no available bed could be found, and she was released. Days later, she overdosed and was revived at an unaffiliated ED.
Patient story: CHART intervention

- LICSW provided counseling in the hospital
- CHW provided intensive support in the community
- CHART team connected her with behavioral health providers
- Pharmacist provided medication assessment
- CHART team attended 90-day sobriety achievement ceremony
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PCMH PRIME: Integrating behavioral health, improving patient care

Under-diagnosis and under-treatment of behavioral health conditions (mental illness and substance use disorders) is a serious public health problem. Almost 50 percent of adults will develop at least one mental illness during their lifetime.

When behavioral health care is available in primary care practices, patients may be more likely to receive appropriate, high-quality care.

The Massachusetts Health Policy Commission’s PCMH PRIME Certification program recognizes primary care practices that demonstrate behavioral health capabilities.

The PCMH PRIME program promotes the delivery of comprehensive and patient-centered care that addresses the emotional, psychological, and medical needs of patients in a coordinated way.

To view a list of PCMH PRIME Certified practices, please visit the HPC website (http://bit.ly/PCMHPRIMEHome).
Accountable Care Organization (ACO) Certification Program Values

1. **Care should be seamless** and guided by patients and families.

2. Systems should **use evidence-based guidelines and be mindful of waste** so resources can be distributed to those who need it most.

3. Support a **pluralism of ACO models** (e.g. community health center-led; primary care physician-led, hospital-led, medical and behavioral health provider partnerships).

4. Encourage medical provider-led ACO to **work with other non-medical providers** in the community.

5. Systems should do no harm, **support safe and effective care**.

6. Commit to regularly **assess the program** to ensure continuous improvement and market value.
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Insurer Oversight in Massachusetts

**Health Policy Commission And Office of Patient Protection**
- The Office of Protection (OPP) within HPC regulates insurer internal and external review processes; OPP’s independent review process meets Federal standards (NAIC-Parallel)
- OPP promotes transparency of carrier collected data pertaining to appeals, provider disenrollment, and other required elements, which is synthesized and released in an annual report
- OPP regulations require transparency of medical necessity guidelines for patients, including for behavioral health and substance use disorder utilization review practices and procedures
- OPP implementing new requirement for insurers to report on claims denials and reasons for such denials, broken down by type of service

**Division of Insurance**
- Regulates insurance industry in Massachusetts
- Accredits health insurance plans and performs market conduct examinations (comprehensive or targeted)
- As licensing entity, has primary enforcement role for parity compliance, pursuant to Code of Massachusetts Regulations, 211 CMR 154.00
- Promulgated regulations and issued sub-regulatory guidance (ie. Bulletin 2014-06) establishing parity compliance requirements
- Convened a working group (Mass Collaborative) to standardize claims and authorization forms for behavioral health coverage across both carriers and providers
- Attorney General (AGO) also monitors parity compliance
2015 OPP Annual Report Data – Carriers Report on Grievances

- **78%** Medical/Surgical Cases
- **22%** Behavioral Health Cases
- **76%** Final Adverse Determination in favor of consumer
- **24%** in favor of consumer

Internal Review
Carrier Reported
Behavioral Health
During 2015, OPP received 330 external review requests. Of the 250 eligible cases, OPP received 163 requests for medical/surgical treatment and 87 requests for behavioral health treatment.

Percentage of external review cases by disposition, by type of case (Medical/Surgical Care vs. Behavioral Health Care), 2015

- **Cases Filed**: 330 (22% Eligible, 76% Ineligible)
- **Eligible Cases**: 250 (2% Overturned, 98% Eligible)
- **Medical/Surgical**: 163 (0% Overturned, 6% Partially Overturned, 2% Partially Resolved, 37% Resolved or Partially Resolved, 55% Upheld, 5% Ineligible, 2% Other)
- **Behavioral Health**: 87 (5% Overturned, 2% Partially Overturned, 5% Partially Resolved, 23% Resolved or Partially Resolved, 66% Upheld, 2% Ineligible, 2% Other)

Source: 2014 Office of Patient Protection external review data
28% of eligible external review cases for behavioral health treatment were decided fully or partly in favor of the patient.

Eligible external reviews related to behavioral health treatment by outcome, 2015

- Upheld: 64%
- Overturned: 22%
- Partially Overturned: 4%
- Resolved or Partially Resolved: 2%
- Other, No Data: 5%

28% resolved in favor of consumers
Inpatient mental health and residential substance use disorder were predominant categories of behavioral health external review matters.

Eligible external reviews related to behavioral health treatment by outcome and type of service requested, 2015:

- Mental Health - Inpatient: 21
- Substance Use Disorder - Residential: 21
- Mental Health - Residential Treatment: 12
- Mental Health - Outpatient: 9

Source: 2015 Office of Patient Protection external review data
Massachusetts’ 2016 opioid law included a provision to add new carrier reporting requirements detailing aggregate data on claims and claims denials submitted annually to OPP (Chapter 52 of the Acts of 2016 & M.G.L. c. 176O, sec. 7)

- OPP’s regulation 958 CMR 3.000, Health Insurance Consumer Protection, has been amended to incorporate the new statutory requirements

The new reporting requirements:

- Provide greater transparency regarding the total “universe” of fully insured claims/requests for services submitted and denied
- Broaden the data currently reported to OPP
- Supplement information submitted to DOI pursuant to DOI’s mental health parity authority
- Capture post-service denials and claims regarding treatments/services that do not require prior authorization (e.g., out-of-network provider, service not covered, administrative denials)
For more information about the Health Policy Commission

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The Panel

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Thank you for attending!

Join us for
State Strategies to Address Opioid Misuse
on Wednesday, August 9 at 9:30 a.m. in room 157 ABC