Person Centered Agenda

- Initial Confusion
- Overwhelmed by Statistics and Acronyms
- Dramatic Engagement of Issue
- Extreme Interest and Curiosity
- Deep Sense of Relief
SAMHSA’S STRATEGIC INITIATIVES
Leading Change 2.0: 2015-2018

1. Prevention of Substance Abuse and Mental Illness
2. Health Care and Health Systems Integration
3. Trauma and Justice
4. Recovery Support
5. Health Information Technology
6. Workforce Development
SAMHSA Priorities

Key Priorities

• Engaging Individuals with Serious Mental Illness in Care
• Addressing the Opioid Public Health Crisis
• Preventing Suicide
• Maintaining the Behavioral Health Safety Net
<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2017</th>
<th>FY 2018</th>
<th>Total</th>
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<tr>
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<td>$110</td>
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<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>Health Resources and Services Administration</td>
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<tr>
<td>Tribal Behavioral Health</td>
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<tr>
<td>Indian Health Services</td>
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<td></td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$250</strong></td>
<td><strong>$250</strong></td>
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## ADMINISTRATION’S $1B EXPANDING ACCESS TO TREATMENT FOR PRESCRIPTION DRUG AND HEROIN ABUSE INITIATIVE

(Dollars in millions)

<table>
<thead>
<tr>
<th>Activity</th>
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<th>FY 2018</th>
<th>Total</th>
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<tbody>
<tr>
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<td>$920</td>
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<td>SAMHSA</td>
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<tr>
<td>NHSC –MAT</td>
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<td>50</td>
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<tr>
<td>National Health Service Corps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohort Monitoring and Evaluation of MAT</td>
<td>15</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>SAMHSA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>$500</td>
<td>$500</td>
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</table>
System Costs

DATAWATCH

Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion

Estimates of annual health spending for a comprehensive set of medical conditions are presented for the entire US population and with totals benchmarked to the National Health Expenditure Accounts. In 2013 mental disorders topped the list of most costly conditions, with spending at $201 billion.

The National Health Expenditure Accounts (NHEA), maintained by the Centers for Medicare and Medicaid Services, provide official estimates of annual health spending in the United States. The NHEA covers spending by the entire US population broken out by type of service and source of payment, but not by medical condition. For many years the Agency for Healthcare Research and Quality (AHRQ) has produced estimates of spending by medical condition from its Medical Expenditure Panel Survey (MEPS), but they are limited to the civilian noninstitutionalized population and include double counting of spending that involves multiple conditions. The Commerce Department’s Bureau of Economic Analysis recently released the Health Care Satellite Account, which promises to be an ongoing source of spending by medical condition, without double counting, for the civilian noninstitutionalized population. Estimates of health spending by medical condition for the entire US population, without double counting and benchmarked to the NHEA, were first developed in a 2009 study published in Health Affairs that covered the period 1996–2005. This article updates those estimates through 2013, using similar data and methods. The inclusion of institutionalized populations has a significant impact on total spending and brings mental disorders to the top of the list of medical conditions with the highest estimated spending: $201 billion in 2013 (Exhibit 1).

Charles Roehrig (charles.roehrig@altarum.org) is founding director of the Center for Sustainable Health Spending at Altarum Institute, in Ann Arbor, Michigan.
System Costs

EXHIBIT 1

Ten medical conditions with the highest estimated spending in 2013

- Mental disorders
- Heart conditions
- Trauma
- Cancer
- Pulmonary conditions
- Osteoarthritis
- Normal birth
- Diabetes
- Kidney disease
- Hypertension

Billions of dollars

- Civilian noninstitutionalized
- Institutionalized and active-duty military
Increasing Costs

Impacts on Physical Health

- MH problems increase risk for physical health problems & SUDs increase risk for chronic disease, sexually transmitted diseases, HIV/AIDS, and mental illness

- Cost of treating common diseases is higher when a patient has untreated BH problems, mostly preventable or treatable

- 24 percent of pediatric primary care office visits and ¼ of all adult stays in community hospitals involve M/SUDs

- M/SUDs rank among top 5 diagnoses associated with 30-day readmission, accounting for about one in five of all Medicaid readmissions (12.4 percent for MD and 9.3 percent for SUD)

- Half of Americans will experience M/SUD; half know someone in recovery from SUD

![Individual Costs of Diabetes Treatment for Patients Per Year](chart)

- With behavioral health problems and diabetes: $300,000,000
- With diabetes alone: $100,000,000

> Individual Costs of Diabetes Treatment for Patients Per Year

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>With behavioral health problems and diabetes</td>
</tr>
<tr>
<td>$50,000,000</td>
<td>With diabetes alone</td>
</tr>
<tr>
<td>$100,000,000</td>
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<tr>
<td>$150,000,000</td>
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<tr>
<td>$250,000,000</td>
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</tr>
<tr>
<td>$300,000,000</td>
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</tbody>
</table>
Federal Behavioral Health Spending in Billions of Dollars by Category, FY 2015

DEFINITIONS

- Direct spending: program resources identified in agency budgets specifically for behavioral health (e.g., Indian Health Service budget for the American Indians Into Psychology Program).
- Indirect or related spending: program resources in agency budgets that combine behavioral health spending with other program spending (e.g., Health Resources and Services Administration Rural Health Program).
U.S. Department of Health and Human Services Behavioral Health Spending in Millions of Dollars by Agency, FY 2015

$66.8 B or 39.8% of Total Federal Budget
The SSA’s budget of $87.2 billion is the largest, representing 51.9% of the federal budget for mental health.
Not even downstream, most funding going to the deepest end of the ocean.
Advent of ACA

- Medicaid Expansion
- MHPAEA
- Improved Insurance Design
- Service Model Delivery
- Movement Toward Value
- Young Adults
- Pre-existing Conditions
Federal Initiatives and Efforts to Support a Different Focus

- OASH: Co-morbidity working group
- SAMHSA’S Primary/Behavioral Health Integration (PBHCI): Physical health of adults w/ SMI and technical assistance for bi-directional integration (Center for Integrated Health Solutions, w/ HRSA)
- Primary Care/Addiction Services Integration (PCASI): Proposed (no traction)
- HRSA FQHCs: Integrating behavioral health screening, brief intervention, and treatment into primary care settings
- Million Hearts: Wrapping behavioral health into efforts to address ABCS
- AHRQ Center for Integration Models: Developing models of integrated behavioral health care in primary care settings
- CMMI Innovative Financing Models for Integration: Grants to test models using SAMHSA and AHRQ indicators and technical assistance
- Medicare Accountable Care Organizations (ACOs): Payment for integrated care & outcomes (ASPE tracking impacts for behavioral health)
Service Models, Payment Structures, and Demos

- State Innovation Models: Support for development and testing of state-based models for multi-payer payment and health care delivery system transformation
- Health Homes (Section 2703): Whole person care for Medicaid recipients w/specific characteristics or conditions (59 SAMHSA consultations with 33 states)
- Accountable Care Organizations: Coordinating high quality care for Medicare recipients, including behavioral health care
- Duals Demo: Ensuring Medicare-Medicaid enrollees have full access to seamless, high quality health care that is cost effective
- Transforming Clinical Practice Initiative: designed to help clinicians achieve large-scale health transformation through sharing, adapting and further developing their comprehensive quality improvement strategies.
- Medicaid Innovation Accelerator Program: Focusing on payment and service delivery reforms to improve health and quality of care for Medicaid beneficiaries; Priority Area SUDs
Selected SAMHSA and Federal Partner Collaborations

- Informational Bulletins: Medication Assisted Treatment (MAT); coverage/service design of BH services for youth with serious emotional disturbance (SED); trauma-focused services; prevention and early identification of mental health and substance use conditions; and strengthening management of psychotropic medications for vulnerable populations; others in process

- Ongoing Interactions: Payment rules; waiver consultation; state plan amendments; regulation review; quality measures; same day billing guidance; and parity implementation

- Section 223 of the Protecting Access to Medicare Act of 2014: SAMHSA developed criteria for Certified Community Behavioral Health Clinics (CCBHCs) and managing state planning grants; CMS developed prospective payment system; ASPE to evaluate outcomes

- SAMHSA/HRSA Center for Integrated Health Solutions
Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.
A health system that provides better care, spends dollars more wisely, and has healthier people

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
</tr>
</thead>
</table>
| INCENTIVES        | - Promote value-based payment systems  
|                   |  - Test new alternative payment models  
|                   |  - Increase linkage of Medicaid, Medicare FFS, and other payments to value  
|                   | - Bring proven payment models to scale  
|                   | - Align quality measures  
| CARE DELIVERY     | - Encourage the integration and coordination of clinical care services  
|                   | - Improve individual and population health  
|                   | - Support innovation including for access  
| INFORMATION       | - Bring electronic health information to the point of care for meaningful use  
|                   | - Create transparency on cost and quality information  
|                   | - Support consumer and clinician decision making  

Source: Burwell SM. Setting Value-Based Payment Goals ─ HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
• **Incentives**: Improve the ways providers are paid, now looking to reward value and care coordination – rather than volume and care duplication

• Pay providers for what works, whether something as complex as preventing or treating disease, or something as straightforward as making sure patients have more than one way to communicate with the team of clinicians taking care of them

  o **Example**: New Medicare payment goals to drive quality and value; many new payment models being tested at the CMS Innovation Center (such as NextGen Accountable Care Organizations)

  o **BH Example**: Section 223 Demonstration – Improving Quality of Community Behavioral Health Services
CCBHC/223 update

• Elements
  o Criteria for CCBHCs (SAMHSA)
  o Prospective Payment System (PPS) to pay costs + quality incentive (CMS)
  o Evaluation to see what difference it makes (ASPE)

• Timelines/Process
  o Planning grant RFA issued – May 2015
  o Planning grant states awarded – October 2015
  o Demonstration states selected – Dec 2017
  o Annual Report to Congress re outcomes and recommendations – Dec 2018
CCBHC/223 update

- SAMHSA has regular TA calls with all 24 Project Directors. We have used feedback from the PDs to develop TA.
- Between all the federal partners we have presented 25 webinars to date – 16 of these webinars were done by SAMHSA and include needs assessment, crisis response, timeline for planning milestones, areas of state discretion, stakeholder engagement, Demonstration Application guidance, certifying organizations, among others.
- Planning TA continues – expect to have around 40 total webinars (all partners) by the end of the grant period.
- SAMHSA has also hosted individual calls between federal cross-agency experts and each of the 24 planning grant state teams.
- Federal partners have responded to over 400 inquiries with integrated cross-agency responses, including posting those applicable to all states on either the SAMHSA 223 web page or the CMS SharePoint web page dedicated to planning grant states.
- ASPE has now completed an evaluation design for the demonstration, emphasizing statutory goals of evaluating impacts in access to community-based mental health services, the quality and scope of services provided, and the federal and state costs. They have prepared a statement of work, soon to be released, for the national evaluation utilizing this design.
Quality Measures

- Quality Measures - there were originally 32 required measures but those have now been reduced to 21 measures.
- While now focused on the 21 measures we did develop technical specifications and reporting templates for all 32 of the measures. Plan to release all 32 measures for use in the field, but will require that the 223 states and clinics only report on the 21 measures.
- Taking the quality measures through the expedited OMB/PRA process at CMS, expecting a 6 week turnaround time for approval.
- The quality measures were submitted to CMS OMB on May 11th – so the packet has been there for three-ish weeks at this point.
- Some anxiety to get the technical specifications as they need to build their data systems to be able to collect the data to report. So we have been working to make them public as soon as possible.
- Put together a series of 8 webinars for the states and clinics on the quality measures and the technical specifications. These webinars will begin in July after OMB approval and release of the tech specs and reporting templates. One webinar each week.
In Conclusion

• The past has been complicated
• Costs drivers emerging
• Clear focus on issues beginning
• Movement in policy, place, practice
• Investing wisely
• Health systems, social service systems, political systems, and advocacy systems can come together to form a community that could change everything
Thank you!

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