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Medicare Policy Changes Impacting Behavioral Health Services Workforce & Population Health

HMA EXPERTS

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TODAY'S AGENDA & LEARNING OBJECTIVES

- Understand how Medicare policy changes and updates on Behavioral Health services will help expand needed care for Medicare recipients and Dual Eligible populations.
- Create strategies for addressing the 2023 CMS rule updates to benefit employers and delivery systems toward improving whole health outcomes and reducing Behavioral Health workforce shortages.
- Q&A

BEHAVIORAL HEALTH NEEDS OF MEDICARE-SERVED POPULATION

- About **one in four** people enrolled in Medicare live with mental illness — conditions such as depression, anxiety, schizophrenia, and bipolar disorder — but only 40% to 50% receive treatment.[1]
- The **prevalence of mental illness is about equal** among individuals enrolled in traditional Medicare (31%) and those in Medicare Advantage plans (28%), although variation in data sources and measurement make comparisons difficult.[2]
- Mental illness is experienced most by those individuals **under age 65** who qualify for Medicare via disability, as well as by individuals in the low-income dually eligible Medicare and Medicaid population.[3]
- Mental illness is more pervasive individuals from **American Indian/Alaska Native and Hispanic communities** relative to other racial and ethnic groups.[4]
- Firearm suicide rates are highest among adults **75 years of age and older** and among **American Indian/Alaska Native and non-Hispanic white** populations.[5]
- **Adults over 65** cite cost as a barrier to adequate long-term mental health care.[6]

1 Fung et al., (2020); SAMHSA (2020); 2 Figueroa et al., (2020); CMS (2017) 3 Medicare Current Beneficiary Survey (2019); Roll et al.,(2013); 4 Ng et al., (2015); USDHHS (2023); Tikkanen et al., (2020); [5] Johns Hopkins Center for Gun Violence Solutions (2022)

[6] Source: Medicare Mental Health Coverage What Changed and What Gaps Remain | Commonwealth Fund

BEHAVIORAL HEALTH NEEDS OF MEDICARE-SERVED POPULATION

While people enrolled in Medicare living in urban and rural areas experience mental illness at similar rates, rural individuals have less access to services.[1]

Medicare participation rates decreased among psychiatrists from 60.7% to 55.1% and remained stable for PMHNPs at approximately 63.0%.[2]

Provider payment rates for in-network mental health services are higher in traditional Medicare than in Medicare Advantage.[3]

To date, only four of 1,200 SNPs focus on individuals with serious mental illness.[4]

An estimated 5.7 million adults over the age of 50 will require treatment for a substance use disorder in 2022.[5]

[1] Chen et al. (2022); [2] Oh et al., (2022); [3] Pelech & Hayford (2019); [4] CMS (2022); [5] Parrish et al., (2022)

MEDICARE AND MENTAL HEALTH COVERAGE

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Medicare beneficiary access to mental health services has been limited and mental health providers participated in Medicare at significantly lower levels than medical providers

- At its inception, Medicare had a limited mental health benefit. Over time, the benefit has grown through changes in statutory authority to add additional benefits, address cost-sharing and expand the types of practitioners that can provide outpatient services.

In 2022, CMS developed a Behavioral Health Strategy to better address these issues in Medicare and Medicaid

1. Strengthen equity and quality in behavioral health care
2. Improve access to substance use disorders prevention, treatment and recovery services
3. Ensure effective pain treatment and management
4. Improve access and quality of behavioral health care and services
5. Utilize data for effective actions and impact on behavioral health

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Medicare Value-Based Care and Behavorial Health

Amy Bassano, MPP
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WHY VALUE-BASED PAYMENT?

- The current system is not working
- Fee-for-service (FFS) payment model incentivizes overutilization
- Fee schedules reward treatment over prevention
- Fragmented care delivery system
- Inefficient/nonexistent data sharing
- Lack of accountability for patient outcomes
- Providers equipped to deliver care to individuals, not proactively manage populations
- Insufficient resources for intensive care management of high-cost patients
- Social determinants of health largely ignored by medical system

CURRENT CMMI STRATEGY

Building on lessons learned to date CMMI looks to set the stage for future model tests and engagement with other payers and partners to support a system wide movement to value based payment.

CMS INNOVATION CENTER AND VALUE-BASED PAYMENTS

- Broad authority to test Medicare and Medicaid models.
- Model can be voluntary or mandatory.
- CMMI portfolio has focused on certain model approaches:
  - Accountable Care Organizations/population health
  - Bundled or episodic payments
  - Primary Care improvement
  - State Based initiatives
  - Health Conditions – ESRD, oncology, etc.
- Total cost of care and episodic models incentivize opportunities to incorporate behavioral health into delivery of care.

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NEW OPPORTUNITIES

NEW PRIMARY CARE MODEL

Making Care Primary (MCP)

- The Centers for Medicare & Medicaid Services' (CMS) Innovation Center announced a new 10.5 year model-the Making Care Primary (MCP) Model. Applications are now open.

Improved Care

- MCP is designed to improve care for patients by: expanding and enhancing care management and care coordination, equipping primary care clinicians (PCPs) with tools to form partnerships with health care specialists; and leveraging community-based connections to address patients' health needs as well as their health-related social needs (HRSNs).

Value-Based Experience

- Through MCP participating PCPs with varying levels of value-based care experience will be able to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration and drive equitable access to care.

Increased Testing

- The MCP will be tested in eight states: Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington.

MCP: CARE REDESIGN REQUIREMENTS

The Care Redesign focuses on person-centered care through the following domains.

- **Care Management**
- **Care Integrations**
- **Community Connection**

Each track will have specific requirements that tie to these domains:

Track 1

- Participants will build the foundation to implement advanced primary care services through activities such as risk-stratifying their population, developing workflows for care management, chronic disease management, and behavioral health and HRSN screenings.

Track 2

- Participants continue to meet the requirements of Track 1 while also expanding and integrating the services available to their patients (e.g. once patients are risk stratified and care management workflows established, implementing chronic care management for high-risk patients).

Track 3

- Participants will continue to meet and build upon the requirements of Tracks 1 and 2, to further optimize and expand care delivery and specialty care integration (e.g. once patients are risk stratified, chronic care management for high risk patients is established, taking this further and ensuring there are individualized care plans for all high risk patients aligned to their chronic health needs as well as linkages to community based supports).

MCP: BEHAVIORAL HEALTH INTEGRATION

CMS acknowledges "Behavioral health integration is an essential part of whole-person care that improves health outcomes and patient experience while also reducing costs and treatment delays. Participants will offer integrated behavioral health services to their patients."

Track 1

- Participants will identify staff and develop workflows using measurement-based care to deliver behavioral health services to patients.

Track 2

- Participants will implement their planned behavioral health integration approach and begin systematically screening patients for behavioral health conditions including depression and substance use disorder (participants must screen for these conditions but may choose to screen for additional behavioral conditions).

Track 3

- Participants focus on optimizing behavioral integration workflows, using the tools and resources gained throughout MCP.

NEW STATE-BASED MODEL - AHEAD

All-Payer Health Equity Approached and Developments (AHEAD)

- **Supports statewide transformation** to curb rising health care costs and invest in primary care

- **Improves care coordination** with primary care and other outpatient providers

- **Improves population health** through statewide health promotion efforts

- **Gives states and providers additional tools and incentives** to align care transformation activities across health care delivery and public health systems

- **Advances health equity** through new policies or programs

https://www.cms.gov/files/document/ahead-infographic.pdf

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Overview of the CMS GUIDE Model

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GUIDING AN IMPROVED DEMENTIA EXPERIENCE (GUIDE) MODEL

- On Monday, July 31, CMS announced a new model for dementia care.
- Delivers on Biden Administration's April 2023 on Increasing Access to High-Quality Care and Supporting Caregivers.
- Creates 8-year CMMI test of a new healthcare payment and service delivery model focused on dementia care, including dementia caregiver supports.

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GUIDE'S GOALS

Improve	Improve quality of life for people with dementia.
Assist	Assist with caregiver strain.
Help	Help people with dementia remain in their homes and avoid institutional placement.
Reduce	Reduce the significant health disparities in dementia care.

OVERARCHING APPROACH

- Defining standard approach to dementia care
- Alternative payment methodology
- Addressing caregiver needs
- Increasing opportunities for respite services
- Screening for SDOH needs

REQUIRED SERVICES

- Participants will be **Medicare Part B providers/suppliers** (excluding labs, DME)
- To participate in GUIDE, patients will be required to have an integrated care team, utilize an EHR, and provide following services:
  - **Care management** and care coordination/navigating for accessing clinical and non-clinical services, including SDOH supports
  - Person-centered **assessments** and **care planning**
  - 24/7 access to a **support line**
  - **Caregiver support and education**, such as training on best practices/techniques for dementia care, as well as **respite** services ($2500/year benefit)
  - Create **health equity plan**
  - **Medication** management

ADDITIONAL NOTES

- Care delivery approach, payment model, and data requirements are standardized. Care delivery specifics—e.g., operational details of care coordination/care management, caregiver services—are not.
- Model will have two tracks: established programs (starting July 1, 2024) and new programs (July 1, 2025).
- CMMI project will cover all geographies and populations.
- Telehealth is allowed and encouraged.
- Provision of respite not dependent on financial assessment.
- CMMI requesting participants complete non-binding LOI by September 15.
- Participants may partner with other organizations to meet requirements, especially for addressing patients and caregivers SDOH needs.

ELIGIBILITY AND PAYMENT

Eligibility

Medicare Part B providers/suppliers:

- Must have demonstrated “dementia proficiency” (i.e., 25% of patients with dementia)
- Serving Medicare FFS beneficiaries, including dual eligibles, who are not residing in a SNF

Payment

PMPM with incentives:

- For higher complexity patients
- Meeting quality goals
- Decreasing health disparities

KEY INSIGHTS

- Will set standard of care for dementia care for next decade (unless ensuing medical breakthrough).
- Entirety of model or many of its components will likely be incorporated into state MLTSS plans.
- Extend federal commitment to increased supports for dementia caregivers.
  - Consistent with ACL 2022 National Strategy to Support Family Caregivers.

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Dual Eligibles and Behavioral Health

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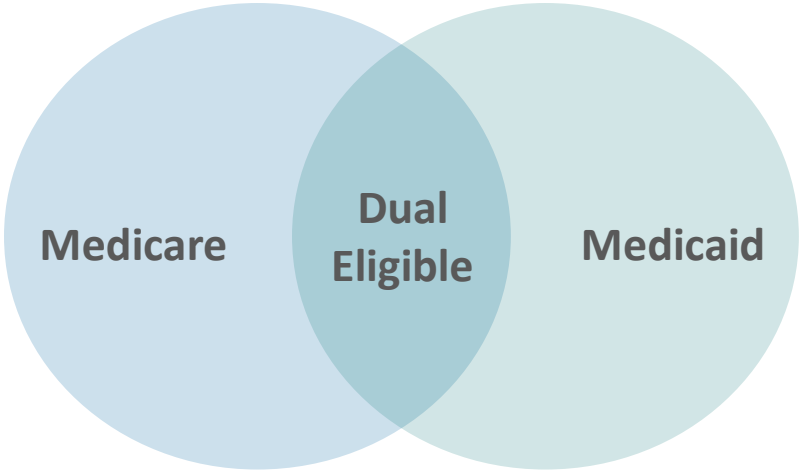
MEDICARE CHANGES IMPACTING BEHAVIORAL HEALTH - DUAL ELIGIBLES

FACTS ABOUT DUAL ELIGIBLES

- 12.5 million enrollees with Medicare-Medicaid in 2020 or 19% of total Medicare population.
- 73% receive full benefits meaning that they were eligible for the full range of Medicaid benefits.
- Dual Eligibles account for 34% of overall Medicare spending.



- CMS and the States have long been looking for a way to better **achieve the Quintuple Aim** with Dual Eligibles and the focus has been on integrating programs and services to **achieve better outcomes**.
- The recent Medicare changes to behavioral health services will impact Dual Eligibles by:
  - Expanding access to care
  - Paying for additional services and paying more for certain services
  - Promoting coordination of care across Medicare and Medicaid

Source: CMS Medicare Current Beneficiary Survey, 2020 Survey File

KEY TAKEAWAYS

Changes to Medicare rules and reimbursement are **expanding access** to behavioral health services and innovations in care for older adults, populations with disabilities, and their caregivers.

There is a window of opportunity for systems to get ahead by extending training and **implementing EBPs** for the Medicare community into their service delivery matrices.

Delivery systems will want to be prepared by **examining and updating** their clinical, operational, financial, and training systems.

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WHAT CAN WE DO FOR YOU?

Our depth and breadth of experience has helped an incredibly diverse range of healthcare industry leaders.

Questions?

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