ALLIANCE FOR HEALTH REFORM

Behavioral Health Briefing
Alliance for Health Reform
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ED HOWARD: Well, good afternoon. My name's Ed Howard. I'm with the Alliance for Health Reform, and I first want to thank you for making your way from Hart to Dirksen, and I hope you didn't think you had to go outside to do it, because it's raining out there, but the superintendent switched rooms on us in the last minute, and we're glad to see so many of you who have made the transition. Sometimes it's difficult.

On behalf of Senator Rockefeller and our board of directors at the Alliance, we want to welcome you to a program that we hope shines a little bit of light on one of the usually dark corners of health policy discussions, and that is mental and behavioral health, and it's a light that's really badly needed around here. Some of you might remember that it took Pete Domenici and Paul Wellstone years and years to pass legislation assuring at least a modicum of fair treatment for those with behavioral health problems, and we're still struggling to get that law and its successors fully and successfully implemented.

We've got fiscal distress behind part of that, but there's always also, as all of you know, been a problem with the stigma attached with mental health and substance abuse conditions. And now health reform's coming, at least for the next few weeks for sure, and whether it's through the

Affordable Care Act or through the responses of all of the parties in the health care system to the crises we face in access and quality and costs, there's a great deal of change rumbling through the health care system.

Today we're going to examine how those waves, or ripples, depending on what the future holds, of change are affecting and are likely to further affect the part of the system that's charged with delivering care, both physical and behavioral health care, to those with behavioral conditions. And we're especially interested in how the public sector is dealing with this area.

Now, we're very pleased to have as a partner in today's program the Centene Corporation, which contracts to provide Medicaid coverage in a dozen states or so – excuse me – operates a number of related services like nurse call centers and behavioral health services. You'll be hearing later from Dr. Sam Donaldson, who heads the Centene behavioral health operations. And first we're going to turn to Deanna Okrent, who's a senior policy associate for the Alliance, who is both going to help moderate today's discussion and get us started on the substantive conversation, with some brief observations about precisely why we are looking at this subject today. Deanna?

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DEANNA OKRENT: Thank you, Ed, and welcome, all. While you're enjoying your lunch, we thought we would set the stage with a little bit of background looking at the U.S. population that is estimated to be in need of behavioral health services and some clues regarding the extent to which those needs are being met.

We'll also look broadly at how this care is financed, what policy challenges we're facing now, and what looms in 2014 and beyond, as Ed was mentioning. Let me see if I can do this. What do I have to point up? Okay. So with regard to current need, studies have shown that close to 50-percent of all Americans will develop a mental disorder in their lifetime. This may sound shocking to some, although I suspect that many of you in this room are familiar with some of those statistics, and as many as 27-percent of all Americans will have a substance use disorder.

When we talk about behavioral health, we're actually talking about both mental health and substance use disorders. And a population group that gets a lot of attention these days because of the high cost of their care, the duly eligible Medicaid and Medicare beneficiaries, report the highest rates of mental illness among all Americans. As you see on this slide, the rate is as high as 50-percent among beneficiaries with disabilities, compared to one-third of adults in the

general population, and 20-percent among beneficiaries over the age of 65.

So how are we doing? How well are we doing in meeting the need of all of these folks with mental health disorders? Some reports have shown that the recession and consequent unemployment may be a contributing factor to this need. And though behavioral health services have increased over this time period, the incidence of mental health illness leaves 60-percent of adults with an untreated mental health disorder. I'm going to repeat that: 60-percent of adults with an untreated mental health disorder. And again we heard a lot about the epidemic of chronic conditions in that high-cost group mentioned earlier. And it's important to note here that 17-percent of adults had both mental and physical health conditions, each having an effect on the other. And people are looking more and more about that relationship between mental and physical disorders, and you're going to hear a little bit about how providers are dealing with the interaction between the two.

Just taking a look at children for a moment, the rate is even higher of untreated behavioral health conditions, and it reaches 70-percent. And another little side note there that is worthy of attention is that children might wait an average of nine years from onset of illness to treatment. So if you

think about a young child needing attention in a mental health issue and not getting it until their teens or beyond.

Now, if we turn to financing for a moment, it's important to note that public funding, the first three categories on this list, federal, state, and local, account for 61-percent of behavioral health spending. Medicaid alone covers more than 25-percent of all expenditures – one of the reasons, as Ed was saying, that we're focusing our discussion today on services that are publicly funded and cover low income vulnerable populations.

We recognize that there are a number of important issues with regard to behavioral health services for all Americans that we're not going to be looking at today, but we felt that we needed to narrow the discussion to focus on this population, and we're kind of drilling down to direct the conversation to those folks.

So we're going to look at some of the current models of integrating behavioral and physical health and how this can be done in a medical home setting perhaps, what it means with regard to filling the provider gap and helping states with their budgetary challenges. And we'll take a look at how federal policy may be helping to support innovations and perhaps take a peek into what the future may hold. Thank you.

ED HOWARD: Thanks, Deanna. Excuse me. Just a couple of logistical items before we get to the meat of our discussion. There are lots of good things in your packets including, where we had them at press time, the copies of the slides that are being used. There are also biographical sketches of each of our speakers, much more extensive than we'll be able to give them orally. There's a webcast and podcast that will be available of this briefing sometime tomorrow courtesy of the Kaiser Family Foundation on their website at kff.org, for which we're thankful, and there will be a transcript probably later in the week or early next week on the Alliance website at allhealth.org.

I'd like to call your attention to something else in your packets, which is the blue evaluation form we'd love to have you fill out, and once this is a pay for performance situation. If you perform, we will pay. Well, we won't pay you, [laughter] except in your heart you'll know you have done well. Normally about a fourth of you fill out the evaluation forms. We appreciate that. If we can get that to 35-percent, we are going to donate $50 to support the new Anacostia Center just opened by Unity Health Care here in the district. And if you get 50-percent of you completing the evaluation, and we certainly do encourage peer pressure to get to that level, the donation to Unity will be $100 from the Alliance, and you're

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welcome to complement that with your own dollars as well. This is a very good operation. Actually, this particular center, one of almost 30 that Unity operates in the district, will be having its ribbon cutting on Monday. It's four times bigger than the antiquated World War II structure that it replaces, and it's going to offer mental and specialty services. So we thought it particularly appropriate to single out Unity for attention today.

So to the program, we have a very knowledgeable group of panelists, broad range of experience. They're going to give brief presentations, and then we'll have a lot of time for your questions and interaction among our panelists. There are green question cards you can use at the appropriate time to write a question. There are microphones you can use to ask it in person.

I'm going to introduce all of our speakers upfront so we can bring continuity to the conversation as well as to the care. We're going to start with John O'Brien. He's a senior policy advisor for the Disabled and Elderly Health Programs group at CMS, the Center for Medicare and Medicaid Services. He's been a senior official also at SAMHSA, and he's advised state and local governments on human services issues as a senior consultant to the Technical Assistance Collaborative.

He's held a number of senior positions in both the private and the non-profit sectors, and we're very happy to have him here.

Then we'll hear from Dr. Joseph Parks, who's the chief clinical officer for the Missouri Department of Mental Health. He's a distinguished professor, research professor of science at the University of Missouri, St. Louis, and the director of the Missouri Institute on Mental Health, also happens to be the president of the Medical Director's Council of the National Association of State Mental Health Directors, and he's a practicing psychiatrist. He's stopping all 27 of those things to be here with us today.

Then we'll hear from Sam Donaldson, who's a clinical psychologist, and Dr. Donaldson is president and CEO of Cenpatico, which is the managed behavioral health care organization that's part of Centene. Cenpatico operates in 14 states, has almost 2 million members, and Sam Donaldson has a total of 30-plus years of behavioral health and substance abuse treatment experience. He's a leader in several related professional associations.

Our final speaker will be Dr. Gloria Wilder, who's president and CEO of Core Health, which is an organization assisting underserved communities in improving access and quality of health care. Dr. Wilder is a nationally recognized pediatrician and a public speaker and an expert on poverty and

social justice. She's won more awards for her humanitarian work than we have time to read off to you, but they're in her biographical information, and she understands what behavioral health challenges can do to patients and their families.

So without further delay, we're going to turn to John O'Brien to get us started in the discussion. John?

JOHN O'BRIEN: Thank you, Ed, and thank you to the Alliance for the invitation for me and for CMS to talk a little bit about what we're doing as it relates to mental health and substance use disorder. I'm very excited. As many of you in the room know I've made a transition from SAMHSA to CMS, and I made that transition because of that organization's renewed commitment to focus on mental health and substance use disorders. They have been very clear over the last several years that in order to be able to make their programs work they need to pay particular attention to these individuals with these conditions because, number one, it's the right thing to do. Number two, it's such an incredible cost driver as it relates to some of the medical surgical services and, frankly, some of the specialty services. So I'm very pleased to be there.

Part of what I'm doing and what I'll try to talk about in the few minutes that we have for opening remarks is what CMS is doing specifically around mental health and substance use

disorder. Now, I could have probably filled the whole hour, but I really wanted to highlight four or five areas that I think hopefully over the next six months you will hear more about from either myself or from other people within CMS or, frankly, for some guidance or other things that come up. But one of the things that I am working on is a plan, is a strategic plan, for the Disabled and Elderly Health Program Group, which is probably the – or has the lion's share of the programs that deal with individuals who are in the Medicaid program who need mental health and substance use services as well as long-term services and supports.

When I walked in the door, they actually had the beginnings of some planning efforts and specific goals around mental health – oops, I did something – there were go – mental health and substance use disorders, and they were pretty straightforward and simplistic. And one is that they want to make sure that the federal policies that exist or will exist in the future support the offering of effective services and supports, especially for individuals that have mental health and substance use disorders.

You will hear lots about this, and Deanna touched on this. The integration of physical health and behavioral health care is critically important, not only in the group that I'm in but, frankly, in the dual-eligible group as well as Medicare,

as well as also the Innovation Center, who is spending a tremendous amount of energy on trying to figure out how to do integration well. We are also making sure that as states begin to think about some of the new programs and, frankly, even the existing programs, that we have out there that they really focus on how those programs are more person centered. We've talked a lot about that for a long time, but we've got a renewed interest in trying to provide some more clarity about what person-centered, self-directed care really means and means to support some of the basic tenets of recovery, resiliency, and successful community integration. And last but not least – and this is meant in a positive way, although my guess is some people could say, Oh, gosh, the "accountable" word makes me a little bit nervous, but really to improve the accountability of our programs. So not so much the people delivering our programs but whether or not the programs that we offer are effective. But also program integrity, to make sure that when we do work with states and we work with organizations that are delivering services, that the services that they're delivering not only make a difference to those individuals that are getting those services but they're doing so in an accountable way.

The key areas that I'm going to focus on are primary care and behavioral health integration. We're doing lots

around that with some of our partners and some of the other federal agencies. I know that there is a lot of interest around the Mental Health Parity and Addiction Equity Act, and I want to talk a little bit about how that relates to the Medicaid program and some of what we're doing around the Medicaid program; exciting opportunities around home and community based services, one – actually two that were posted yesterday; and then talk a little bit about children and youth with behavioral health needs, both mental health as well as youth with substance use disorders, because I've been fairly passionate that that's a group that we just don't pay much attention to and need to do more.

So I'm going to talk a little bit about our integration efforts and specifically focus on health homes. Many of you may have heard of these. They are an effort to really incentivize states to think about how to do better primary care and behavioral health integration. We're fortunate enough to have Joe Parks here from Missouri, who I often think of as really probably one of the premier thinkers around this and doers around this. It's good to have a thinker and a doer around this. But here was our goals around 2703, and they were pretty straightforward: certainly to improve the outcomes of our individuals and not just the behavioral health outcomes but some of their physical health outcomes, making sure that when

they get the care, that the experience of care is really a valuable experience to them. We know that lots of times when people show up, both in primary care and behavioral health care, many of them might have one visit and then never come back again. And we want to make sure that if, in fact, some of that's the way that they experience what they get when they walk in that front door, that it really is a better experience, and, frankly, build off of some of the work that SAMHSA and the University of Wisconsin and others have done around the NIATx program.

We want to certainly focus on some of the important things like reduction on emergency room use and/or making sure that there aren't multiple re-hospitalizations, focusing on the extent to which we can actually prevent people from going in to long-term care facilities. And one of the things that were part of this program was reducing overall health cost. We, on this program, have been working really closely with SAMHSA and HRSA around this. States, if they're interested in this program, actually have to go to SAMHSA and get some consultation with them around the structure of what they're proposing, not only with individuals with serious mental illness and substance use disorders but some of the other chronic conditions that have underlying behavioral health conditions as well.

Here's a brief summary of where we're at with the state plan amendments. Some of the draft proposals may actually be on the clock, and some of the on-the-clock proposals may be now approved over the last week or so, but this gives you a flavor of who is asked for those, who's been approved. Lots of interest in this, and, again, I think the partnership with HRSA, SAMHSA and CMS last year at this time to do dog and pony shows in each region around this option hopefully was helpful.

We do have parity both as a law and a regulation. There is a mention in the regulations or in the law around its application of Medicaid managed care organizations, but there is also further guidance and further law that applied it both to the Children's Health Insurance Program and to the benchmark plans and the benchmark equivalent plans. We are in the process now of developing guidance around that. I know there's a very keen interest in seeing that sooner rather than later, but hopefully we will get that out soon, and all things will be a little bit clearer.

Around home and community based services, yesterday we hosted two regulations that we're really excited about. One is the final regulations, kind of sort of, around Community First Choice, and then the other one is an NPRM around the 1959 program. The 1959 program, the home and community based services program, a state plan program, is not new, but it got

a nice makeover in the Affordable Care Act. And so because it got that nice makeover in the Affordable Care Act, we actually had to put out some regulations that were consistent with the Affordable Care Act. I think there's lots in that regulations that is interesting. A couple of things that I'll highlight is that it really, in this program, breaks that link between the old 1915(c) program, where it said you had to be eligible for an institutional level of care – in the (i) program, you don't. There has to be some level of care, but it doesn't have to be institutional level of care. Second, it also expands service opportunities under the (i), the Affordable Care Act did that. So prior to the Affordable Care Act, it was limited to a subset of services that were the 1915(c) program. Under the Affordable Care Act in this regulation it's been expanded to include additional (c) services and other secretary-approved services, which really means that there's some flexibility about what you can offer or what states can think about putting in their 1959.

And last but not least, services for children and youth, we are awaiting. Not to put any pressure on SAMHSA, but the technical expert panel that they did in December around youth with substance use disorders, and we're looking for the recommendations, because we're really interested in being able to share that with our Medicaid directors around what we think

is a good benefit for that population. But we're also wanting to focus a little bit on the early periodic screening and diagnosis and treatment screening that often doesn't occur, even though it's supposed to occur, and it provides some good guidance around that. Also provide some good guidance around benefits for youth with SED and youth with other mental health issues and autism. And then last but not least I'll just focus on two points, our work with ACYF around kids and foster care and the importance of really rethinking of what the right services are for that population and the use of psychotropic drugs of children in foster care, which is a big issue.

So in your packets you will see letters and regulations that you are free to peruse on our website that give you lots more information than I just did.

ED HOWARD: Terrific. Thank you, John. Let's turn to Joseph Parks.

JOSEPH PARKS: It's a pleasure to be here with you today. I'm going to give you three key takeaway points that I'll do some detail on. First is that people with mental illness, in particular serious mental illness, are a health disparities population. They have more burden of illness and die younger due to chronic medical illnesses than the general population.

The second point I want to give you is that to change this requires forming a data driven personal relationship with the people whose health you want to improve. If it's not data driven, then you don't know what you're addressing and what to change. And at the end, people really only change their health behaviors – adherence to treatment, change in lifestyle – as a result of a personal relationship. They don't do it due to anonymous phone calls and letters.

The third, as I'm going to show you, that there are substantial health care savings to be had if you can implement these data driven personal relationships. I'd like to point out that in your packet is a new document from the National Association of State Mental Health Program Directors that has a lot more background information of things that can be done to really accelerate integration.

In Missouri we take multiple approaches to integration. I'm just going to talk about our health home and disease care coordination efforts at this. But basically we do integration by any means we can get our hands on, both from the primary care side and from the public mental health/community mental health center side. We were the first state to get a plan amendment. Actually Rhode Island got theirs up and running a little sooner, but we were the first one to get the amendment in.

We have three kinds of health homes. We have primary care based health homes at all the FQHCs statewide. We have CMHC based health homes at all the CMHCs statewide. These are not regional demo projects. This is all in total system transformation. We have a parallel initiative on the commercial side that's a multi-pair person centered medical home, a slightly different model. We won't go into that detail today.

I'm often asked why would we have CMHCs be health care homes instead of keeping everybody in primary care practices. Well, as I mentioned, people with serious mental illness die with a life expectancy in their mid 50s. This was demonstrated in a landmark piece of research done by Ron Mandersheid, who's with us here today. Wave to the crowd, Ron. Beautiful piece of work that really recentered the whole field on the fact that people with serious mental illness in the public system are dying at about the life expectancy of sub-saharan Africa. It's appalling. It's an epidemic.

Sixty-percent of these premature deaths are related to untreated chronic medical conditions. In a recent national study of people with schizophrenia that was done at multiple academic centers, over half the people had hypertension, dyslipidemia, and over two-thirds of those were not being treated. Two-thirds at academic centers that can do research

were not being treated. About 15-percent had diabetes, and a third of those were not being treated. Academic centers during research can miss diabetes in 5-percent of people. It's appalling, and many of the medications also drive these conditions.

I want to briefly show you a study of Maine, again demonstrating that this is a health disparities population. Elsie Freeman in Maine sorted out the people between having serious mental illness and not. This controls for socioeconomic class, and you see for every condition, people with serious mental illness have a substantially higher portion of that chronic medical condition. If you want to take care of chronic medical conditions, you have to look at people with serious mental illness. That is where the burden of illness lies disproportionately.

So the principles that we pursue in Missouri is that physical health care is a core service for people with mental illness, and that the mental health system has a primary responsibility to assure access to care and to manage and integrate that care. That's because they see us more than anybody else, and the person, the entity, and the health care system that sees the patient most often is the natural entity to coordinate, organize, and make sure that preventive care occurs. You have more opportunity.

We've done a number of integration projects over the last five to eight years. I want to tell you about three of them, briefly. In the first one we implemented health homes both on the primary care side and the CMHC side. The program as a whole broke even at 18 months, which is about average for care coordination disease management programs. The CMHCs actually, when you looked at them separately, saved more money. The initial per member per month cost in this group was $1,500. One reason that we save money is the people that we're seeing cost a lot more money. You have to cost money to save money. So you want to focus on the sickest people. When you look at people with serious mental illness, you automatically get that population.

Mercer thought that our expected trended cost should be $1,800 per member per month. Our actual was $1,500. This is about 6,700 people, a $21 million savings. We believe that we're able to outperform primary care because we had those personal relationships. They were using nurse care managers, doing 15-minute phone calls. We had bachelor level social workers and psychologists meeting with people for an hour a week to an hour a month personally, face to face.

When you break out those savings, pharmacy actually went down 23-percent. This is unusual. Usually pharmacy goes up in disease management programs, but that's because most of

them focus on healthy people, and you add meds. These people are already taking 20 meds, and they're taking multiple meds because they're not adhering to their meds. If you only take your antihypertensive, your antidepressant half the time, as your doctor I'm going to think it's not working, so I'll give you a second one because I don't know you're not taking it half the time. It's a different pattern for the deep end. Hospital went down 7-percent. CMHC services cost more to do the disease management. Clinic is all the general primary care. Total savings 16-percent off trend.

Here's what it looks like when we looked at it pre-post. This shows 24 months of care before going into service and 24 months of the costs after. These are per member per month costs. When the line goes from red to blue, that's the point in time when the person went into community mental health center service. So starting 24 months before, you see their total health care costs being about $750 per member per month. It raises to $1,750 per member per month. At the point of going in, you see a spike often associated with hospitalization intake initial assessment costs, and by 36 months out, they're down to $1,250 per member per month, a very nice response to the intervention in reducing a very threatening trend cost.

In addition, when you compare our outcomes annually a year later to the initial, the independent living increases by

33-percent. Vocational activity is up by 44-percent. Legal involvement's down. When you stabilize somebody's life, get them housing, get them a regular supportive relationship, everything tends to straighten out. Hospitalization goes down. You don't want to do this for everybody. These are expensive clients. You have to choose the correct people to apply this level of care to. Illegal substance use goes down substantially.

We do the second outreach program. What I just showed you was what we can do with people who are getting our services if we attend more to their medical conditions. We're now doing an outreach program where we identify people with serious mental illness that cost over $25,000 a year in the Missouri Medicaid program. Then, instead of waiting for them to come to us, we go out and find them. What we found is you can't send them a letter, you can't give a phone call, they're on cell phones that run out of time, they change addresses, they have unstable housing, and they don't answer the door. You have to go knock on the door. You have to personally go to their door and talk to them. We get about a 50-percent catch rate. These people, about a third, have asthma or COPD. About a third have diabetes, 11-percent congestive heart failure – again, a very select population.

Nine months in we've been able to get 1,300 people to engage in services at the six-month level, $346 per member per month actual untrended savings cost, actual savings. If you trended it, it would be $619, if you trend it on their trajectory prior to getting in. That's what you can do with a data driven personal relationship.

I have a few thoughts that I wanted to share on opportunity for federal policy. First, when you do integration, you have to include substance abuse. We believe that next year we'll be focusing primarily on substance abuse. The people we couldn't engage, it was more a substance abuse problem, and we need better interventions, and it certainly has to be a part of integration.

Second, you need to push for deeper integration of parity, in particular in the rehab area. Right now we have good movement on parity for outpatient visits, for psychiatry services, but if you think about it, if you get a stroke or a heart attack, most benefit plans will give you about three to six months of rehabilitative service. Occupational therapy will come to your home and work with you about that stroke. You'll get cardiac rehab. You don't get that when you get discharged after your first psychotic episode or after a suicide attempt. All you get in most benefit packages is a doc visit within a month and maybe some therapy. Parity means that

you get rehab supportive community services following a hospitalization for psychosis or suicide. That's a parity issue that needs to be attended to in the essential benefit package also, as well as in general parity.

The behavioral health net providers, both the CMHCs and the state hospitals, were not allowed to participate in the federal subsidies for IT. This is all IT-driven stuff. You know, the biggest advantage we've done with IT is we take our Medicaid claims, and we give that information to providers. If you think about it, your insurance company knows much more about your medical care than any of your individual doctors, because they see everything everybody does. They know all your meds, they all your diagnoses, they know all your visits. And most payers don't make that information available to the treaters, which is dumb business.

So we put that information up on a website. They can drill down if you're a provider. Only a provider can get on to it. And we actually drive our analytics, where we analyze who needs care, off the claims. The health information exchanges are currently being billed only on electronic medical record extracts. They need to also be billed on claims. Payers have tons of information that are unavailable and unused to manage care, not a good business decision.

So the behavioral health providers should be able to get the federal subsidies to support getting IT systems. Also, CMHCs are not able to participate in 340B pricing that gives cheaper pharmaceuticals. FQHCs can. They should be allowed that same opportunity.

Those are my opportunities that I would give you as policy work or as specific actionable items: funding for HIT, 340B participation, and making sure that parity includes the rehab services. Thank you very much.

ED HOWARD: Terrific. Thank you so much.

JOSEPH PARKS: And there's our website.

ED HOWARD: If we can reclaim the clicker and move it down that way. Thank you. Now, I'm sure that Dr. Parks, when he was talking about dumb business, was not talking about Centene and the behavioral health operations.

JOSEPH PARKS: Absolutely not. [Laughter].

ED HOWARD: Sam?

SAM DONALDSON: But we are proud to recently be awarded a contract in Missouri, and so the opportunity to meet Dr. Parks. So he already has some important assignments for me, and I'll get to work on that. Anyway, it's a privilege to be here and to be a cosponsor of this meeting today. What I'm going to do today, I guess, I like the approach of what do I want to leave you with. I think there are a few things. I

want to leave you with the same message that we've been talking about, that physical care has to be a priority and integrated and those with serious mental illness, and I'll talk a little bit about that.

Second, I kind of want to educate you a little bit about what a managed care company does. I'm always horrified when I read about us and what we allegedly do and how we operate. I think you'll be surprised. I hope you will be after you hear that part as well. And, third, the bright light that needs to be shined on this area. We're talking about these numbers and prevalence rates et cetera, but to kind of make this real, raise your hand if you are close to someone who's currently in treatment for either mental illness or substance abuse, and that can be yourself. You're not outing yourself. So look around. And yet we hardly have any real public dialogue or discussion about what's going on in this area, and as you've heard already – and I'm not going to repeat all that's been said – the enormous impact on cost. And as a managed care company, I believe there is enough money in the system. I don't think there's a lack of money in the system. I think there's a lot of waste, inefficiencies, and lack of coordination that is costing us dearly.

So I'll talk about Cenpatico, give you a little glimpse into how we work in our company, and then hit on a couple of

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challenges — and I keep forgetting I'm self driven here. Alright, just a little bit of how we work. Centene has basically two divisions. One is specialty companies, and one are the health plans. This is a wonderful opportunity for us at Cenpatico and behavioral health to actually have living laboratories. We work close to close, side by side with our health plans to really identify those who are struggling, who are outliers, who are not getting the treatment either on the physical side or the behavioral health side, and so this allows us to be extremely innovative in what we do.

If you'll notice on the specialty plans, we're one of the specialty plans. These are all independent businesses, which means that they hire and employ some of the brightest people. We are not a bunch of departments. We actually have businesses that are accountable, accountable for having expertise and for delivering that expertise in an integrated solution with the physical side and our health plans.

In terms of my company, Cenpatico, I've been with for going on eight years, we are a managed behavioral health care organization. We are NCQA accredited. Our core services are in delivering behavioral health services to our members, but I would say, if I really identified the most important thing we do in Medicaid for our consumers, and that is coordination of care — coordination of care among physical, also coordination

with the community. That includes housing, transportation, et cetera, et cetera. These are not diagnoses. These are people that are suffering through a culture of poverty. And to approach them – and I think a lot of the industry does not understand this – you have to understand that whole poverty milieu and all the needs that are wrapped in there if you're going to successfully treat.

We also do some day programs, private day treatment, and we've recently gotten into special therapy and rehabilitation services. Here's a current overview of where we are operating and just kind of a big picture. Alright, well, end of commercial, and now, thank you for bearing with that, and we'll talk a little bit about health care integration.

The reason we're talking about this is because of the cost and the enormous cost, and for Medicaid recipients, those who have behavioral health disabilities, they're also known as seriously mentally ill or persistently mentally ill. It's 15-percent of all recipients, but they account for 42-percent of Medicaid spending, which is really enormous in terms of the impact. By “serious mental illness,” many of you may not know that I'm referring to a primary diagnosis of major depressive disorder, bipolar or manic depressive disorder, schizophrenia, panic disorder, obsessive compulsive disorder, and post-

traumatic stress disorder, of which we're seeing just among war veterans a double in increase of incidence right now.

So Medicaid beneficiaries as a group, as an eligible group in Medicaid, are basically per capita the highest spending of any eligible group, those with disabilities, and those are disabled, so huge, huge cost factor. Key drivers that account for some of the costs, you can see the average Medicaid recipient versus recipients with mental illness and then recipients with both mental illness and substance abuse disorder, and the key drivers basically are that these are folks that are suffering from brain diseases. So by definition, when you have a serious mental illness, you are having a profound disease that affects your brain and therefore affects your ability to judge, to think, to perceive, to be motivated and to take actions.

So when we talk about non-adherence of people who are on Medicaid, we're talking about people who already have impaired brains and also lack basic transportation and other sources as well. But other key drivers in terms of the cost also are impacted by prescription and drug cost, of which it's been cited before. Because of lack of coordination, they're on so many different drugs, and we're just not keeping track of that. And also higher levels of care. We're committed to keeping people in their community and keeping people in their

community with proper supports, both from a behavioral health service delivery model, but also working closely with the community to make sure that the folks get what they need.

Interaction of physical and behavioral health conditions. On the left, you can see what is going on in terms of diabetes, hypertension. A lot of smokers in this population. They don't eat right. They don’t exercise. They don't have access to even some of the basic knowledge and tools for that. The psych meds cause a lot of weight gains. I've talked about the adherence to treatment plan. And presentation confuses treatment. When I was working at a staff model HMO, I was the psychologist there. I was young. And I had a patient who had stomach problems, constantly stomach pain. So I sent her over to the physical side. And the physician finally got into my face one day after sending her for the fourth or fifth time and said, “I've done every known test known to man. There's nothing physically wrong with her.” Turned out she was not disclosing to me her abusive drugs. So I didn't know anything at that time, but this is a very important example of why we really have to get our hands around and understand when somebody is suffering from a behavioral health condition.

So one of the things that we believe that’s very important is establishment of behavioral health homes. One of the things that I do get concerned about is, a lot of reform

has been focused on medical homes and typical what I would call medical model approach. The problem is that folks suffering from serious mental illness often have their relationships with community mental health centers and mental health providers, and they are not apt, much less feeling very equipped, to start hooking up with medical facilities and working with PCPs. So one of the things that we work in – and I'll tell you in a minute how we've internalized this kind of behavioral health first approach to treating both the physical and treating all comorbid conditions.

Now, some numbers. We have integrated care management system, which means that we, at the point of entry into our system as a managed care company, determine what is the most critical problem going on. And what we find is that we used to do kind of traditional – well, if you had a primary medical diagnosis, you were dealt with on kind of a medical case management approach. If you had a primary psychiatric diagnosis, you were behavioral health. And what we've learned is that we need to have a model that basically our care managers have to understand both physical and behavioral. That doesn't mean that they're experts in everything, but they have to be able to identify some of these basic issues that are going on. And also at the point that they come in, if their behavioral health symptoms are the predominant symptoms, even

though they may have all kinds of medical issues, we actually handle it from a behavioral health point of view. If we do not get those symptoms under control, they are not going to be able to follow through and manage their care.

So in our programs, if you look at just the savings alone, these are in four markets, and this is based on 2011 claims data. You can see the savings alone of our serious mentally ill recipients who are in this program, on health care savings, both from behavioral health and the medical. It's quite impressive, and this is why I assert that there is enough money in the system. The next slide also shows similar. A lot of folks go to the ER rather than getting health through primary care or even through the community mental health centers. And since we've implemented this and enrolled in 30 days or more, you can see again significant savings as we start to reduce ER visits, which are the most expensive care that you can deliver.

So in approaching health care integration, we look at the three fundamentals, what's clinically effective, educating our providers – we spend a lot of time educating in terms of best practices, et cetera – and of course payment integrity, avoiding waste and fraud.

I could give a list of concerns, in terms of what are some of the obstacles that we have for a managed care company,

but the two biggies are, one, the workforce issue, psychiatrists. The slide says it's acute. It's more than acute. It is a crisis. We have been able to successfully build telehealth systems and work with our providers, so that we can get people seen at least via teleconference, et cetera. But at the rate that we're going, it's going to be hard to even find psychiatrists to do that. In terms of policy, one of the things I think is important is that we should have something akin to almost a Peace Corps effort to get psychiatrists back in the field, including policies on a national level that might pay for their schooling, their loans, for so many years of service. And the second thing is the limitations for behavioral health providers on the health IT funds. There's currently in the Senate committee Behavioral Health Information Technology Act that will amend the Public Health Service Act to allow incentive money to be paid to psych facilities, psychologists, social workers. Only 8-percent of these providers have fully implemented electronic records. And yet right now under the current law and reform, they don't have access to those funds. Thank you.

ED HOWARD: Great. Thanks very much, Sam. Now we'll turn to Dr. Wilder.

GLORIA WILDER: Thank you. I sit on a panel today to put a face on the conversation that we're having today about

behavioral health, mental health. I have to preface it by saying I'm not at all politically correct, so you're all going to have to excuse me if I slip. I'm a pediatrician. I work in Ward 8 here in Washington, D.C. I've been here for 22 years delivering mobile health programs and developing clinics and wellness centers. And I've been lucky enough to also work with 33 different states in trying to do the same thing. And when it comes to this issue, I want to get us right back to where we started, with the issue of 50-percent.

I don't want us to lose sight of the numbers that we're talking about here. Nearly half of all Americans will develop a mental illness in their lifetimes, and that means, if we look at the face of who we're talking about and that you guys probably know that for a long time, when it came to behavioral health issues and mental health issues, nobody wanted to claim what we all knew some folks were struggling with. Nobody wanted to say, I'm depressed. Nobody wants to say, I have bipolar. My father is schizophrenic. My son tried to commit suicide. This is happening. That is happening. And in a lot of communities across our nation, still folks aren't comfortable stating this disease or these diseases, and so the face of mental illness has no face yet. It has every face. I am mental illness. You are mental illness.

Alright, at some period in your life, you will be touched by somebody who has it or you may have something yourself that you will struggle with. And so when I was asked to come today, I was so excited, frankly, that this conversation was taking place, because as a street doctor – and that's all I am – I'm a regular old doc, most times in jeans and things like that. And I see folks who have insurance, who don't have insurance, who have stable homes, some who have no homes, the children of our country who have been thrown away and some who are well warmed and wrapped each night – like that. But when we talk about the face of behavioral health, I felt like I wanted to talk a little bit about my own family and our own history and just put a little bit of a period on the conversation. Because I know there are so many of you who sit here today who either are just finding your voice or may even feel intimidated to say something: What happens when your boss finds out? What happens when the professor finds out? What happens if you have to tell your university that you need three months off so that you can stabilize yourself? What happens when you enter the behavioral health home and somebody reads that on your medical record and suddenly believes that you're not qualified to do something you've been doing all your life? What happens with this?

So for me, let me say, my family is a family that has mental health issues throughout the family. My grandmother, who was put into a nursing home at 33 years old after walking out into the middle of the street pushing a carriage that contained my mother and pushing it in oncoming traffic, then pushed the carriage forward. My mother survived. My grandmother was hit by the truck and spent the rest of her life in a nursing home – because that's what it was called back then. It wasn't until we were grown that we figured out that she had actually been in a mental hospital her life after 33, never meeting the grandchildren that came from the baby who was in the carriage who survived the push. And then when I started medical school, I was lucky enough to be the first person in my family to graduate from high school and got into Georgetown University Medical School. And in my second year of medical school, I had noticed that my sister, who had helped me get through college – she worked while I got to go to college – that she was starting to drive in the car, and she would laugh out loud. Then I'd be like, What? I don't hear nothing. What's so funny? Like that, and she'd be talking to the mirror or having conversations, and she was perfectly happy. And in my second year of medical school, she had a psychotic break and moved herself and her children overnight from New York City to

California, thinking that Michael Jackson had called her to be in one of his records.

This is the face of mental health, and for me in that second year of medical school, it meant that flying back and forth to try to get my nephews out of foster care. Because, again, we don't think of mental illness as a disease – we think of it as something that is punishable, and so you take away the children instead of trying to reconnect them with the rest of the family. And then I remember walking the rounds, the wards of the hospital at Georgetown and having one of the attendings, who really cared about me and my family, come up to me, and he pulled me to the side, and he said to me, I need to tell you something, and when I tell you this, you cannot tell anybody else. And I promised I wouldn't tell anybody else, and I was devastated. I didn't know what to do, and he said, My son has schizophrenia, and he's in Italy. We sent him to Italy. No one knows. You cannot tell anybody about your sister. Just go on and graduate from medical school, and you will save her life. And I guess in a lot of ways he was right, but I, for one, want to stop hiding. I, for one, want to tell. And so out of the two children, my nephews, who we got out of foster care – and we were able to get my sister back here – I actually had to move from the District of Columbia to northern Virginia. Why? Because I was smart enough to do some research, and I

realized that in the District of Columbia at that time, if you had a mental illness, your mental illness was handled in the criminal justice system. While in northern Virginia, I could get my sister into community programs called the PACT Team, and there would be psychiatrists who could actually come out to the house and help us stay on medication. *Us*, right? I wasn't swallowing the pills, but she's my sister. And at 17 years of age her son, who had gotten out of foster care, was in high school in New York, when he suddenly he started to laugh out loud at stuff that we didn't hear. And shortly thereafter he was diagnosed with schizophrenia, and so I moved him with me to northern Virginia.

The Virginia congressional members may be concerned, [laughter] but one of the realities of families who face behavioral health issues is that you learn to do your research, if you're lucky and you've got the time, if you've got somebody in your family who's got the education to go online and find this stuff. It shouldn't be this hard, for anybody, and so my children grew up helping to care for their aunt and nephew, who didn't need much care other than they needed to be connected to a good behavioral health system.

When my nephew fell into the doughnut hole, and medications that he was taking stably for five years were cut off for 30 days, he ended up in the Fairfax County Detention

Center, and spent two years incarcerated because of $564 worth of medications that I would have easily paid for had I known. Instead his psychiatrist decided, Well, if it's not paid for by Medicaid, I'll just change it. The doughnut hole. And so my children grew up knowing what I knew, that we are the face of families who care about each other but aren't allowed to say anything in this country when we have these diseases. And when my daughter was 16 years of age, my daughter, who was a dancer, brilliant, straight-A student, doing great, went to New York to dance for the Broadway Dance Center. And I was here in Washington, D.C., seeing patients, and got a call at three o'clock in the afternoon that said, “Your daughter was seen getting into a limo in Brooklyn, New York, with all of her stuff, and she is missing.”

You may know the face of my daughter. My daughter was on the National Exploited and Missing Children's website for five days. If you lived on the East Coast, you heard of my daughter at 5 o'clock, 6 o'clock and 11 o'clock news. My daughter was found five days later because a lot of people helped to find this girl. She was taken to Mount Sinai and spent the next year stabilizing, with the diagnosis of bipolar disease.

In the first six months of that stabilization period, my daughter had another break, and we needed long-term

residential care, which as a doctor, I thought, Okay, whatever it is, I'll just work more hours – until I found out it was $12,000 a month, and I got three other kids. Geez. Like that. So luckily we lived in northern Virginia [laughter] where there was a program that you could apply to, a community mental health program, and we applied for emergency Medicaid, and this doctor's daughter got it and got six months' worth of long-term residential care, graduated from high school a year early, got her GPA back, and is in college right now.

The face of these illnesses are all of our face. And I'm going to just stop here and hopefully open this up to questions and things. But I just wanted us to not forget that when we see these staggering numbers, we're talking about real people, real families, right? And real everyday struggle, and for those of us who are part of this issue, who have these families, I just encourage you to speak. And I'd like to, before I close, just introduce you to my daughter. Here's Kai. [misspelled?? 01:00:55] [applause].

ED HOWARD: Wow. Thank you so much, Dr. Wilder. I don't know about anybody else, but I was stunned with the number of folks who raised their hands when Sam Donaldson asked the question about who had a connection. And of course I raised mine as well. And I guess we *are* the face of behavioral

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health – I have a niece who had a relapse last week and is in a rehab facility.

We have a lot of time for questions and comments, and you cannot be intimidated by asking any question after the presentations that we have had the privilege to hear. If you can either fill out the green card or come to one of the microphones, we'll try to get to you. Those of you who do come to a microphone, I would ask that you identify yourselves and be as brief as you can so that we can get to as many questions as we can, and I believe, Rob, you were first.

ROB MORRISON: Thank you. My name's Rob Morrison. I'm with the National Association of State Alcohol and Drug Abuse Directors. Thanks very much to the panelist, and I appreciate the tie wear at the end, Doctor [laughter].

Just a quick comment and a question under financing. I just wanted to add in the importance of the Substance Abuse Prevention Treatment Block Grant that wasn't mentioned, for the addiction side. That's about 40-percent of expenditures for state substance abuse agencies across the country and the majority of substance abuse prevention across the country for state substance abuse agencies. I mention this because Medicaid, as many of you know, either includes less than adequate coverage or no coverage at all for substance abuse in a number of states across the country. But the question is on

a growing problem of prescription drug abuse and misuse. And as we struggle with this in states across the country, is this an area that you've seen ripe for integration with primary care in particular – for example, medication assisted treatment, for one, or training, working with practitioners across the country. And I know a couple of you have some ideas or experience with this already.

Thank you.

ED HOWARD: Joe?

JOSEPH PARKS: No. You do well to mention the difference between the mental health block grant and the substance abuse block grant. In my state, the substance abuse block grant is important money, but it's not the larger part of our budget. The substance abuse block grant is one of the two backbones of the budget on the substance abuse side.

Regarding prescription drug abuse, I'm up to my ears in it in clinic every day, people coming and asking for stuff. It's really tough to figure out who's trying to do diversion and who really needs treatment. It would be much easier if I had more substance abuse treatment capacity integrated in my primary care practice. You know, I'm at a primary care practice, but we don't have substance abuse counselors, and that would have helped me a great deal.

Regarding medication assisted treatment, it's under-prescribed both on the primary care side and on the psychiatric side. The primary care docs keep on thinking the psychiatrists are doing it; the psychiatrists keep on thinking the primary care docs are doing it. And as a profession, we have not clearly come to the realization that both of us are up to our ears in people with substance abuse, and if we're not going to treat it, it's going to come back in the office door anyway. It's sorely needed. We need more initiatives in that area.

ED HOWARD: Yes, go ahead, Sam.

SAM DONALDSON: And that's why I wanted to reinforce that the solution really is IT. We've got to have electronic health records, where providers can easily see the whole treatment that's going on with any, particular Medicaid, recipient, and I think that really is the solution. We're starting to get our arms around the kind of prescription abuse.

Too often our industry – and a psychologist, we've separated ourselves differently behind the cloak of confidentiality. And as a result, we've not been integrated with the entire system. So I think it's important really to look at the advances in IT and electronic health records.

JOSEPH PARKS: Second his point on IT. We send a couple thousand letters every month to doctors, suggesting how

they could prescribe better, and usually they complain that we shouldn't meddle in their decision. The ones they like are the letters where we point out that their patients are getting multiple controlled substances from other prescribers other than them. That's a very popular use of IT as analyzing the claims and letting them know when they're going to six different pharmacies and ten different docs.

GLORIA WILDER: Let me just say I think that's a critical point is the claims data, not just the integration of IT where we read each other's notes. As a pediatrician — you're right. If we don't see the claims data, we don't start to see all of the vendors that are prescribing to our patients, we really can't help to help them manage their own care.

The other thing that I don't want us to lose sight of is HIPAA issues around the mentally ill. We really need to start looking at HIPAA and the gaps of HIPAA, where there are certain times where family members with certain diagnoses should be encouraged to pick somebody to be their advocate for the long run and go through the court system, or whatever system we need to do, early on in the treatment plan with the behavioral health home, so that you don't have folks falling into these gaps simply because the provider can't talk to the family.

ED HOWARD: Can I just follow up with these comments, because Dr. Wilder raises the privacy question, and there are a lot of consumer advocates who are very concerned about the implications for privacy of widespread availability of electronic health records. It isn't as if we don't read every week about a hundred thousand records being stolen on a laptop. And I wonder, particularly when we have been quite straightforward in acknowledging that the stigma that it still attaches, how you deal with privacy in this context, which it seems to me is probably even more sensitive than the more general questions?

Go ahead. Yes, Dr. Donaldson?

SAM DONALDSON: I think that privacy in some ways is going to kill our seriously mentally ill, in the sense that these electronic health records do not have detailed notes of conversations, what therapists are saying. They really are focused on medications, treatment, diagnosis, et cetera. The rest of the medical industry shares this information, works together, and works effective. And I understand very much – this is where I'm not going to be politically correct – what the advocates are fearing, but I also fear on the other hand that we're basically going to let a lot of people die behind that cloak, and we do need to work on stigma.

MALE SPEAKER: So let me just add to that. I know Al's chomping at the bit to ask a question there, but –

AL GUIDA: Don't worry about it.

MALE SPEAKER: One of the things that we do need to pay attention to is 42 CFR, especially as it relates to individuals that have substance abuse disorders. And while I think it's a terrific law that really does protect some good information, what we're finding, especially in these integrated care models, how challenging in some respects 42 CFR can be, at least for the front-end purpose: examples being, if we're trying to create accountable care organizations, or we're trying to create other types of organizations that really are supposed to work at integration, trying to get some of the information out of the claims files into the hands of the ACOs is a challenge. And so they're only getting part of the picture, and we understand they're only getting part of the picture, but they're saying, What should we be paying attention to on the substance abuse side based on who's going to be in our accountable care organization or in our primary care medical home. And we have to be theoretical about it more so than specific about it. And so it's this good but tough balancing act we have there.

ED HOWARD: Okay. Yes, sir?

AL GUIDA: Yes, hi. My name is Al Guida. I'm with Guide Consulting Services. I represent the National Council for Community Behavioral Health Care. We say that's Latin for community mental health centers, and just a comment for Dr. Donaldson and then a question for John.

The legislation that Dr. Donaldson was referring to in his presentation that would include behavioral health providers in the HITEC Act is the Behavioral Health Information Technology Act, S.539. It is a bipartisan piece of legislation under the leadership of Senator Whitehouse and Senator Collins, and if your bosses have not cosponsored, we hope that they would. And then, John, I'm wondering whether you could talk a little bit about the SAMHSA Primary Care Behavioral Health Integration Initiative. That program was started under the leadership of Senator Jack Reed and Senator Harkin, and it attempts to provide some primary care capacity in community mental health centers. And then I'll sit down and take the response.

JOHN O'BRIEN: I'll try not to speak for SAMHSA, but I don't know if Trina Dutta is here, but Trina Dutta from SAMHSA is the project lead for the Primary Care and Behavioral Health Integration Project. I think that at last count, if I haven't erased most of my memory banks, we're up to about 62 or 63 agencies throughout the nation, most of them mental health and

I believe mental health and substance use organizations that were partnering with primary care, often times at federally qualified health centers, really to implement good models of integration for individuals with serious mental illness or individuals that have co-occurring serious mental illness and substance use disorder.

I think we're now approaching three years, and while I think we're having some good data come in, we are seeing a couple things coming out of that. One is that there is a much stronger relationship between primary care and behavioral health than there was in the past in some of these communities, and so we think that that's really important. And, second, we're beginning to see that certain health indicators are improving in some of these individuals, and in particular as it relates to cardiac issues and blood pressure issues. I also think that there's an amazing opportunity here to also address some of their smoking because that was part of the focus of some of the money that the projects got, because a significant number of these individuals are cigarette smokers, and we know the damage that can do both to their current health and also their morbidity.

There's also another a part of that program that is a grant to the National Council to draw technical assistance to those organizations and was also providing and may still be

providing some technical assistance thankfully to some of the states that were participating in the CMS health homes. So I think that's the extent of my knowledge on that.

JOSEPH PARKS: That's a good point, John. That's the Center for Health Integration Strategies. You can all find that on the National Council website. They've been key not just on the CMHC integration grants themselves but also on helping health homes, states interested in that and on integration in general. It's been a wonderful resource for the field where it wants to move forward.

ED HOWARD: Yes, go ahead.

ANDREW KESSLER: Good afternoon. My name is Andrew Kessler, here today on behalf of the International Certification and Reciprocity Consortium, which is responsible for the certification and testing standards for over 45,000 substance abuse counselors both in the United States and worldwide. My question is for Mr. Donaldson, and it's kind of a layered one: When I heard you mention workforce, I became excited that you consider that a key issue. But then you focused only on psychiatrists, and the number of people who receive care for mental health and substance abuse that are treated by a psychiatrist is microscopic. Those who receive care, if they can get care at all, are usually treated by a counselor, whether it be a substance abuse counselor, mental

health counselor, licensed profession counselor and so on, and these counselors are the bulk of the workforce that handle the people with mental health diseases and the disease of addiction and substance abuse disorders.

I know that John O'Brien is familiar with the work of counselors and Mr. Parks, in his answer to Rob Morrison's question, mentioned substance abuse counselors. So I'd like to hear from you –

JOSEPH PARKS: And I'm married to one. [Laughter].

ANDREW KESSLER: There you go. So bonus points. [Laughter]. I'd like to hear from you, Mr. Donaldson, what you view as the role of counselors in the integration of behavioral health and to primary care and how they can possibly work with psychiatrists, and how we can encourage more people to become counselors and to enter this workforce.

SAM DONALDSON: You raise an excellent point, I certainly didn't mean to omit. The reality is that we would be nothing without the counselors and our provider network. We wouldn’t have anything to sell as a managed care company, and we wouldn't be effectively treating people.

First of all, I think there's a perfectly appropriate role. We have counselors in all levels, from marriage and family to substance abuse certified counselors, et cetera, and we make extensive use in our treatment and behavioral health

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delivery system. My concern is that with health care reform, we're going to be having a huge influx of people – and I think that's appropriate. I want you to understand that my position is, I do believe everyone should have access to health care in this country, but my concern and my fear is where are we going to get all the trained counselors to do this job. And so that is something that I don't have an easy answer for. I doubt that our government has an easy answer for but something that we have to focus on. And really, we use paraprofessionals. We use peer specialists. Peer specialists are people who are in recovery from either a mental illness or a substance use disorder, and we use them to support people in the community, as well. So we use professionals and paraprofessionals. But, yes, I agree. They are the backbone of this system, and we've got to get more of them. And I would also like to add that I would like to see, again, community mental health centers become the behavioral health home and home for the seriously mentally ill and for counselors to work directly with the physicians there. And I think that hopefully gets to some of your points and comments.

ANDREW KESSLER: Thank you.

SAM DONALDSON: Thank you.

ED HOWARD: Go ahead.

DEANNA OKRENT: I just wanted to mention there were actually two questions on green cards that you sent forward that are related to workforce issues as well, and while we're on that topic I wanted to put these in the mix. One questioner asked specifically asked about ER staff because one of the things we talk about is how many folks present to emergency departments and how expensive that type of care is, and you're talking about integrating care. Are the emergency room physicians, nurses, what have you, trained to pick up on behavioral health issues and not necessarily just have folks in the medical, physical side of the system? And the other in relation to workforce focuses in a little bit about primary care, which we've been talking about a little bit. But we've also heard something about – you mentioned telehealth – how telehealth is actually being used to – or telemedicine – is being used to train primary care providers, so that psychiatrists that we have a shortage of, based on some things you've been saying, are actually helping primary care providers, especially in rural areas, serve the needs of that community by helping them recognize some of the issues that are presenting.

So if you want to comment about those two things.

ED HOWARD: John, you look like you're ready to comment.

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JOHN O'BRIEN: Yeah. I will comment on those two things or some of those two things. I also just wanted to just do a follow up to the last person and say that we're really concerned. CMS is really concerned in a good way about 2014 in terms of the numbers of individuals that are currently not Medicaid eligible that will become Medicaid eligible that have mental health but more importantly substance use disorders. And so we are looking for all smart thoughts both at the federal level and the state level around how can we make sure that as we get closer and beyond 2014 – we know we're going to have access issues, but how can we minimize those access issues?

Some of it, frankly, at the state level is going to be conversations with your licensing and certification authorities in those states with the Medicaid agencies who have to know what the scope of your practices are in order for them to wrap their brains around coverage and wrap their brains around practitioners. So that's one thing I did want to add.

There's probably other people in this room that can speak much more eloquently than I can about this, especially as it relates to the emergency room issue. On the mental health side, I have seen some really creative ways, in a good way, of how emergency rooms have retrofitted and/or had personnel to be able to deal with psychiatric crises, I think, in just

exceptional ways, in order to either avoid hospitalization or to minimize the length of hospitalization. And some of it was, again, integration, making sure that there was someone on their staff that understood a variety of issues around emergency psychiatric interventions of medications, so that it was that person's responsibility to educate the team, regardless of who was on that shift that night.

On the substance abuse side – and I know, again, maybe someone like Mady could talk a little bit about this – but to the extent to which a quick screening and maybe some brief intervention or other types of training for those individuals and for the docs and other professionals in the emergency room have worked and worked well. And so I think that there's pockets of excellence out there that need to be looked at and expanded upon.

I will admit that I am not the most astute on rural and telehealth issues. So if there's someone else on the panel, I'll let them talk about that.

GLORIA WILDER: I'd like to make a comment about both use of counselors, other allied health professionals, and mental health professionals. I think as a nation, we have to decide how we value things, what the reimbursement is. And right now in the field of mental health reimbursement for the M.D. is much higher than it is for everybody else, and we've

got to start looking at where revenue is going and how is it getting to the state level and the city level, county level. And I also think the associations and the bodies that certify mental health professionals have to be willing to take responsibility for that certification, and what I mean by that is, you can't always say you've got to have the M.D. bless everything that the counselor is doing. There needs to be some things that the counselor does or that the therapist does that they just do on their own, because we know they're qualified to do it. And until you disassociate those two things, and that's what a true behavioral health home does, works with primary care, but primary care doesn't necessarily – the M.D., Dr. Gloria or the internal medicine doctor, doesn't have to be in charge all the time. Sometimes we need to be second in command.

ED HOWARD: Okay. Yes, go ahead.

KAIT ROE: Hello. My name is Kait Roe, and I'm a newly transplanted D.C. person. I'm transplanted from Maine, which actually has some pretty good behavioral health integration attempts going on right now. I've been working, just before I moved, with the HIE, trying to work on how do we move the information for behavioral health into physical health, and one of the things I said is, You've got to stop calling them different things. The number one thing is, it doesn't matter

what they are, where it is happening in your brain. It's an illness, and I don't think we're ever going to get parity if we keep calling it something different. It's how humans think. It's how we process information. So the first thing we need to do is stop calling it behavioral health, because basically everyone thinks that we can fix it with our behavior if we only just try hard enough.

I am a lifelong sufferer of major depression and PTSD and generalized anxiety disorder. I am also a 25-year sober ex-alcoholic. I spent an incredible amount of time struggling to work the system so that I could get the services I need, and, frankly, Mr. Donaldson, I'm really happy you don't practice anymore, because I would not be able to work with you. I felt really patronized by some of your conversation and how you describe the people that you purport to care about. And I just need to let you know that, because if you're sitting in a room full of patients, they're going to feel really, really not okay with that. It's something you can change. It's something I hope you will change, and I hope that you take this kind of critical advice and say, Wow, maybe I should invite some patients into my boardroom so they can hear what we're doing.

The next thing I wanted to mention, and I'll wrap it up, is the conversation we're having about emergency departments and health IT, and can we just get this information

for these people. One of the dangers and one of the fears of the advocacy community is that when we go to an emergency department, the moment they read “mental illness,” suddenly our physical illnesses don’t matter. They don't count. We must be psychosomatic. And what I've experienced and what I've heard experienced is that suddenly we could die on the table from a burst appendix because we're imagining the pain. It happens. It's real. And until we start training docs differently and getting real-time conversations happening with emergency departments around discrimination and mental illness, this isn't going to change, and people are going to continue to be afraid to share that information.

I work really hard in both the physical and mental health sides to get all data integrated, all data accessible, but it's not just about getting what we're paying for. It's about making sure that what's in the data is correct and true, and so I also urge you to think about patient portals. What can patients offer? How can we make sure that we're as empowered as we can be in this process?

And I really applaud all of you for showing up and suiting up. And Dr. Wilder, I thank you for sharing your story because it brought back why we're here, and I, again, thank you all for your time and your energy and hope that I can help if you'd like. Thanks.

JOSEPH PARKS: I love your point about getting a patient portal up. We've been running a claims driven electronic health record in Missouri for about seven years and where the providers could get access to all this information. About a year ago, we stood up a patient portal, where they could get the same information and make some priority lists about what they wanted to talk about next. We did it because we wanted to empower them and it was the right thing to do. Frankly, we had a second hope is that they'd go talk to their doctors about what we thought the doctors should know about, too, because doctors don't always follow all this administrator stuff, and we need our patients' help to get the doctors to do the right thing.

SAM DONALDSON: First of all, to the person that was talking, I want to congratulate you on successful recovery. It must have been a very long and hard road. I am always willing to accept criticism. I want you to come get my card, and I'd like you to send me the specifics of where you heard that patronizing, because I'd be horrified if that ever came across that way. I'm also in successful recovery from major depressive disorder, moderate to severe. I've struggled with it all my life. So I do know what that's like. And in terms of the boardroom, we have a NAMI representative that sits on my board of directors and is a voting member.

KAIT ROE: [Inaudible] the patient. NAMI is not only the patient [inaudible] family. And I would like to have both sides of that conversation.

SAM DONALDSON: What I don’t want to see happen, kind of like what happens in our Congress, is we've got family advocates pitted against consumer advocates, and I don't think there's any need for that. So I feel like NAMI does an excellent job in terms of what it does and its advocacy, and really believe a lot in that organization. And I appreciate your comments.

ED HOWARD: I don't want to cut this conversation off, but maybe you can do it offline so we can get to some of the other questions?

KAIT ROE: Sure.

ED HOWARD: You bet.

RON MANDERSCHEID: I'm Ron Manderscheid, the Executive Director of the National Association of County Behavioral Health and Developmental Disability Directors and first want to thank you for this presentation, which I think is tremendous. We need to be doing many more of these types of presentations here. Secondly, I want to raise two concerns. It's one thing to talk about those who have access to insurance and having difficulty getting care. I want to talk about two groups who are excluded. The major portion of people with substance abuse

issues, in fact, do not have access to Medicaid. If you actually look at the prevalence of mental illness and substance abuse in Medicaid, the prevalence in mental illness is 12- to 14-percent. The prevalence of substance abuse is 1 percent to 1.5 percent, because the latter group has been systematically excluded since 1998. So we need to look at our regulations and our laws governing that particular population, which has been systematically excluded.

Secondly, a second population of great interest is the incarcerated population that was also raised in this presentation. Tonight there will be 800,000 people in the county jails of the United States. 600,000 of those people will be people who either have a mental illness or a substance abuse condition. None of those people currently is eligible for Medicaid reimbursement for their care. Therefore, they either need to be moved out of the jail into an inpatient setting to get access to care or probably get a reduced level of care because the counties don't have the resources to staff the county jails appropriately. So I want to put both of these populations on the table as concerns going forward, both here on the Hill and also for the field, because I don't think we frequently talk about that. Thank you.

ED HOWARD: Why don't we add one question to that bundle and that is, will any of this change if the ACA is fully

implemented in 2014? In other words, will Medicaid eligibility as it's extended in the ACA pick up a lot of the folks that the gentleman was referring to?

JOSEPH PARKS: The expansion population will have a large representation of people with substance abuse needs and then who have mild to moderate mental health problems. It will do nothing to address the lack of benefit support for people in county jails. That remains a substantial policy problem, but it would really substantially fix — If there is parity on the substance abuse side and mental health side, it would substantially fix the lack of coverage for – particularly the men with mild to moderate mental illness and substance abuse.

ED HOWARD: Further comments, John?

JOHN O'BRIEN: I do. I mean, that was some of my questions – my response to the credentialing issues, which is that we do know and we do have some good data that the number of people that are going to be participating in the Medicaid expansion group that have a substance use disorder is anywhere between 15- to 25-percent. And that's probably an underestimate, because we don't have exact data. And I think that's one of the things when I was at SAMHSA, and, frankly, at CMS, it keeps you up at night, because we know that is going to be a group of individuals that's going to hit our system, and we need to be prepared for it.

I also want to reiterate right now, there are many youth with Medicaid with substance use disorders who have eligibility for Medicaid or, frankly, for private insurance, and we don't have the benefit for it. And so to the extent that there can be some thinking and some advocacy in that area and mostly at the state level, I think that would be tremendously helpful.

ED HOWARD: Yes?

RAFAEL SEMANSKY: My name is Rafael Semansky. I'm a health care consultant. I wanted to ask Dr. Parks a little bit more. It's great to hear that your state was able to do something proactive in terms of looking at the population with both physical health and behavioral health issues, and if you have any thoughts or suggestions for other states that want to implement innovative programs such as yours, what would be three or four of the key things that they should keep in mind in doing this, so that it does improve health care quality and also provides in savings?

JOSEPH PARKS: The key things that moved us forward was first we started looking at our data, and we started basing our discussions on data as opposed to anecdotes about who had some policy the other party at the table didn't like or who was being mistreated. Looking at the data early and having people that can cut your data and asking questions of it was key.

The second thing that helped us in deciding to move forward was coming to a culture of where we attended to the other party's problems as much as our own. We used to have a lot of infighting between our FQHCs and CMHCs and between DMH and MIMH. That's because we would go to each other and whine that we had needs that weren't being taken care of that were really important. That doesn't usually work when you're starting a new relationship, and it didn't work bureaucratically either, and so it's getting to a policy or a culture of trust in taking care of each other's needs between the agency advocacy and bureaucratic players.

The thing that really helped us change the CMHCs were adding nurses. There is a culture. We all get cultural training, and there are professional cultures. Psychologists, if they don't know what to do, measure things. Social workers, if they don't know what to do, affiliate. Doctors, if we don't know what to do, we take action. Nurses, if they don't know what to do, they form a committee, write a policy, and nag each other to follow it. They're great for implementing stuff. [Laughter]. So there's my three top tips. [Laughter].

ED HOWARD: Yes, go ahead.

MADY CHALK: I'm Mady Chalk. I'm Director of Policy Research and Analysis at the Treatment Research Institute. A comment and a question. While we're talking about privacy

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issues in HIT and HIPAA and 42 CFR, keep in mind – and I will ask that HHS, any of you who can talk with HHS, pay some attention to the fact that it continues to be an issue that if a treatment service for substance use disorders is provided to a patient, and it is in their record – they are very likely to not be able to get life insurance, health insurance for their employees if they own a firm, a company, and they are not likely to be able to get any other kind of insurance. There are health care organizations in this country who are doing beautifully well with 42 CFR and HIPAA and who are providing top-notch services for substance use disorders, among them Kaiser Permanente, and have seen the impact of putting it in the record that a person received a service – never mind a diagnosis, a service with a label of substance use disorder of any type whatsoever, and thereafter, that person was not able to get life insurance and a variety of other insurances. I would just ask that some attention to be paid to using the federal bully pulpit to addressing that kind of an issue, because I think we need more of that. It cannot simply be left at the advocacy level for patients to talk about.

ED HOWARD: John, do you have anything to say about that?

JOHN O'BRIEN: Well, I think Mady said it quite nicely. And part of it is, I think, us at HHS being very clear about

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what the policy is, and making sure that as we begin to roll out these programs that whether they're accountable care organizations or primary care medical homes or whatever we want to call them, that they understand both what this law means and at the same time how to be effective in terms of how they treat that information, because you're right. There are some good ways to be able to do this. And what we've seen is either systems freeze and say, We're not going to do anything as it relates to substance use disorder because of 42 CFR. Or we've seen systems be very [inaudible] about, this is how we're going to go about really protecting that confidentiality in a very smart way.

JOSEPH PARKS: I'd like to make two comments on this. First, this is something the ACA would help with on the medical insurance side. If it goes through its "no preexisting disorder," you have to get an offer in its community rating, if that part holds past the Supreme Court. Second, on the life insurance side, what you say of substance use disorder is true of every chronic medical issue: You can't get life insurance if you have cancer or [inaudible] diagnosis, even if it's been cured ten years ago. You can't get life insurance with diabetes. The issue is the way they rate life insurance, and the answer is not to treat substance abuse different than you

would any other serious chronic medical illness and hide it under the carpet when we don't hide the others.

ED HOWARD: Okay. I think we do have time for the folks who are standing at the microphones, and actually, though you're one and they are two, I think they were in line first.

MALE SPEAKER: Yeah, I think you were ahead of me actually.

ED HOWARD: Yeah, alright.

JENNIFER PAUK: Hi. My name is Jennifer Pauk. I work for the Primary Care Coalition in Montgomery County, where I'm the Director of the Montgomery Cares Behavioral Health Program, and we integrate teams of behavioral health providers into primary care settings. And I wanted to comment that today you spoke a lot about health homes, which is mostly focusing on the severely mentally ill population, and the benefits of integrating care for them in a variety of settings, and I fully support that. What I didn’t hear, though, is much about the models of integration and the benefits of integration in primary care settings for the entire population. The chronic mental illness population is probably about 5-percent or less of the entire population. Whereas we know 50-percent of the population will have a mental health or substance abuse disorder, 45-percent of them are receiving their care in primary care settings. I've been a little disappointed in the

last few years that most of the focus now is on the severe mentally ill population and not the general population. It turns up early identification, treatment, and resolutions of problems before they become chronic and mental illness and substance abuse problems. Could you speak about that issue?

JOSEPH PARKS: I can say a few words about what we're doing in Missouri with the primary care health home model we have. The parts that are about integration there are, all of them get funding to add a behavioral health consultant that is, in part, expected to do part of their time doing the Cherokee model, which intervenes on behavioral aspects of chronic medical illness as well as identifying mental illness itself. They all have to implement a brief screening for substance abuse, alcohol, and tobacco, with interventions that John spoke of, called SBIRT. They have to do depression screening, and they have to do mental health items on the child, early periodic screening disorder, the EPSDT screen. They get extra resources for the SBIRT also, and we appreciate SAMHSA allowing us to adapt our SBIRT grant for that.

So the behavioral health person is doing both substance abuse and mental health and also behavioral aspects of primary care. We're very excited about going forward. They have 80-percent the same performance indicator set as the CMHC health home. So both of them have to attend to medical stuff and

behavioral health stuff, and I apologize for not flushing that out more previously.

ED HOWARD: Yes? As we go to these last two questions, I would ask you to listen to the questions and the answers to the questions as you fill out the blue evaluation form. [Laughter]. Yes?

JOHN CUSTER: Hi. My name is John Custer. I'm with ML Strategies, which a consulting arm for government relations of Mintz Levin's law firm. My question actually kind of falls in to a little bit of what we're calling things, the definition of things aspect that was just brought up in a previous question and comment. From a pathology standpoint, disease is generally defined by signs and symptoms combined. A lot of times, with mental illness they're symptoms but not necessarily signs, meaning that if you are sick and you're throwing up, and then they find that you have a tumor that's cancerous, generally the diagnosis would be cancer – the throwing up came from the cancer. Whereas with mental illness, if you're anxious or depressed, there's not necessarily a tumor or a brain lesion or anything that always can cause that. It can be emotional factors, things like that. So do you tend to find that that sort of deviation in the pathology definitions is part of the reason that stigma is caused? And this maybe an interesting debate between the medical doctors that we have the PhD doctor

that we have up here. And then I guess my second part of that question is, it was stated that 50-percent of the population now may experience mental illness over the course of their lifetime. I believe it was in the 1960s or -70s that that figure was actually said to be 10-percent. Do you think that we are having more instances of mental illness, or we're just noticing it more at this point in time? Thank you.

JOSEPH PARKS: That's a way cool question [laughter]. [interposing] I think the percentile has gone up in a large part because stigma is down. I think stigma is more due to things people don't understand and feel helpless about. Remember how stigmatized HIV was before we thought we had effective reasonable treatments and how much less stigmatized it is now? The biggest change in stigma that happened with mental illness were the SSRI antidepressants in general and Prozac in particular. That gave everybody the message that treatment is available and effective, and that's when stigma goes down. So I think that's been the bigger issue of driving stigma is, mental illness, traditionally people have felt helpless, felt there weren't treatments that helped and didn't know what to do, and when we're in the face of something like that, we push it away from ourselves.

There is a real lack of what you refer to as signs, which are objectively measurable things of mental illness. In

part that's a problem with how we do our evaluations. Cognition is the major example. Most of us test cognition by asking you to spell a word backwards and subtract sevens. It's dumb. It's loose. There are very nice HIT tools that can do standardized testing that generate statistically reliable reports on your concentration, your memory, your response speed, and the extent to which it is either changed with the treatment. And those are available right now, but they haven't been implemented everywhere. Those are my thoughts initially.

JOHN O'BRIEN: And what's really cool about that question is, in the past five years, what we've discovered as – we used to believe the brain developed over so many years, and then it was kind of fixed. Now we know that the brain constantly changes, including the receptors, the pathways, the level of neurotransmitters, and are affected by things such as your relationships, your lack of relationships. The things that you do in life constantly are rewiring your brain. So we are really digging into looking at the brain and some of the PET scans and other research where we can actually show some of these disorders. There's a lot of research that's showing that you can actually pinpoint and see the problem.

MALE SPEAKER: I think that's it.

GLORIA WILDER: I'm just going to give you my politically incorrect answer. Let's not get lost in the

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minutia of terminology and whether a sign is there or a sign is not there. For most of the folks that we're talking about, if you simply believe your patient, if you just sit with your patient and you're listening to them and you're listening to their family and you're listening to the experience that they have at that moment, then just like every other part of medicine, which is this much science and that much art — like every other part of medicine, the treatment plan is one that comes about organically through conversation together. It's not about us saying, This pill works on this day, and we've got to do an EKG, and then we know that the pill is working. And I think as a provider who's on the ground – I saw 30 patients yesterday and I'll see another 30 tomorrow — I would say the struggle that we have with our mental health colleagues is that the disenfranchisement around reimbursement creates a lack of ability to collaborate together. And what I mean by that, the psychiatrist for a 19-year old girl that I saw yesterday – I see this girl every single week, right? I don't see her every single week because she's sick physically. I see her every single week because she comes by because she knows my daughter has bipolar. She has bipolar, and I talked about it during the first visit. So she comes by and just talks. And what I've gotten from her psychiatrist, who she only went back to see six months after talking with me, because I told her, You really

got to go get your medicine. You got to. Let's start working on this. What I got back was a request for an EKG that she doesn't need. I said no. She's seeing him now, and she's getting some treatment, and that's the good news. And she came yesterday with her bottle of pills to announce to me that she's doing this, and she's going back to school, and her three-year old son is fine – he's not going to be taken away and all that kind of stuff. But, again, let's not get lost in whether I'm the medical provider and you're the behavioral health provider. In her life, we're her team. We're the background of her foreground, and so, again, I get frustrated with some of the dialogue that happens to us nationally, because we really do forget that these are lives that are being lived every single day, and that the clock ticks.

ED HOWARD: I don't know how else – how more appropriate we could find to end the discussion than on that note. You want to throw that slide up there? That's the one, yes [laughter]. So I won't have to tell you orally anymore to fill out the blue evaluation form. I do want to thank you for being so active a group of participants in the conversation that we've had today. I want to thank the Centene Corporation and the Cenpatico company as well for their contribution to both thinking through this program and cosponsoring it, and I want to ask you to join me in thanking the panel for one of the

most thoughtful and moving conversations that we have had in a very long time. [Applause].

That was tremendous. Thank you so much.

[END RECORDING]