FOURTH EDITION

TRENDS IN BEHAVIORAL HEALTH

Brought To You By: Otsuka

Volume 3

Population Health Management & Service Innovation

FOR CONSUMERS WITH BEHAVIORAL DISORDERS

A Reference Guide On The U.S. Behavioral Health Financing & Delivery System

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TRENDS IN BEHAVIORAL HEALTH
Executive Summary

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Health Plans Driving Change in Behavioral Health Systems

Health plans command a unique position in the American healthcare marketplace. As business managers for insurance product lines, they exert great influence over payments, benefits and services delivered to enrolled members, including individuals with mental health and substance abuse conditions. Health plans can control access to behavioral health through network design (open vs. closed provider networks) or structure payments in a way that incentivizes or de-incentivizes certain services or procedures.

Health plans also operate as change agents, introducing new technologies and business practices that improve care delivery, or implementing new laws and programs to achieve desirable health outcomes. The Affordable Care Act of 2010, for example, required health plans to adopt minimum “essential benefits” including coverage for mental health and substance abuse disorders. It also leveraged the health plan role to support innovative medical and behavioral healthcare delivery methods designed to improve the quality and lower the costs of healthcare for Americans.[1]

While most Americans receive their health insurance in private employer-based plans, significant numbers are covered under various public programs established to ensure access and coverage to behavioral health services for vulnerable segments of the population. Chief among these are Medicare—the federal healthcare program for older, blind, and disabled populations—and Medicaid, the jointly operated federal/state program providing coverage and services for children and adults who meet certain income eligibility requirements.[2]

1. Executive Summary *Continued*

In 2022, roughly 61.6 million Americans are enrolled in all of Medicare, and 88.5 million receive coverage through Medicaid and the Children's Health Insurance Program (CHIP).[2,3]

To extract the greatest value for tax dollars invested, public behavioral healthcare programs are increasingly leveraging the role of private health plan businesses to operate their programs. Medicare Advantage, for example, in 2022 covered 31.1 million Americans through private plans that serve as an alternative to traditional Medicare.[3] In the Medicaid program, most states adopted a managed care business model to oversee behavioral healthcare service delivery and operations within their jurisdictions.[4]

These widespread movements to privatize government-funded behavioral healthcare systems present multiple opportunities for health plan innovation to improve access and the quality of care to recipients with mental health and substance abuse conditions.

1.a. The 2023 Survey On Health Plan Innovations In Behavioral Healthcare Service Delivery & Additional Research

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This reference guide on the U.S. behavioral health financing and delivery system is partially created from research across the industry and an original survey.

In 2023, Otsuka commissioned a survey designed to capture how health plans are innovating within their contracted programs and networks to improve healthcare quality and reduce disparities in access to care within behavioral health systems. The survey also identified targeted plan initiatives to meet the needs of the most vulnerable populations receiving behavioral health services.

The survey data is referred to in the *OPEN MINDS* Market Intelligence Payers Proprietary Database.[14]

1.b. Percent Of Americans By Type Of Healthcare Coverage, 2018-2022[2]

% of U.S. Population

	Employment-based	Direct-purchase	TRICARE	Medicare	Medicaid	VA or CHAMPVA	Uninsured
2018	55.1	10.8	2.6	17.8	17.9	1.0	8.5
2020	54.4	10.5	2.8	18.4	17.8	0.9	8.6
2022	54.5	9.9	2.4	18.7	18.8	1.0	7.9

*Chart does not total 100% as individuals can have more than one type of insurance coverage.

While most Americans are covered under employer-sponsored health insurance plans, significant numbers receive coverage through public insurance programs such as Medicare and Medicaid.[2]

1.c. Growth Of Managed Care As A Health Plan Business Model, 2017-2022[4]

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	2017		2020		2022		% Change (2017-2022)
Medicaid Enrollment By Coverage Type*	Enrollment	%	Enrollment	%	Enrollment	%	
Total Number Of Medicaid Beneficiaries, Including Expansion Population	87,342,468	100%	86,975,312	100%	95,135,042	100%	9% ↑
Fee-For-Service (FFS)	16,334,072	19%	11,931,880	14%	17,784,506	19%	9% ↑
Comprehensive Managed Care	65,172,524	75%	67,824,128	78%	73,335,808	77%	13% ↑
Primary Care Case Management (PCCM)	5,835,872	7%	7,219,304	8%	4,014,728	4%	-31% ↓

*Enrollment totals may vary, due to inconsistency in State and CMS reported data. The programs listed do not encompass every program offered by Medicaid.

1.c. Growth Of Managed Care As A Health Plan Business Model *Continued*

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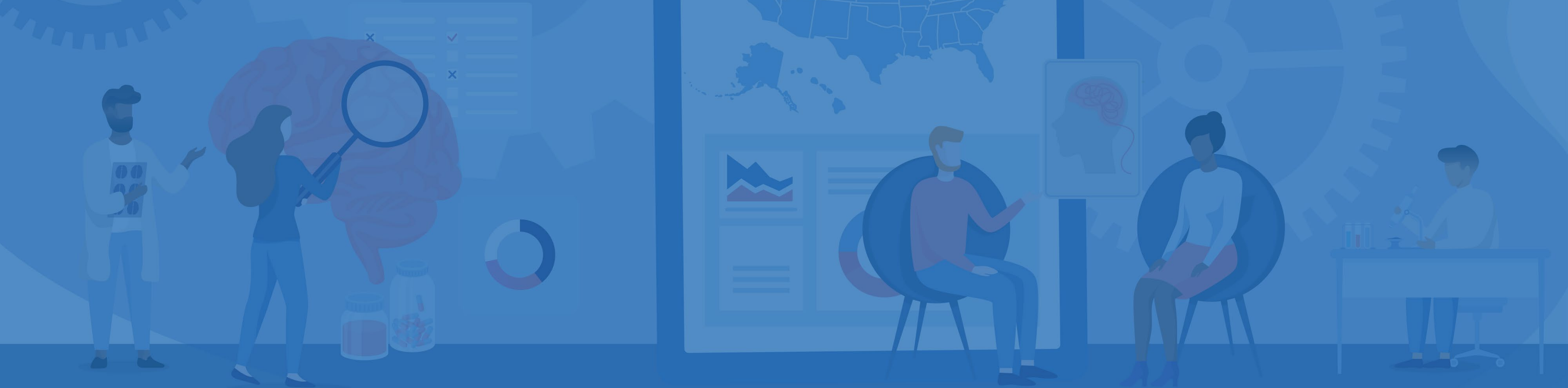
- In 2022, 77% of recipients were served in managed delivery systems. Fee-For-Service (FFS) healthcare programs still account for one in five (19%) of Medicaid recipient services.

- States with the largest proportion of their Medicaid population in managed care are Connecticut, Hawaii, Nebraska, Pennsylvania, Tennessee, and Vermont at 100%; states with the lowest proportion of Medicaid population in managed care are Alaska and Wyoming, both at 0%.*

- States with the largest swings in managed Medicaid penetration between 2017 and 2022 include: Arkansas (-62%), Florida (+44%), Maine (-54%), New Hampshire (+58%), New Mexico (+89%), North Dakota (-64%), Wisconsin (+43%) and Wyoming (-100%).*

*See *2023 Trends In Behavioral Health. Volume 2. The State Behavioral Health Landscape*.

Quality



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Major Health Plan Innovations To Improve The Quality Of Behavioral Health

Advancing Integration Of Care

Integrated care is a way of organizing fragmented services and silos of care to deliver a more whole person care approach.[5] Integration addresses how services and organizations are structured to improve access and promote communication. Common examples include Patient-Centered Medical Homes, where multiple disciplines work on a single healthcare team, or primary care providers co-located within a mental health agency.

Increasingly, health plans themselves are integrating by assuming full risk for all care across medical, behavioral health and pharmacy services. More states are requiring their Medicaid plans to absorb the costs of all three domains, and fewer are carving out behavioral health into its own management entity.

Integrated care is also associated with new technologies that improve care coordination and identify patients needing more intensive supports, as well as payment models that shift the focus of service delivery from paying for doctor visits to paying for health outcomes.

Improving Coordination Of Care for Complex Members

In 2019, 5 percent of persons accounted for almost half (48.8%) of all U.S. healthcare spending.[6] Efforts to control those costs center on bridging the gaps between the delivery of medical and behavioral health services through care coordination programs for members with greater needs.

Many health plans operate care management programs that use claims and other datasets to identify patients that would benefit from personalized follow-up to help manage medications, appointments, and other self-care activities within their home. Care managers are an extension of the healthcare team, providing additional support to address chronic conditions.

Other initiatives target the highest cost and highest risk patients: designing a special team to focus on reducing hospital readmissions or diverting behavioral health emergencies to specialized mental health settings and away from general emergency departments.

2. Quality *Continued*

Targeting Social Drivers Of Health (SDOH)

Many health plans have adopted formal programs to address social drivers of health. These initiatives highlight non-medical factors that influence health outcomes, such as unstable housing or homelessness, lack of access to healthy food choices, poverty and economic stressors, sedentary lifestyles, smoking, and excessive alcohol use. County Health Rankings & Roadmaps suggest social and economic factors alone determine 40 percent of the length and quality of human life and are twice as influential as factors related to clinical care services.[7] Common health plan strategies to address SDOH include requiring providers to screen for social needs and including requirements or incentives for quality metrics associated with SDOH. Recent changes in Medicaid policy have granted health plans greater flexibility to address SDOH by investing a portion of their payments in short-term housing and rental assistance.

2. Quality *Continued*

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Increasing Quality Through Technology

Technology solutions focused on patient engagement and improved care are a growing focus for health plans as tools for competitive advantage. More sophisticated health plan technologies include population health platforms that integrate data from claims, EHRs and other sources to provide deep insights into patterns of utilization and cost outliers. This data is essential to managing the value-based contracts, as well as identifying high-risk patients for assignment to care management. Health plans are also adopting high-touch technologies at the front door of services to improve customer satisfaction and engagement in their care. These include digital tools to support call center operations and rapidly connect callers to appointments and mobile and online applications that empower patient self-care and self-management.

Promoting Digital Health Solutions

The increasing integration of technology with healthcare practice is also leading to greater health plan investment in digital therapies and digital health tools that optimize delivery of behavioral health services by making it more efficient and improving the speed and accuracy of treatment. Digital health tools include both hardware and software programs such as wearable devices, telehealth platforms, and remote patient monitoring units used to prevent, manage, or treat a condition. It also includes artificial intelligence applications that reduce clinician time spent in documenting notes so that more time is available for direct patient care, and the use of pads and hand-held devices to rapidly collect symptom and outcome data directly from patients.

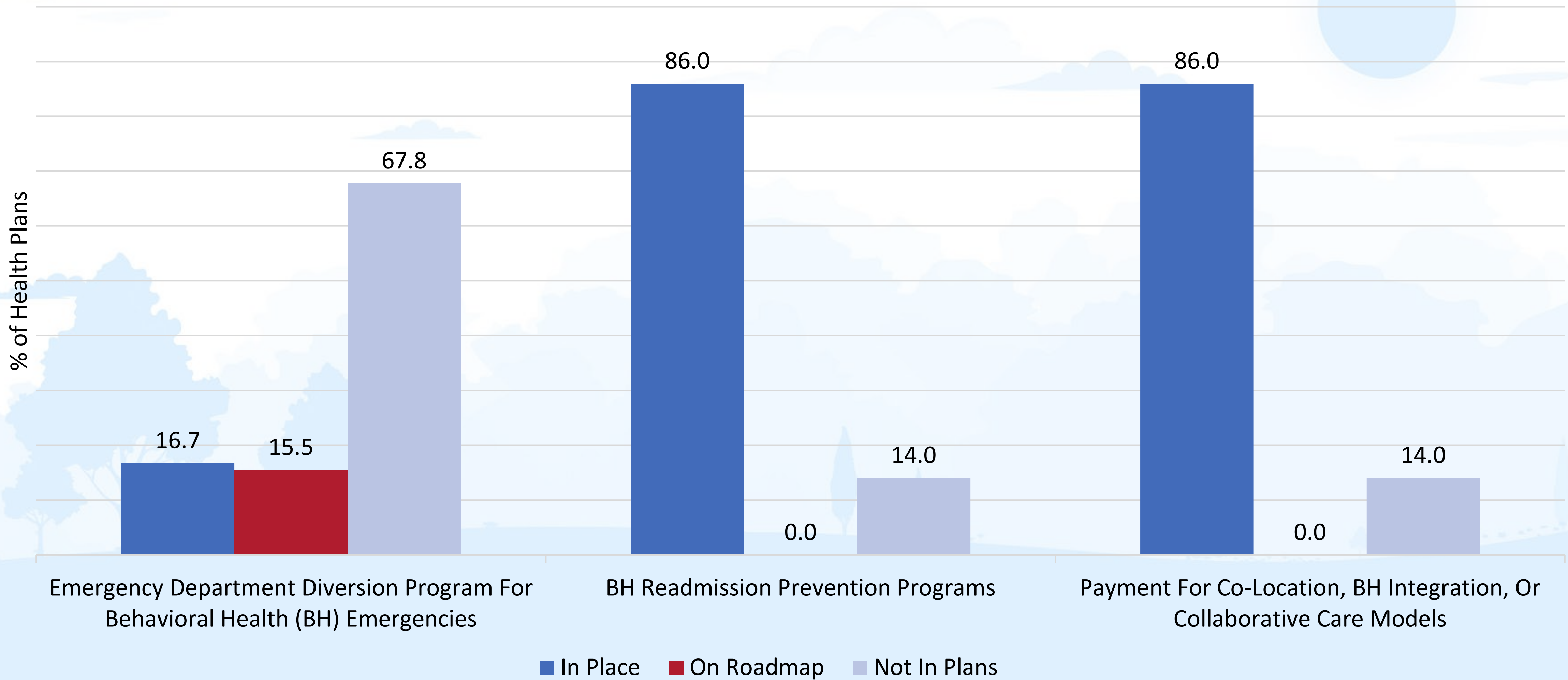
2.a. The Rise Of Integrated Delivery Systems: Alignment Of Medicaid Financing For Behavioral Health, Physical Health & Pharmacy, 2019-2022[15]

Financial Arrangement	Medicaid Health Plans*		% Change – Medicaid Health Plans
	2019	2022	
Count of State Medicaid plans with financial risk for behavioral, medical, and pharmacy in the same plan	63	72	14%↑
Count of State Medicaid plans with separate entities at risk for behavioral, medical, and pharmacy benefit	2	0	-100%↓
Count of State Medicaid plans with a carve-out of behavioral health financial risk – with medical and pharmacy risk in the same health plan	18	12	-33%↓
Count of State Medicaid plans with a carve-out of behavioral health pharmacy risk - with medical and behavioral risk in the same health plan	0	2	100%↑
Count of State Medicaid plans with medical and behavioral risk in the same health plan, but not including pharmacy	1	6	500%↑

*Count includes all plans covering medical benefits for Medicaid beneficiaries – FFS and health plans for all 50 states and DC.

More states are requiring health plans to assume all financial risk – medical, behavioral health, and pharmacy – for their Medicaid recipients, and fewer are carving out behavioral health into a separate payer entity.

2.b. Coordination Of Care Strategies For Complex Members – All Plans, 2023[14]



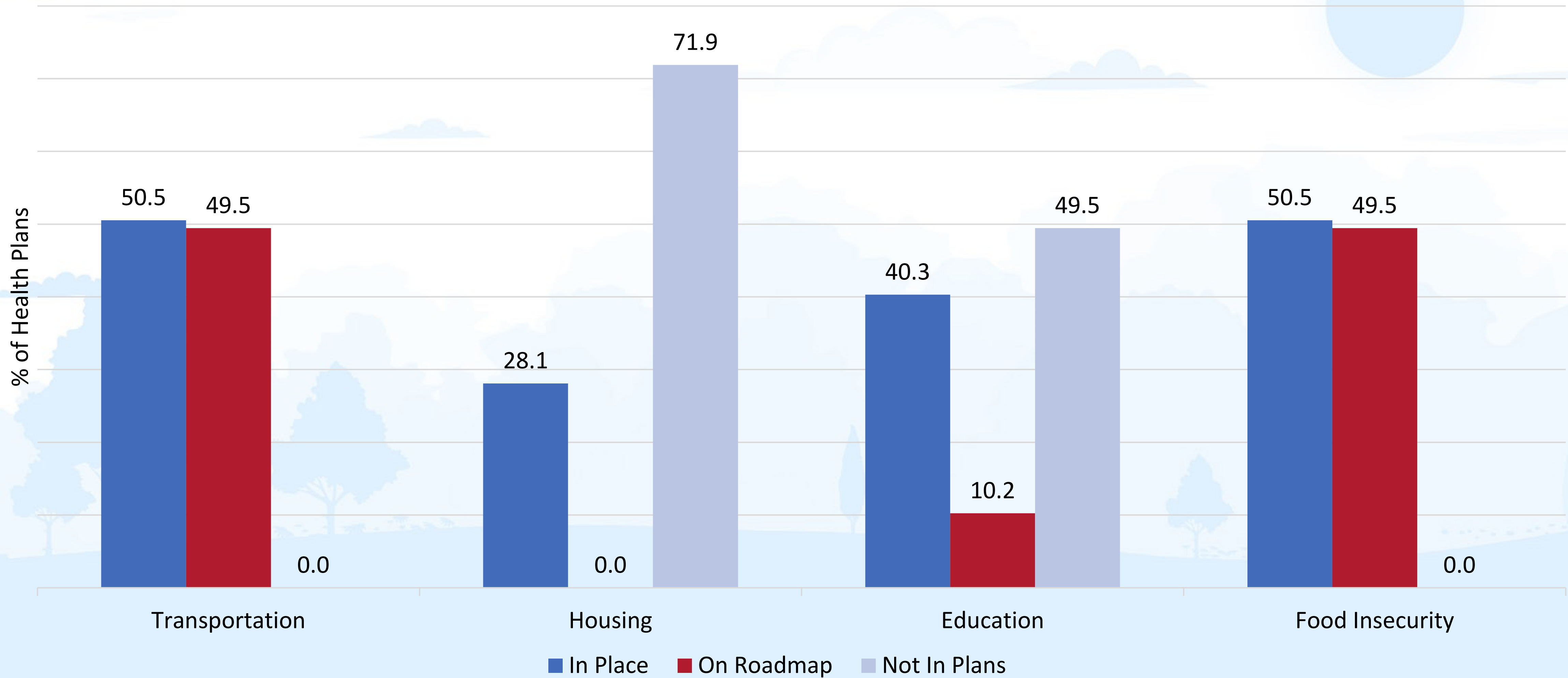
Survey respondents reported actively funding or supporting a variety of initiatives to improve care coordination for complex members.

2.c. Coordination Of Care Strategies In Place For Complex Members – All Plans, 2019-2023[14]

% of Health Plans	2019	2021	2023
Emergency Department Diversion Program For Behavioral Health (BH) Emergencies	58.5	51.3	16.7
BH Readmission Prevention Programs	84.8	99.6	86.0
Payment For Co-Location, BH Integration, Or Collaborative Care Models	71.3	98.1	86.0

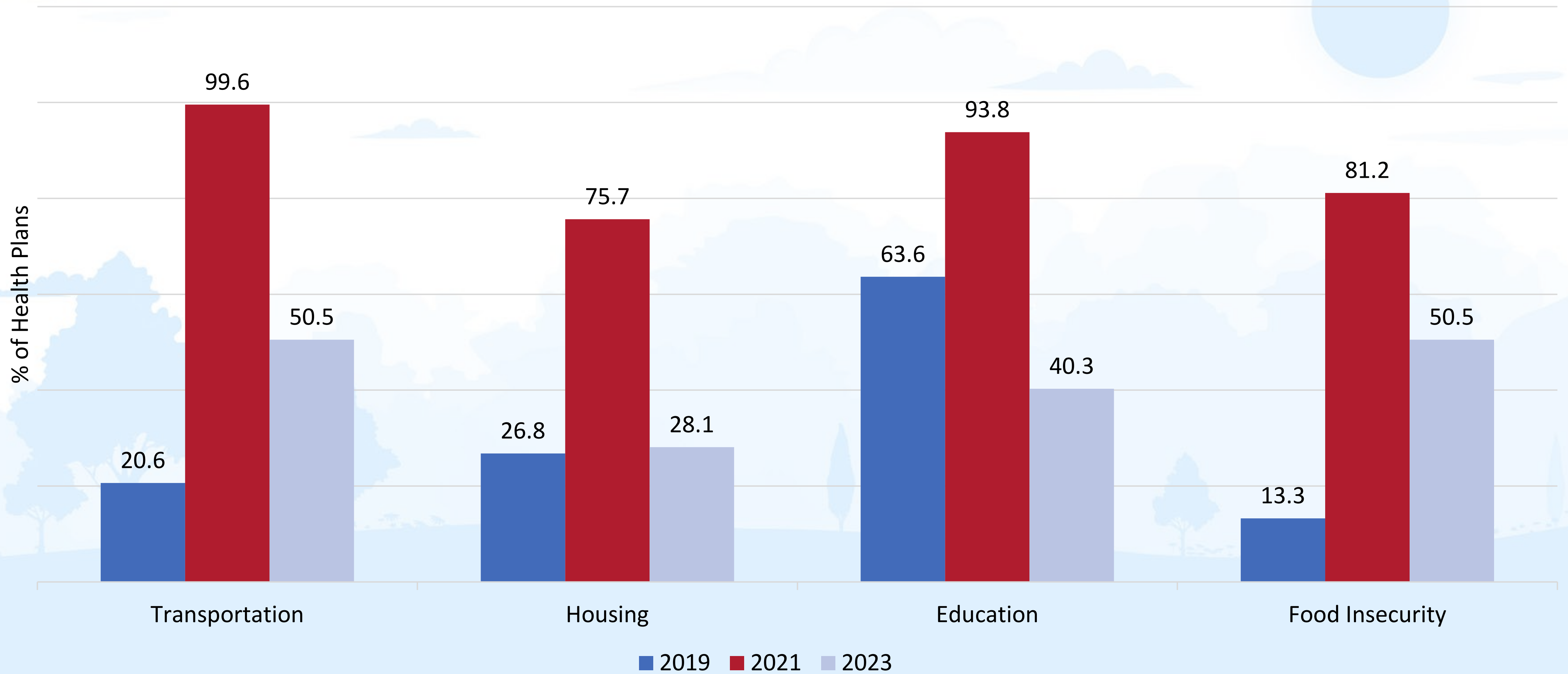
Most health plans have implemented programs and services targeting complex members, including initiatives to reduce hospital readmissions for behavioral health and to expand integration of behavioral health and primary care.

2.d. Utilization Of Social Determinants Of Health Strategies – All Plans, 2023[14]



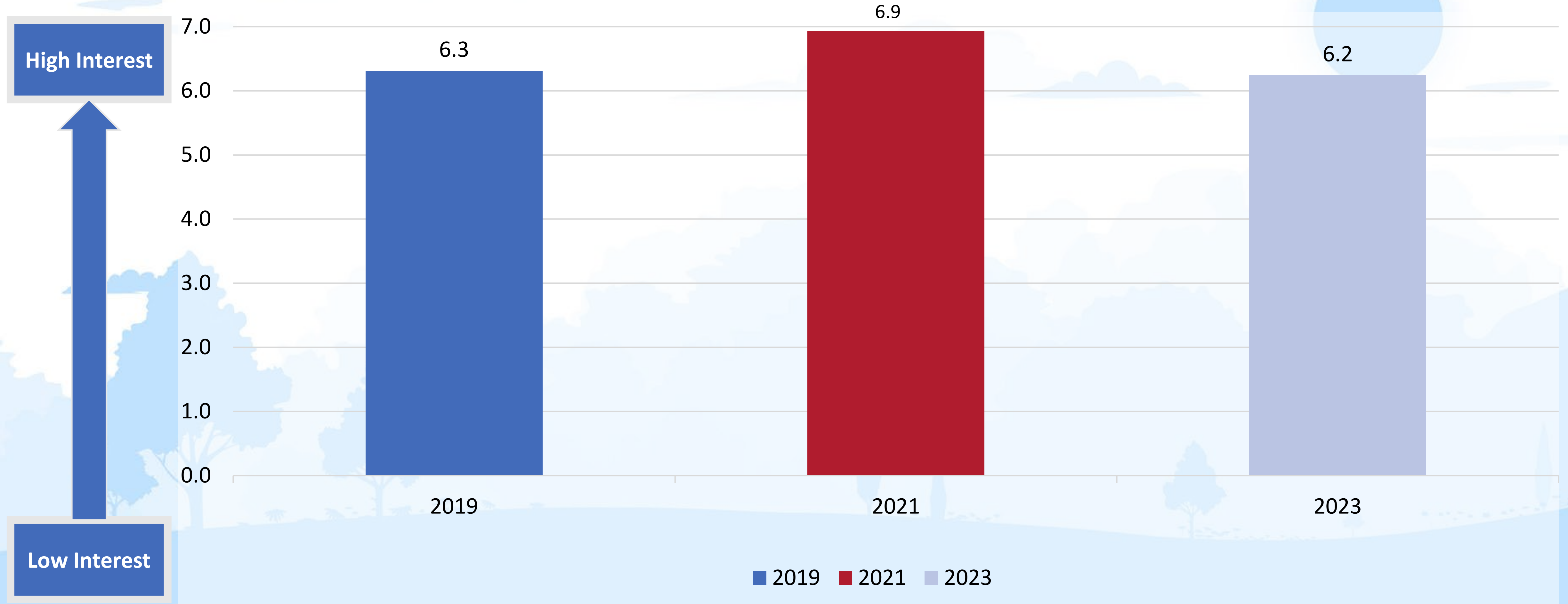
Health plans are focusing resources on non-medical services and supports that affect health outcomes, including food insecurity and transportation. A small number are also exploring housing programs as a strategy.

2.e. Social Determinants Of Health Strategies In Place – All Plans, 2019-2023[14]



Health plans reported investing the most resources in non-medical programs addressing social determinants of health during the peak of the COVID-19 pandemic.

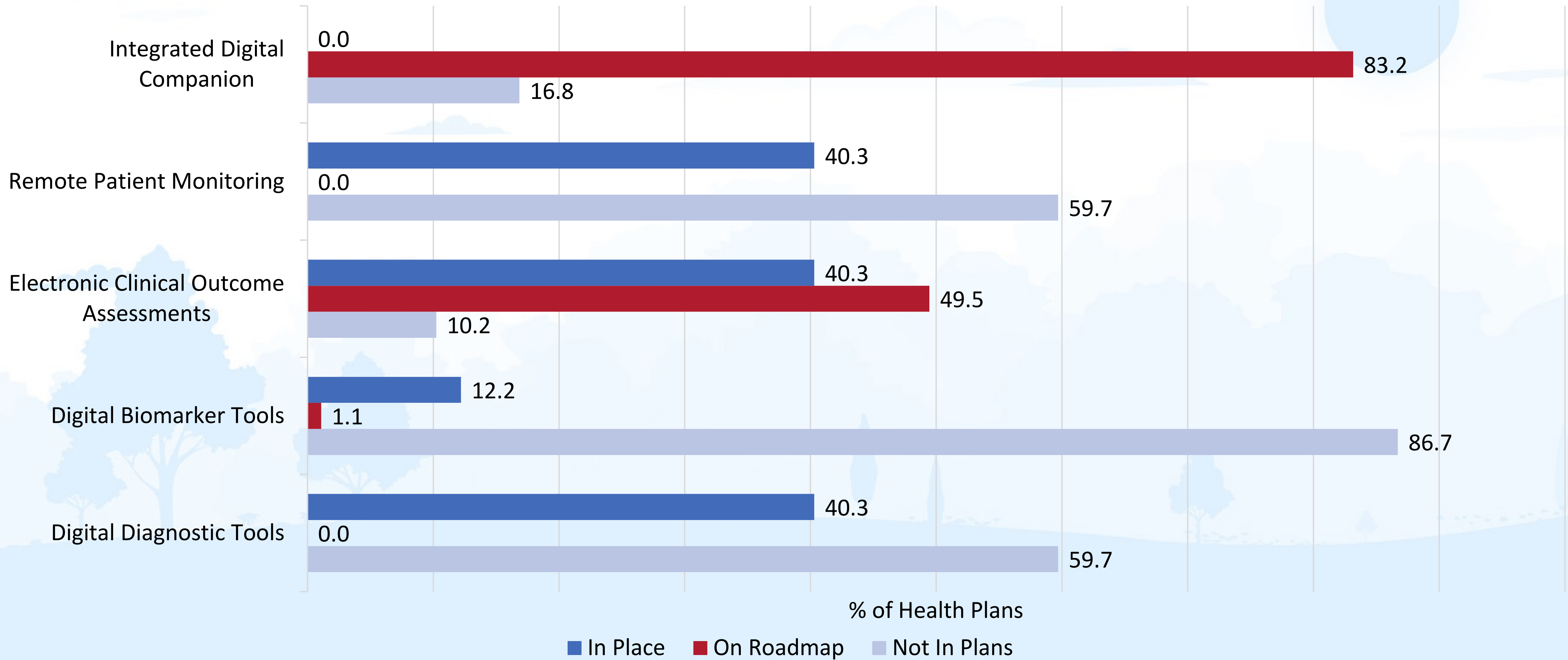
2.f. Interest In Data Analytic Tools – All Plans, 2019-2023[14]



*2019 and 2021 scores are based on the proportion of plans that responded they were using data analytics.

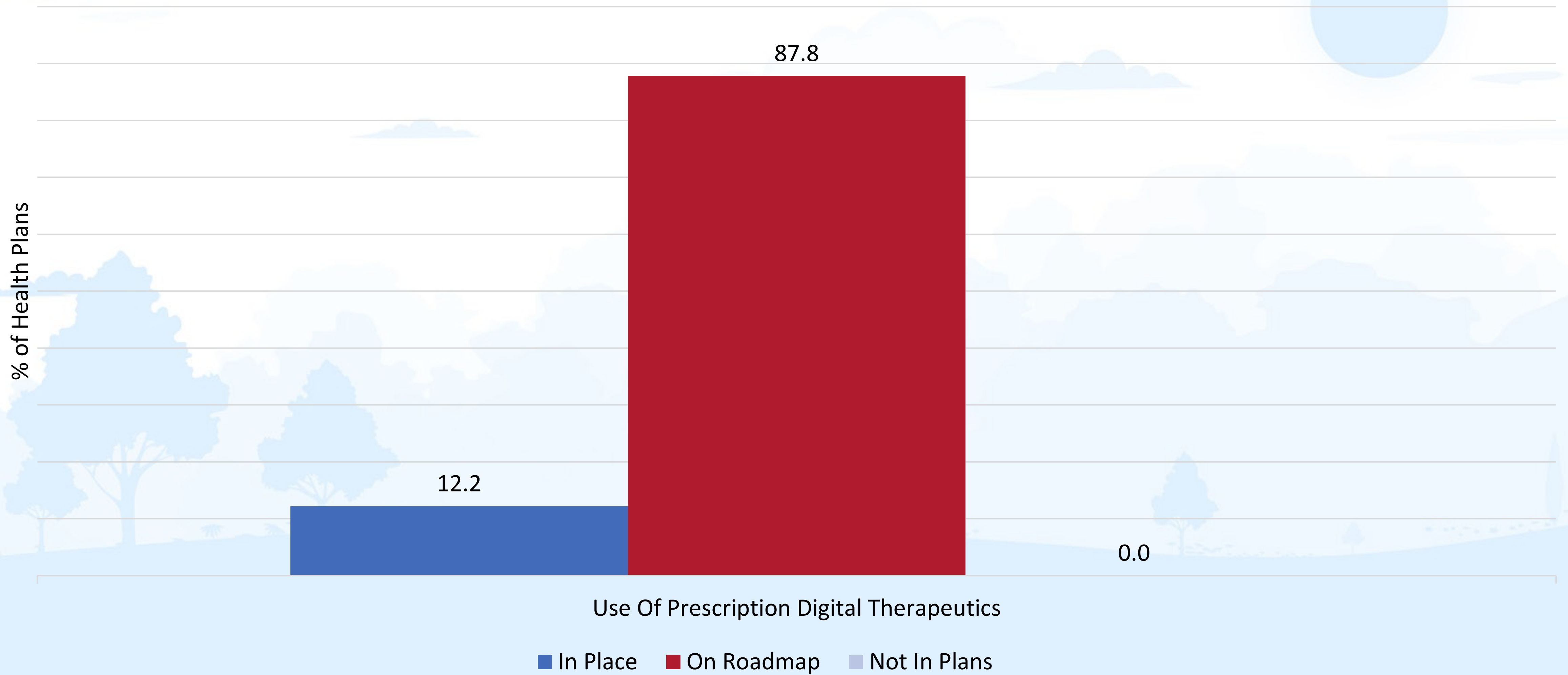
Health plans report a high degree of interest in analytics solutions to identify and segment patients as part of their population health programs.

2.g. Utilization Of Digital Technology Strategies – All Plans, 2023[14]



Widespread adoption of smart phones and other mobile technologies are driving health plan interest in tools that interact with consumers through their digital devices, such as appointment reminders and self-service education.

2.h. Utilization Of Prescription Digital Therapeutics – All Plans, 2023[14]



Most health plans are planning initiatives over the next few years to utilize prescription digital therapeutic products to prevent, manage or treat behavioral health and other health conditions.

Cost

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Advancing APMs For Lower Costs & Improved Care

A single theme has dominated health plan financial policy over the past 10 years: moving from volume to value in healthcare payment arrangements. From federal programs to test innovative care delivery and payment methods, to the emergence of a multi-stakeholder leadership initiative to accelerate payment reform, health plans are playing a key role in advancing Alternative Payment Models (APMs) across public and private sectors.

CMS Innovation Models

Since 2012, the Center for Medicare & Medicaid Services (CMS) has launched dozens of "innovation models" designed to test new approaches to delivering and reimbursing for healthcare that maximize provider performance and value. Only a fraction of these APMs and model programs have focused on behavioral health—most recently the Maternal Opioid Misuse (MOM) model and Integrated Care for Kids—both of which include tracts addressing substance use disorder treatment.[8]

However active involvement by healthcare organizations across the country in CMS' behavioral health related models is expanding rapidly, from 438 demonstration organizations in 2012 to over 2,500 today.[8] This suggests a need for the federal agency to increase its focus on behavioral health and specialty behavioral healthcare providers as an important factor in improving quality and reducing costs through its innovation portfolio.

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Healthcare Payment Learning & Action Network (HCP-LAN)

Recognizing the need for a unified voice and vision in the rapidly-evolving movement towards payment reform, healthcare leaders across public and private sectors implemented a learning community in 2015. The purpose of HCP-LAN is to accelerate adoption of alternative payment models tied to quality and value and away from traditional fee-for-service reimbursement.

Best known for its framework that standardizes the definitions and features of common payment models, the HCP-LAN conducts an annual survey charting the progress of APM adoption. For 2022, the survey recorded small gains in the most advanced payment models—those characterized by two-sided risk—and little movement in the large volume of health plan revenues still attached to fee-for-service payments.[9]

Behavioral health and other specialty healthcare providers are less likely than others to participate in value-based alternative payment models. Responding to a 2023 survey, just 60% of specialty providers reported participating in value-based contracts compared with 92% of primary care and Federally Qualified Health Centers.[10] Of those holding an APM contract, most (42%) were paid fee-for-service plus a performance bonus for achieving health plan-specified quality goals. Case rate and capitation payments were far less common.

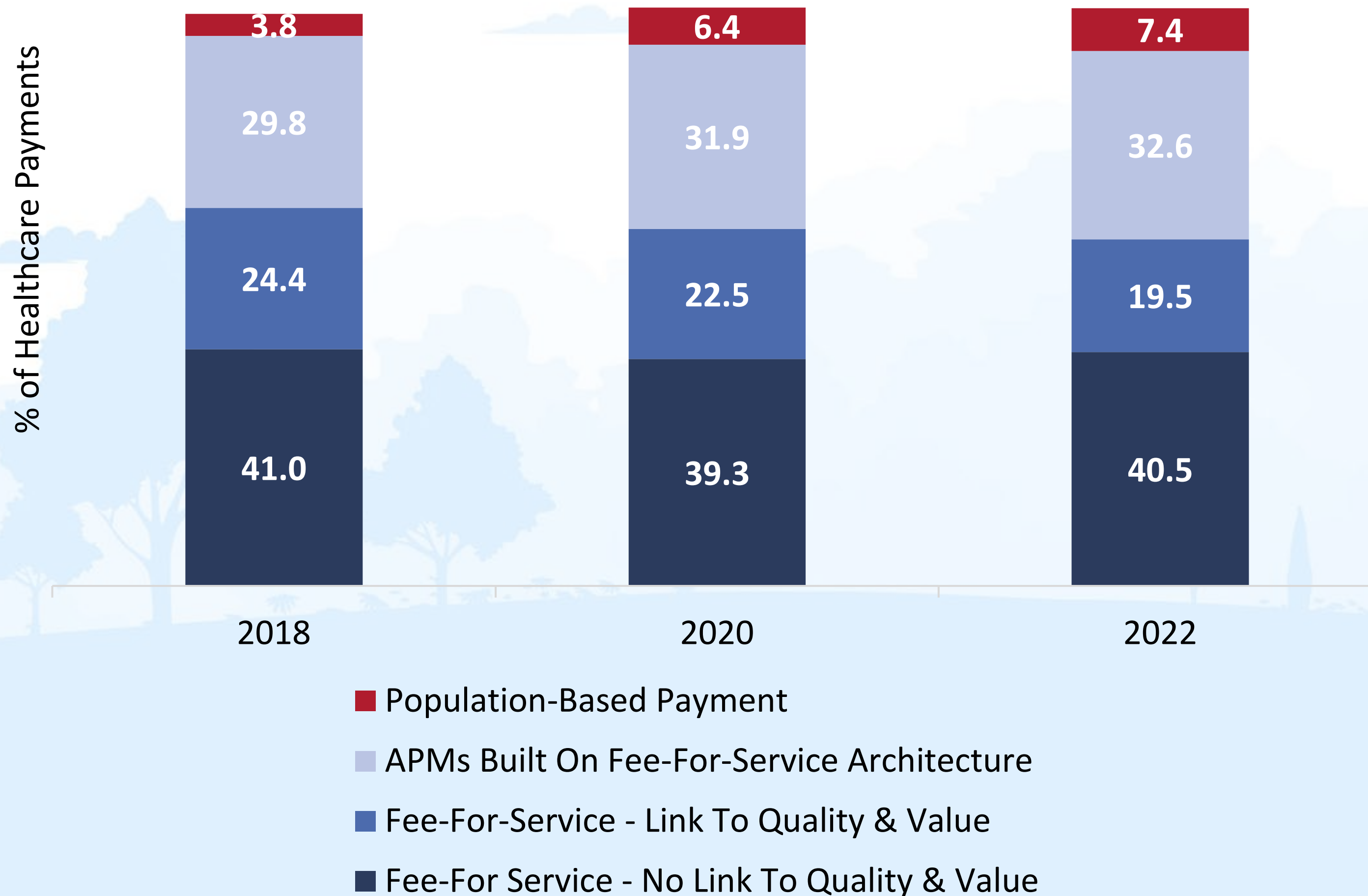
3.a. U.S. Medicaid Behavioral Health Innovation Initiatives: Organizational Trends Over Time, 2012-2023[8]

2012 → **481% increase in organizations participating in active Medicaid innovation initiatives.** → **2023**

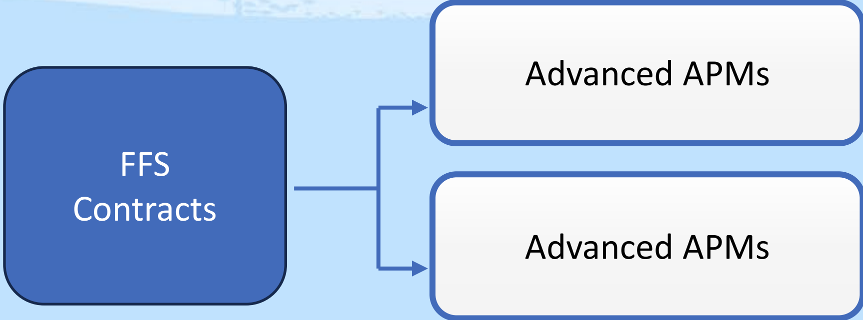
Year	Count Of Organizations Participating In Active Initiatives
2012	438
2013	454
2014	500
2015	385
2016	400
2017	330
2018	159
2019	42
2020	57
2021	2,572
2022	2,572
2023	2,544

A growing number of healthcare organizations are enrolling in CMS Innovation Models that test new payment methods and service delivery models aligned with value-based care.

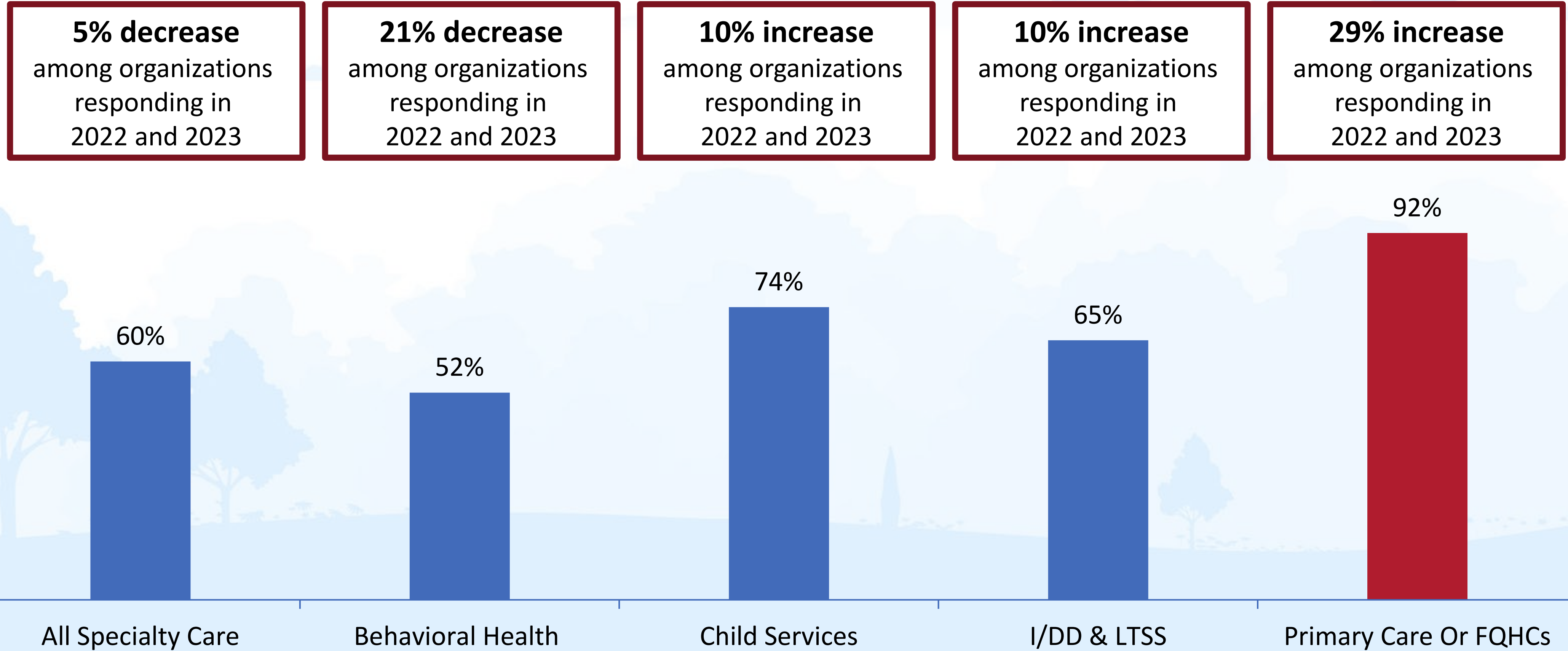
3.b. Alternative Payment Models, Distribution Of Healthcare Payments By Model Type, 2018-2022[9,14]



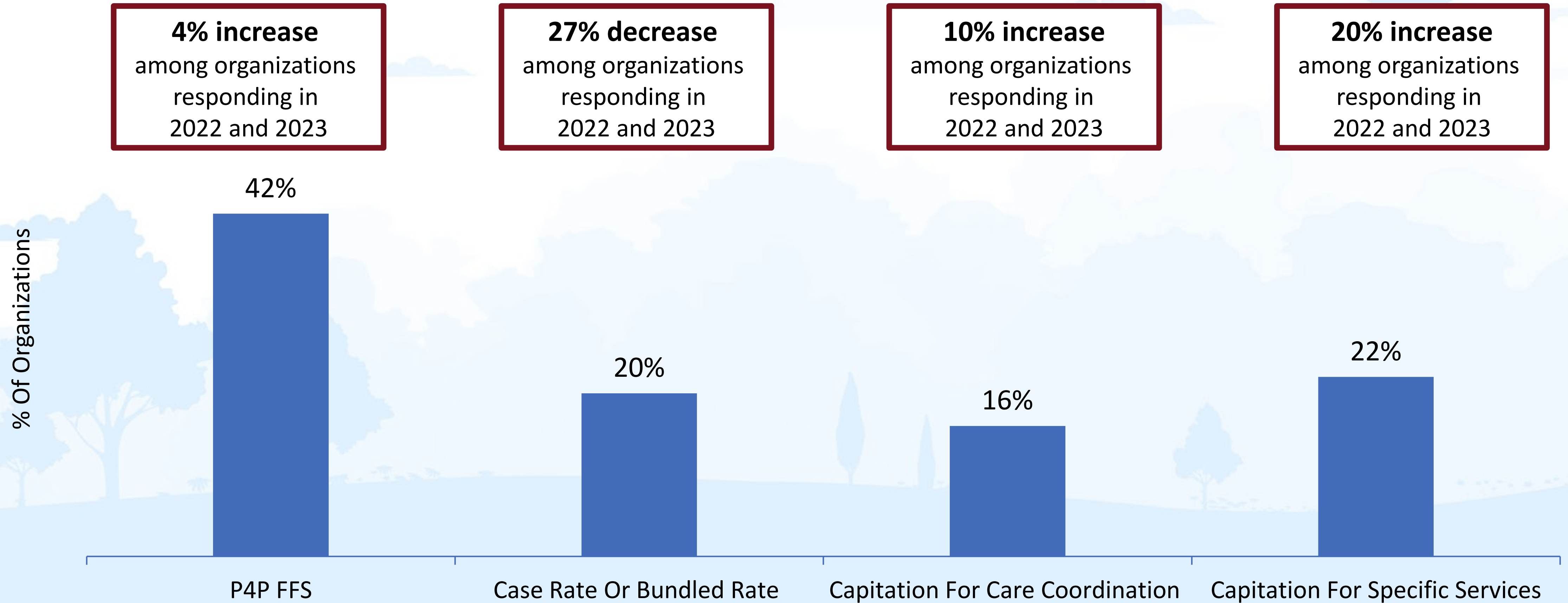
The annual Health Care Payment Learning Action Network (HCP-LAN) Alternative Payment Model survey shows some incremental shifts in the proportion of healthcare payments flowing from Fee-For-Service (FFS) contracts to more advanced Alternative Payment Models (APMs).[9,14]



3.c. Specialty & Primary Care Provider Organizations Participating In VBR Arrangements, By Market, 2023[10]



3.d. Specialty Provider Organizations Only Participating In VBR Arrangements, By VBR Type, 2023[10]



*Note provider organizations could select that they were participating in more than one type of VBR arrangement

TRENDS IN BEHAVIORAL HEALTH
Access To Care

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Expanding Access To Behavioral Health Services

Health plans play a leading role in provider network design and contracting to improve consumer and family access to behavioral health services. Access policies established by health plans generally follow industry standards or minimum guidelines in Medicare and Medicaid around appointment wait times and the distance consumers must travel to reach a behavioral health service. Thus, access to care can vary widely among states and for populations within the same state, many of whom face added challenges to accessing care due to severe mental illness and addiction disorders.

Access management decisions are also highly influenced by changes in the environment, including new policy initiatives and emerging events such as the COVID-19 pandemic or the nationwide opioid epidemic. Additionally, health plans are sensitive to the various performance measurement ratings published annually by the Center for Medicare/Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA). These performance scoring systems provide transparency into how well health plans address important consumer health goals and allow for comparisons among plans using standardized scales and measures. CMS attaches payment bonuses to certain of its STAR measures and can restrict or cap enrollment in a health plan for failure to achieve performance goals.

HEDIS* & STAR Measures

The NCQA HEDIS and CMS STAR scoring systems evaluate health plan performance on a variety of measures addressing access to care. These include HEDIS Follow-Up Measures which rate the effectiveness of the health plan's contracted network in providing a timely follow-up appointment following urgent behavioral health events, such as emergency room admission for overdose or discharge from a hospital due to mental illness.

CMS' STAR measures include data from member surveys aimed at assessing how well health plans meet member expectations. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) has been in use since 1997 and measures various domains reflecting customer service, convenience, and ease of obtaining information or getting an appointment quickly. STAR and CAHPS ratings are released annually and reflect the experiences of people enrolled in Medicare Advantage and Part D prescription drug plans, as well as health plans operating on the federal health insurance exchange.[11]

*Healthcare Effectiveness Data and Information Set (HEDIS)

4. Access To Care *Continued*

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Health Equity

Health equity is a new healthcare North Star. It recognizes that different populations and communities have different circumstances and face unique challenges on their journey to health. During COVID, it quickly became clear that certain minorities and marginalized communities in the U.S. experienced disproportionately more severe consequences of the virus in terms of increased infection rates and hospitalizations and less access to immunizations and COVID tests. Health plans are now responding with significant investments in programs to address equity in behavioral health, from programs to provide reduced or free wireless broadband access in remote communities to services targeting SDOH factors such as homelessness and food insecurity. As part of its 2023 HEDIS program, the NCQA introduced eight health plan measures that will be stratified by race and ethnicity in future reports.

Proposed CMS Rules to Enhance Access to Care

In early 2023, CMS proposed two new rules with far-reaching consequences for health plan access management policies in the Medicaid and CHIP programs. The two rules establish the first-ever national minimum standards for appointment wait times and include mandatory "secret shopper surveys" conducted by independent entities to validate health plan compliance with standards. The rules also require states to intensify health plan monitoring programs around adequacy of their contracted networks and use the same secret surveys to validate the accuracy of health plan provider directories. The goals of the new rules are greater transparency and accountability for funding invested in healthcare services for the most vulnerable populations and to ensure equitable access to services.[12]

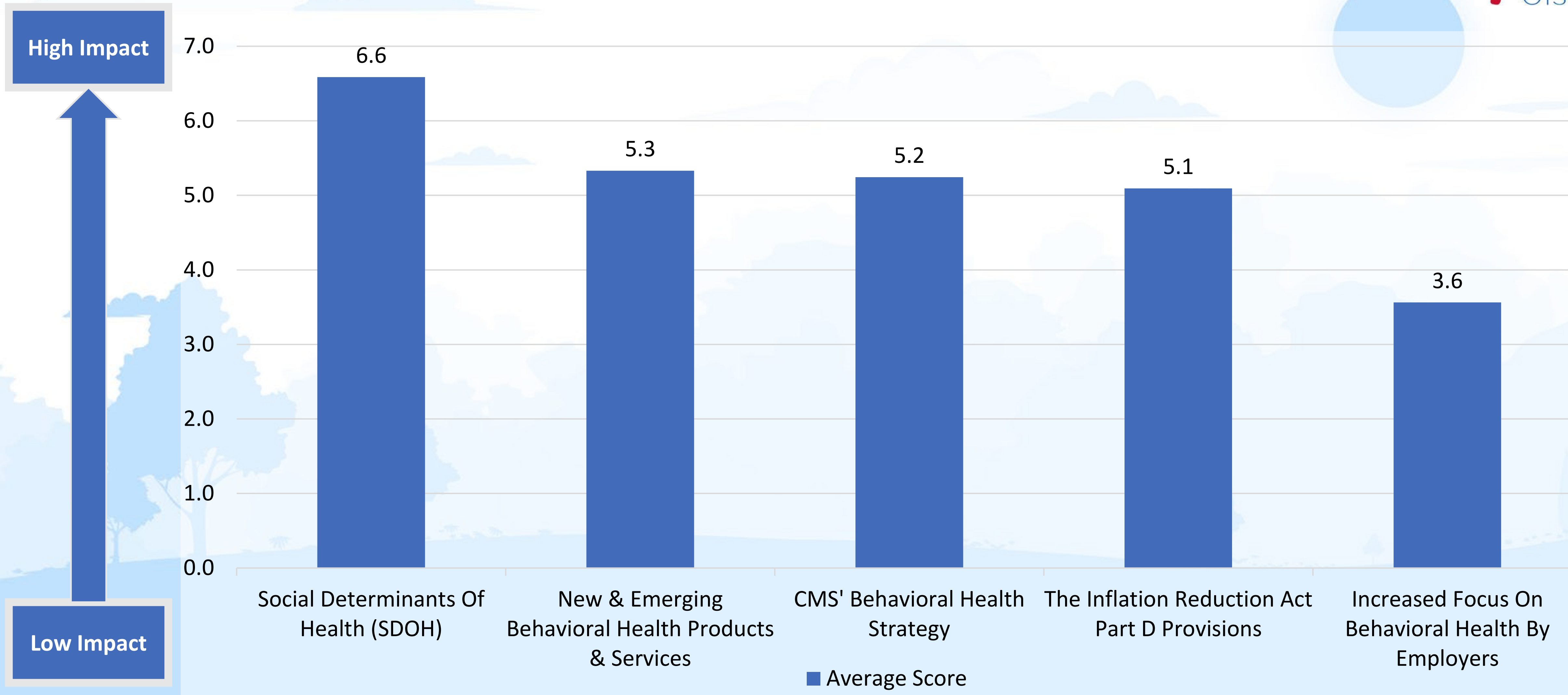
4.a. CMS CAHPS* Ratings For Medicare Advantage & Part D Prescription Drug Plans, 2021-2024[11]

Measure	2021 Average Star	2022 Average Star	2023 Average Star	2024 Average Star
Getting Needed Care	3.3	3.6	3.4	3.5
Getting Appointments and Care Quickly	3.4	3.6	3.5	3.5
Customer Service	3.5	3.8	3.4	3.6
Rating of Health Care Quality	3.3	3.6	3.4	3.3
Rating of Health Plan	3.2	3.5	3.2	3.1
Care Coordination	3.4	3.7	3.5	3.6
Complaints about the Plan	4.8	4.7	4.3	3.9
Members Choosing to Leave the Plan	4.0	4.1	3.5	3.6
Health Plan Quality Improvement	3.2	3.7	2.6	3.0
Plan Makes Timely Decisions about Appeals	4.3	4.6	4.6	4.1
Reviewing Appeals Decisions	4.5	4.6	4.4	3.6
Call Center – Foreign Language Interpreter and TTY Availability	4.3	4.6	4.3	4.3

* The Consumer Assessment of Healthcare Providers and Systems

Health plan measures reflecting the consumer experience continue to score slightly below 2022 average STAR ratings, affecting bonus payments and new referrals to Medicare Advantage and Part D plans.

4.b. Trends Impacting Health Plan Management Access Decisions – All Plans, 2023[14]



Social determinants of health is the key driver of health plan policies on access to care in 2023.

TRENDS IN BEHAVIORAL HEALTH

Vulnerable Populations

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Creating Partnerships To Support The Most Vulnerable Populations

A major focus of health plan activities in public healthcare programs is organizing resources and services to support the populations with the most severe and chronic conditions. In behavioral health, this includes persons with serious mental illnesses (SMI) and children with severe emotional disorders (SED), as well as individuals with multiple medical co-morbidities in addition to their behavioral health condition. Many of these individuals fall into the highest cost groups in overall medical spending, where persons with a behavioral health condition are estimated to cost 3.1 to 7.2 times more than persons with no behavioral health condition.[13]

Medicare and Medicaid from 2019 through 2022 has continued caring for more aged, children, and disabled populations.[3] Health plans in these public markets are increasingly partnering with community organizations, government, higher education, and biopharmaceutical manufacturers to develop and test new strategies for reaching the most vulnerable and addressing their unique needs. Among the most promising approaches:

- Strategies to address social deficits and social drivers of health, including partnerships with housing providers and social service agencies
- Caregiver support and education programs targeting social and custodial care networks, including families, assisted living and home health
- Programs to improve medication adherence and minimize off-label medication uses

5.a. Health Plan Perspectives On Unmet Needs For Behavioral Health Services – All Plans, 2023[14]

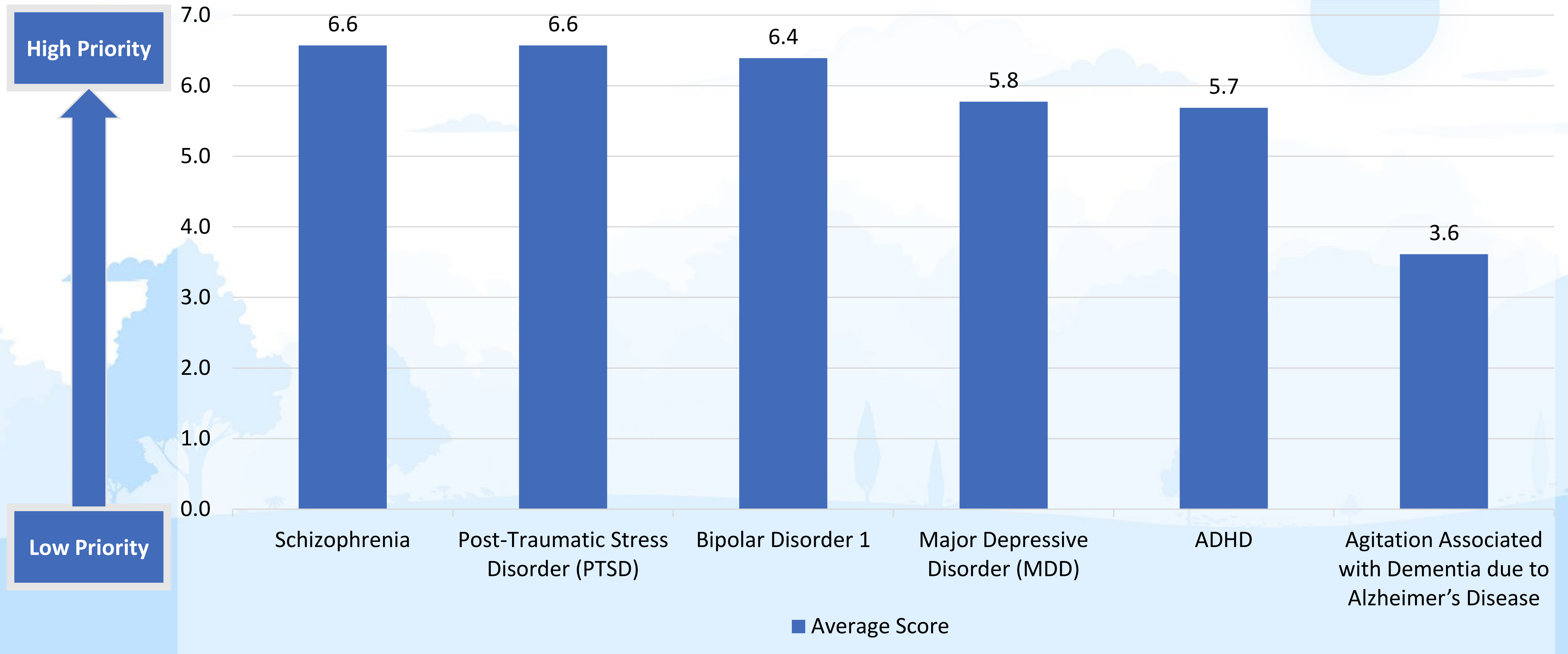
High Unmet Need

Low Unmet Need

	Average Score
Schizophrenia	6.2
Bipolar Disorder 1	5.6
Major Depressive Disorder (MDD)	4.8
Post-Traumatic Stress Disorder (PTSD)	4.8
ADHD	4.3
Agitation Associated with Dementia due to Alzheimer's Disease	4.0

In the eyes of health plans, persons with severe and persistent mental illnesses remain the single most vulnerable population with the greatest level of unmet needs.

5.b. Health Plan Priorities In Behavioral Health Population Management – All Plans, 2023[14]



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5.c. Health Plan Interest In Partnerships with BioPharmaceutical Companies – All Plans, 2023[14]

High Interest

Low Interest

Partnership Type	Average Score
Substance Abuse Counseling Programs	6.9
Resources Aligned To Support Specific HEDIS Or STAR Ratings For Behavioral Health	6.4
Evidence-Based Therapy	6.3
Data Analytics	6.2
Resources To Improve Adherence & Persistency	6.2
Physician Education Programs That Target Improved Outcomes	4.9
Caregiver Support/Education Programs	4.8
Programs To Minimize Off-Label Or Inappropriate Use	4.6

Health plans are seeking out new collaborations and partnerships to solve service delivery issues, including expanding access to substance use disorder services and improving the plan's STAR scores.

TRENDS IN BEHAVIORAL HEALTH

Conclusion

6. Concluding Thoughts

The annual Otsuka Payer Survey offers unique insights into what payers and health plans are prioritizing within their markets, and how they are responding to environmental changes and challenges that affect the delivery of healthcare in the U.S. today. Among the most impactful trends identified in the 2023 survey:

- **Managed Care.** Federal and state governments are continuing to transition to managed business models and delivery systems for oversight of public healthcare funding and services. Today, managed care is the most dominant management structure for services in Medicaid, and a growing presence for Medicare and commercial payers.
- **Quality.** Health plans continue to innovate within their quality programs to address an expanding set of population needs, including services to identify and address health equity and social drivers of health, and integration and coordination models that link services across multiple treating providers and delivery systems.
- **Cost.** Stemming the rising costs of healthcare has proven a particularly intractable goal. The U.S. spends as much as 18% of its GDP on healthcare, yet Americans die younger and are less healthy than residents of other high-income countries. Efforts to "bend the cost curve" through alternative payment methods have yet to pan out.

6. Concluding Thoughts *Continued*

- **Access to Care.** As measured by the latest STAR ratings, payers, like hospitals and most other healthcare providers, continue to rebound from the disruption of the COVID-19 pandemic. STAR ratings for 2024 remain below their 2022 peak and many payers in Medicaid and Medicare Advantage will feel the impact in their pockets for the second consecutive year. At the same time, CMS is expanding its oversight of how health plans manage access to care and services with a new set of compliance standards establishing minimum appointment wait times.
- **Vulnerable Populations.** Persons with severe and persistent mental illnesses including schizophrenia and bipolar disorder continue to top the list of populations with the greatest unmet needs and health plan management priorities for behavioral health in 2023. Payers are forging connections with a variety of partners to help fill in the gaps in care for these individuals, from social services agencies providing food and housing to biopharmaceutical research organizations advancing evidence-based medicine and medication management supports for physicians and caregivers.

Despite the many changes and continued challenges with rising costs and expanding regulatory expectations, this survey demonstrates that payers continue to occupy an important role in the U.S. healthcare delivery system today and into the future.

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