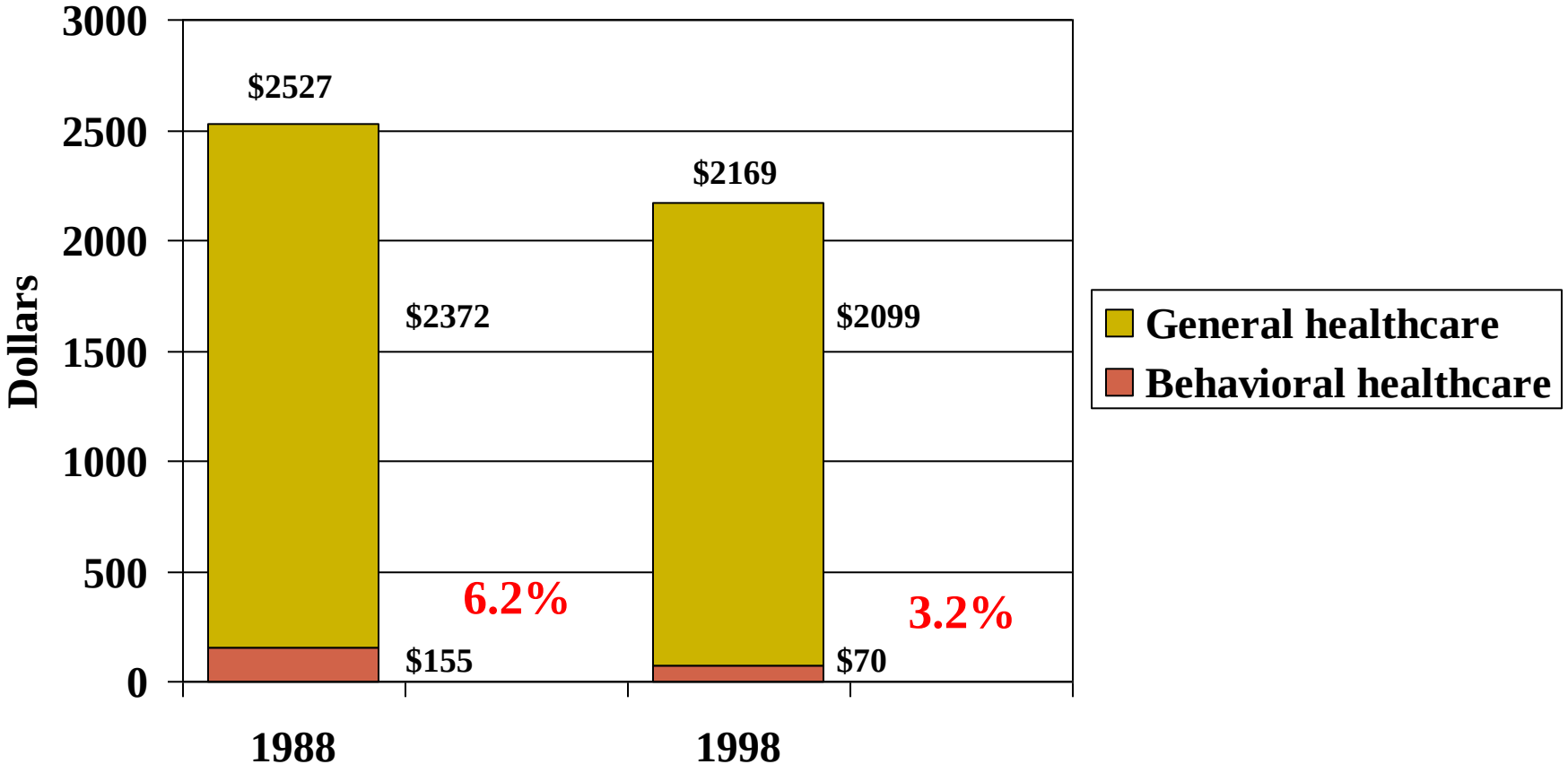
The Promise and Pitfalls of North Carolina's Medicaid 1915 b/c Waiver Program

MARVIN SWARTZ, MD
PROFESSOR AND HEAD
SOCIAL AND COMMUNITY PSYCHIATRY
DUKE UNIVERSITY SCHOOL OF MEDICINE
DIRECTOR, DUKE AHEC PROGRAM

AUGUST 23, 2012

Public and Private Managed Care Trends So Far

Value of Private Behavioral Health Benefits, 1988-1998



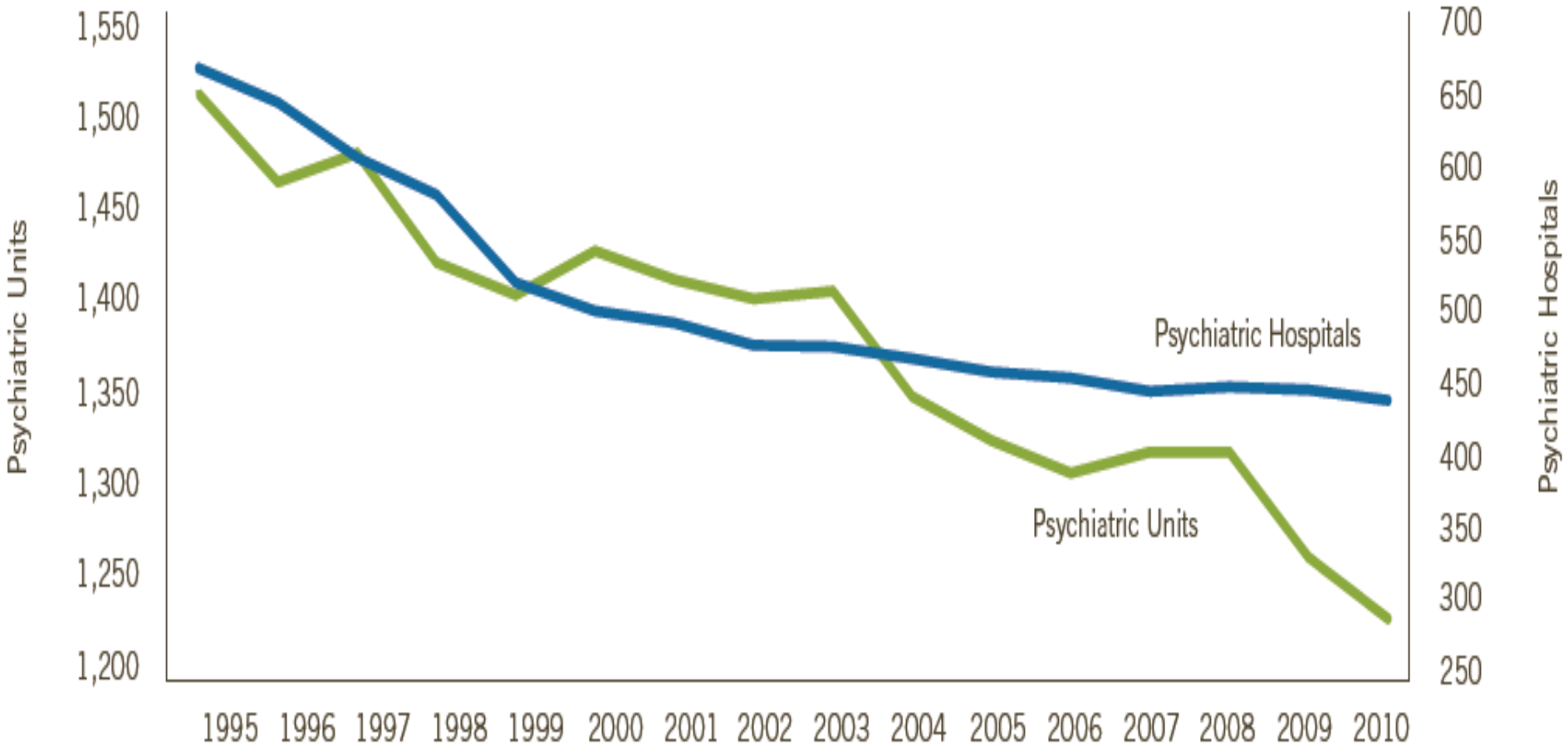
Private Managed Care Experience

- Current trends in mental illness and substance abuse treatment spending are adding to large treatment gaps for people with severe mental illnesses.
- Outpatient care and partial hospitalization programs for people with serious mental illness are not growing fast enough to meet the increasing need for services.
- Provider organizations continue to grow outpatient services, but insurance industry pressures and psychiatric hospital policies have led to the lack of needed outpatient treatment and services.

Source: Trends in Behavioral Healthcare Systems: A Benchmarking Report (NAPHS)

The health care system's capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units[1] in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals[2] in U.S., 1995-2010



Note: Includes all registered and non-registered hospitals in the U.S.

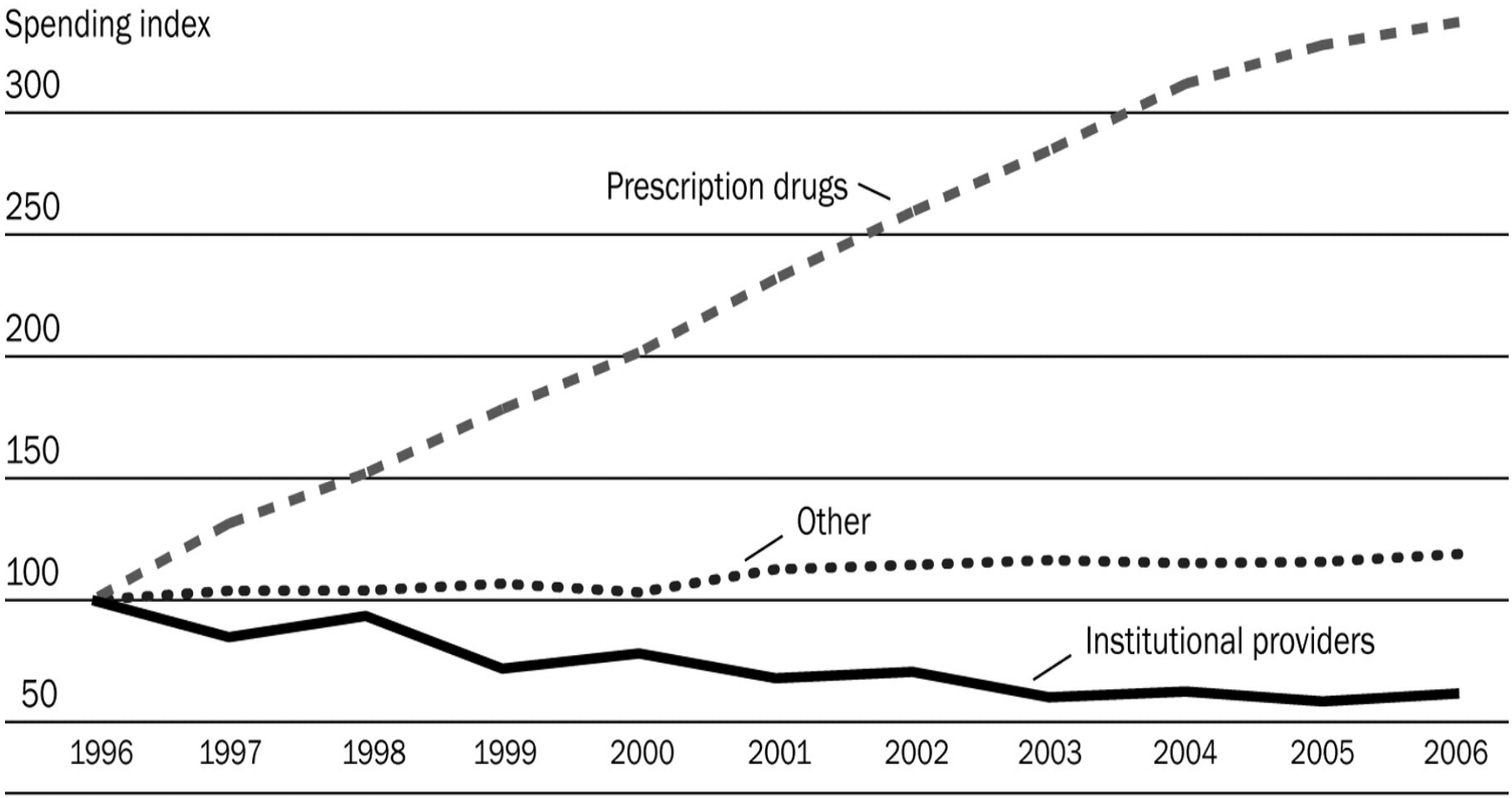
(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.

(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.

Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2010.

EXHIBIT 6

Growth In U.S. Mental Health Spending (Indexed To 1996), By Sector, 1996–2006



SOURCE: Medical Expenditure Panel Surveys, 1996–2006.

NOTES: Spending index constructed through regression analysis, available in the online appendix at http://content.healthaffairs.org/cgi/content/full/28/3/649/DC1. 100 represents mean spending in 1996 for each group. For regression details, see Exhibit 3 notes.

Increased utilization of prescription drugs and decreased reliance on inpatient services has shifted spending over time.

Chart 7: Distribution of Mental Health Expenditures by Type of Service, 1986 and 2005

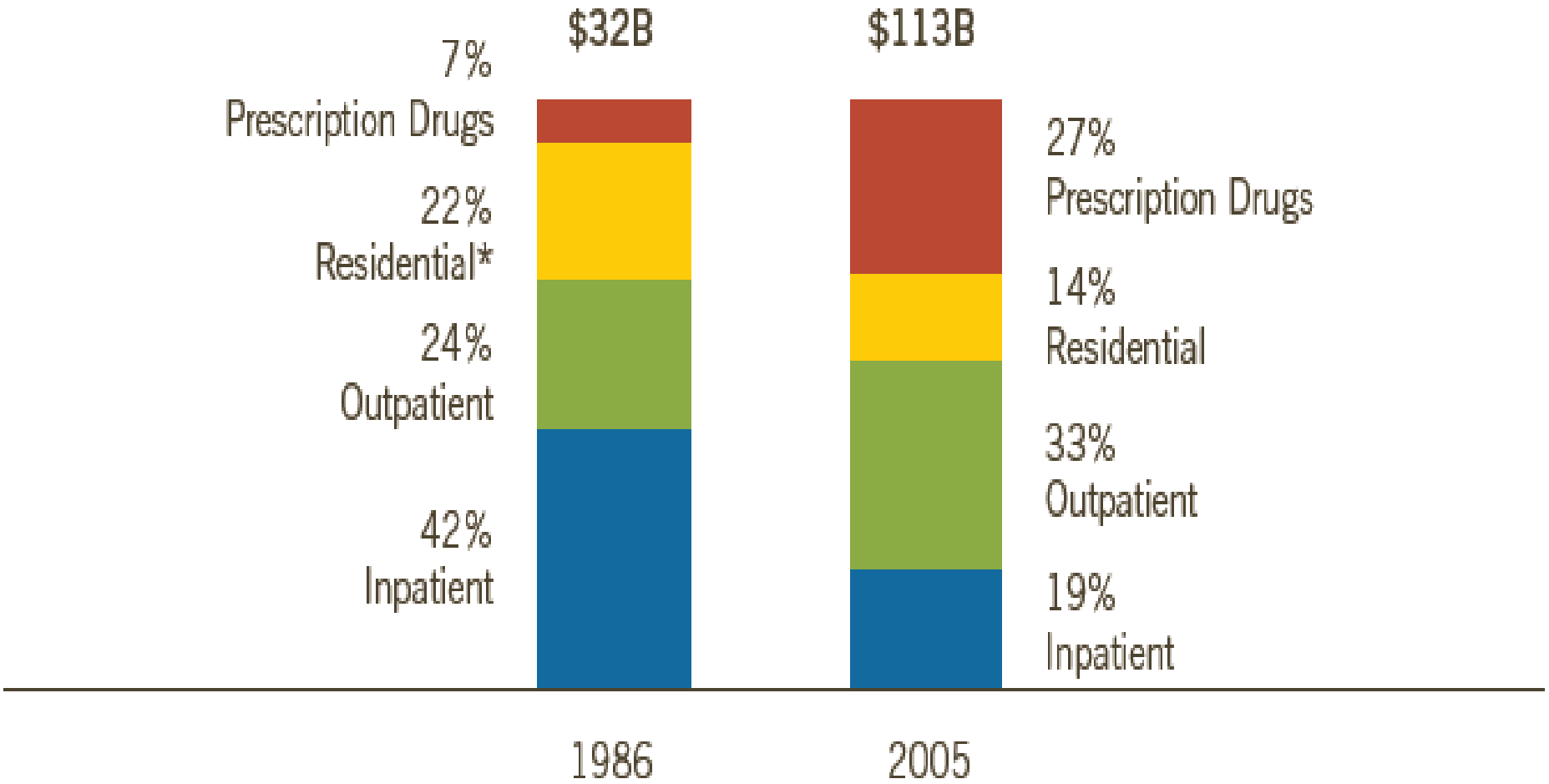
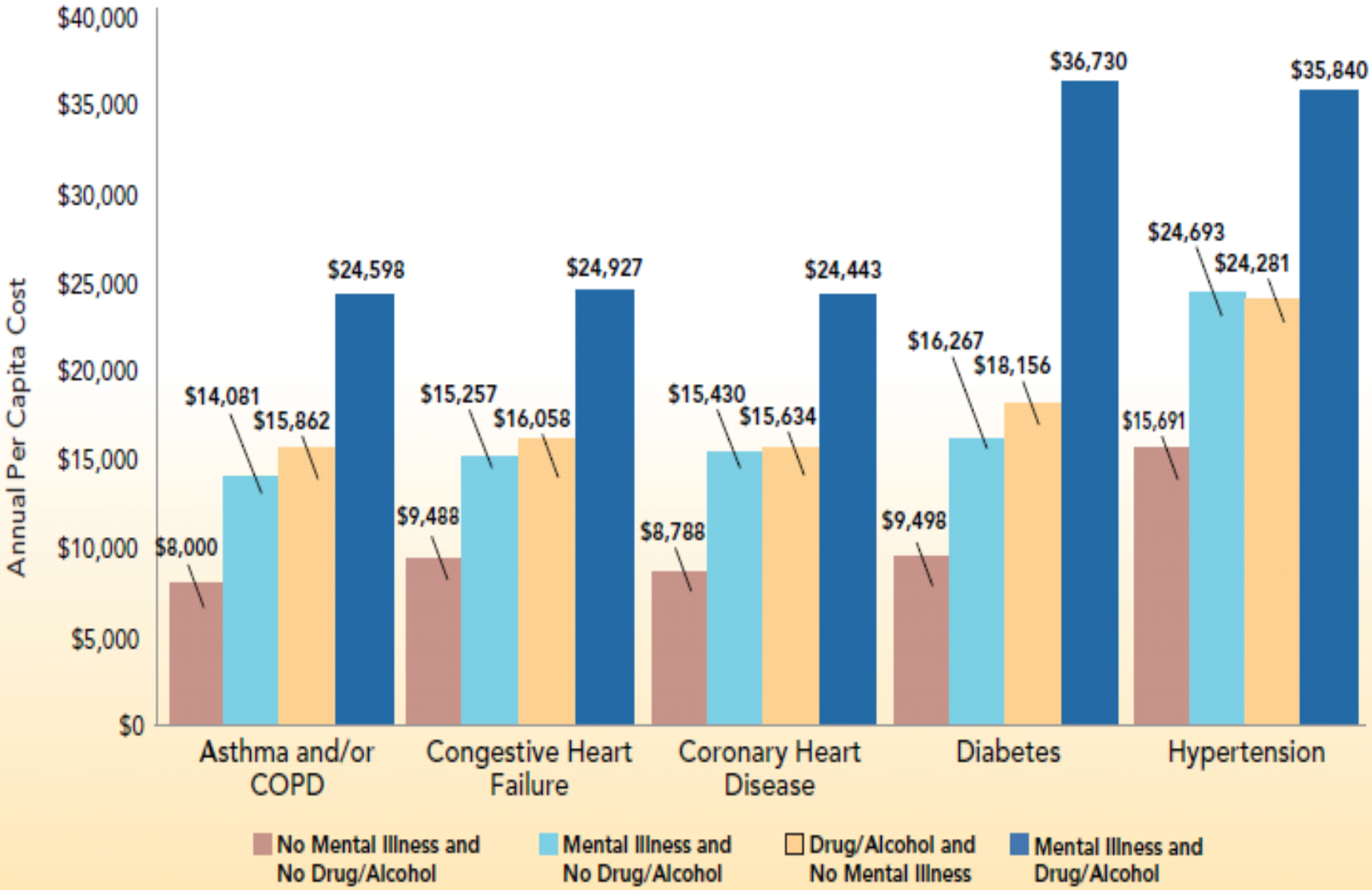


Figure 3 | Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities



Trends in Medicaid Managed Care

- Arguably--Trend is toward “carving-in” behavioral health in interest strengthening primary care homes.
- Few states are currently moving ahead with carve-out models for Medicaid Managed Care
- How will “carving out” mental health care affect other parts of the Medicaid program--general health, medication costs, etc
- Will it encourage cost shifting to primary care, medication costs, criminal justice costs?

Incentives under Capitation

- Turns traditional FFS incentives on its head
- Allows more planning allocation of treatment resources
- Allows for re-investment of saving (largely) from inpatient care into alternatives
  - BUT: Are there inpatients days to save and re-invest with massive loss of public and private beds?
- Incentives to over-treat switch to under-treat
- BUT: providers will stay in a FFS system
  - Misaligns incentives between the MCO and providers undermining joint panning.

Cautions on Implementation

- Bringing up 11 new or re-aligned MCOs –many from scratch--in a little over a year strains credulity
  - Must find qualified staff in state with relatively low managed care acumen and create host of operating procedures
  - Likely that some MCOs will be delayed or fail outright
- Most provider organizations already under severe financial strain with severe cash flow problems
  - Additional cash flow problems could send many provider organizations into insolvency

Alternatives

- SLOW DOWN Waiver.
- Engage private MCOs to teach public MCOs the business and then exit.
- Extend “pilots” and try different approaches.
- Work with academic partners to develop more robust planning and bed need methodology tools