



On Wednesday June 27<sup>th</sup> in San Antonio, Texas, the Mental Health America Regional Policy Council conducted the second in its series of nation issues forums on topics related to the Affordable Care Act. The panel of experts from academia, industry, economics and the peer leadership community addressed a regional audience on the topic of *Accessing Treatment and Services People Need and Want*. Panelists included Certified Peer Specialist Charles Willis of the Georgia Peer Support Resiliency Project; economist Dr. Howard Fleeter, author of a widely cited study on the costs of prior authorization; Marianne Burdison, LCSW, the Director of Product and Business Development at Cenpatico speaking about the cost effectiveness and outcomes of peer services in Medicaid managed care; and the renowned Dr. King Davis, from the University of Texas at Austin, School of Social Work, outlining the policy implications of what was presented, and providing a call to action.

Preceding the issue forum, David Doman, MS, RPH, of Johnson and Johnson who serves a number of leadership roles as a member of the National Quality Forum (NQF), led a discussion on the need for expanded behavioral health quality measures. The fifty attendees included MHA affiliates; sister mental health advocacy organizations, including representatives from NAMI's local, state, and national offices; industry partners; local provider representatives; and local law enforcement. What emerged from this pre-issue forum roundtable discussion was a deeper understanding that the NQF, while seeking to address behavioral health outcomes, is only looking at clinical services site-based outcomes, such as hospital stays and the use of outpatient clinical services. What became clear to the discussion participants was the immediacy of the need to advocate for quality measures that reflect community based, recovery-focused services, and to create measures that reflect quality-of-life and community inclusion rather than only clinical usage outcomes.

Charles Willis set the tone for the issue forum by sharing a deeply personal story that was at once inspirational, and also a rallying cry for the imperative for peer support, self-determination and whole person perspective in the implementation of the Affordable Care Act. He told of how he began to self-medicate as a teenager in order to dull the pain of childhood abuse, which was followed by periods of confinement in hospitals and jails, living on SSI in public housing, and on to losing his wife and family as his addictions and mental illness led him to homelessness. In doing so, he wove a story of recovery and transcendence that began with a literal need to come in out of the cold. AA meetings, Charles explained, provide a warm place to get a free cup of coffee. In addition to the coffee, Charles found what he called "a renewal of life" in the form of peer support. "Trauma-informed peer support based on the all-important question 'what happened to you,' rather than the perspective from which most behavioral health services begin, 'what's wrong with you,' is what will get people on the road to recovery and hold down health care costs." "We have found the neck," Charles reminded the audience. "The head is connected to the rest of the body and therefore we must treat people as holistic, spiritual beings." Charles went on to explain that real health care reform must come by supporting self-determination, which begins by asking people what they want, and what they need in order to be productive in the community. By doing so he asserted, we can avoid many of the most expensive and debilitating aspect of mental illnesses provide people paths to change their behaviors and move towards wellness.

Charles offers himself as proof of this. Once he found the support he needed, he was able to take responsibility for his health and wellness, and his behavior. He completed his education, earning a

master's degree, reconciled with his wife and family, and now in his position as the Executive Director of the Georgia Peer Support Resiliency Project, he travels the county training peers, modeling recovery and spreading hope.

Economist Dr. Howard Fleeter explicitly demonstrated how Prior Authorization policies, contrary to what they are purported to do, not only do not save money, but they actually increase the usage of the most expensive services, such as crisis, emergency and inpatient, and substantially shift costs to other even more expensive systems like courts, jails and prisons. Discussing his 2008 Ohio study, entitled *Estimate of the Net Cost of a Prior Authorization Requirement for Certain Mental Health Medications*, and citing research from other state studies and material he's collected for a follow up study in Ohio, Dr. Fleeter presented direct and indirect costs that counter the claim that prior authorization saves money. Unlike medications for other types of health conditions, psychiatric medications have what he described as a "smaller margin of error." The reason for this Dr. Fleeter explained is two-fold.

Unlike medications for common physical ailments, psychiatric medications have less predictable efficacy, and have much harder to predict side effect profiles and more costly outcomes when the wrong medication is chosen or the preferred one is denied. "It is not like getting the wrong cholesterol drug," Dr. Fleeter offered as a comparison. If a person has to discontinue his cholesterol medication because a formulary requires a lower- cost, off-patent drug be tried first, and it does not sufficiently lower the cholesterol level, or the side effects are severe, a period without medication until the next doctor's appointment can be scheduled, or while authorization for a non-preferred medication is obtained, there will be little (if any) short or long-term consequences. He contrasted that with statistics showing that 80 percent of people that have a medication interruption of more than 30 days will suffer a relapse of acute symptoms requiring crisis services, hospitalization, threaten employment status, and sometimes result in criminal justice involvement and/or homelessness. In addition to the suffering this would cause, the economic costs are likely to be at least tens of thousands of dollars.

Lastly, Dr. Fleeter spoke of the administrative and legal compliance costs of prior authorization programs. Proponents of prior authorization programs, he explained, downplay the damage that prior authorization causes by pointing out that the expectation is that 9 times out of 10 when an appeal is filed the preferred medication will be approved. However, this occurs only after patient and doctor angst and inconvenience, a great deal of paperwork, and administrative expenses add to the cost of the medication. Some people may not appeal, maybe saving money in the short-term, but then face costly adverse consequences. Dr. Fleeter left the attendees pondering a question that he that he says defies logic in light of the economic and human costs that he is at a loss to answer in light of continued legislative initiatives to introduce and pass prior authorization legislation: "Why do it?"

The next speaker on the panel was Marianne Burdison, LCSW, who had come to offer her presentation *Managed Care Perspective on Funding Services and Supports in the Public Sector*. However, before Ms. Burdison did so, she took a few minutes to say how moved she was by Charles Willis's recovery story, and that it inspired her to share with the forum participants why, for her too, the work that she does is very personal. She went on to explain that her goal as the Director of Product and Business Development at Cenpatco is to create programs from the perspective of people working towards recovery because she too is a person in recovery, by asking the question: "How do we create the businesses that help us go to where we want to go?"

Like Charles, Marianne stressed that health care services must be whole-person focused and person-centered. She explained that the impact of mental health and physical health conditions is bi-directional.

Even though serious mental health conditions have a very high correlation with conditions such as diabetes, hypertension, weight gain, acute respiratory illnesses, and substance use disorders, doctors for the most part are only attending to one condition at a time and overlooking risk factors for other illnesses. Therefore, not only are people dying on average 25 years younger, but they often get inappropriate or incomplete treatment, and consequently health care costs are much higher than they need be. Integration of health care, Marianne explained, will help prevent, for example, treating someone only with psychotropic medication when they present with psychosis, but not checking liver enzymes to check for conditions such as HIV and hepatitis, which can also precipitate a psychotic episode, thus missing the underlying comorbidities and treating only symptoms.

“Margin follows the mission,” Marianne declared, as she outlined how doing the right thing also makes good business sense. By paying for “valued added services,” she explained, such as detox and residential substance use treatment, even when it might not be a covered service or deemed to be medically necessary, is not only good for individuals receiving services, but also for the corporate and public bottom line. She offered several examples, such as how it costs exponentially more to pay for neonatal intensive care than for adequate substance use services for a pregnant mother. She also described how peer services provide extraordinary return on investment by achieving the triple aim of providing improved health, better care and decreased cost. But requisite to achieving integrated care, providing value-added services, and insuring there are adequate provider networks of behavioral health care providers in every state will largely depend on how the Mental Health Parity and Addiction Equity Act is implemented. Marianne concluded by reminding the participants the ability to achieve the goals she put forth will very much depend upon how parity is implemented.

Behavioral health elder statesman Dr. King Davis rounded out the forum. He offered an astute summary of the panelist presentations, and led participants in a focused discussion of what they should be prepared to do to operationalize implementation of the Affordable Care Act. He began sharing some of his observations about his time as “keeper of the keys,” otherwise known as the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services for the Commonwealth of Virginia, and showing how his experiences are reflected in the panelist presentations, beginning with the undeniable fact that the provision of mental health services is big business. He related that when he was Commissioner in Virginia, mental health was the state’s fourth largest business. And he highlighted how then (in the 1990’s) and now (as well as historically) there are undeniable commonalities shaping mental health policies.

One of the common factors, as highlighted by Charles, is an inordinately high rate of premature death for people with serious mental health conditions. Dr. Davis said he recognized this as epidemic among people in the mental health system in the 1990’s (as did others as early as the 1930’s). And that despite well documented reports, such as the 2006 NASMHD *Morbidity and Mortality in People with Serious Mental Illness* and the many initiatives that it spawned, there has been little improvement in this horrific statistic. He agreed with Marianne that the only way to address co-morbidities and achieve the triple aim in health care reform is to fully implement whole-person integrated care. Dr. Davis also concurred with Charles’ observation that personal responsibility is essential to lowering high rates of serious co-morbidities and premature mortality.

Dr. Davis strongly agreed with Howard that lack of insight is also a problem among policy makers because historically, despite data to the contrary, it is quite common for legislators to ignore logic and act contrary to stated objectives. He noted that they also act similarly with respect to scientific information. Even when science demonstrates with reasonable certainty, or research shows quantifiable

outcomes, legislative changes are always difficult to achieve and slow to come. All too often, Dr. Davis pointed out, what it takes to break such intractability and force change is a lawsuit. He related that when he was Commissioner in Virginia he was sued 385 times. Some of these cases are still wending through the courts. Political involvement, personal stories and public education are key, but in his experience what drives systems is fear—fear of pressure from vested interests, such as political parties, and opposition from unions and guilds because change will affect their business interests, and fear of being sued. It is incumbent on all of us, Dr. King urged, to create mental health literacy (especially among policy makers, the public and especially within minority communities) and to advocate that policy reflect a public health perspective.

Questions from the audience sparked discussion on parity, medication use, mental health literacy and prior authorization. Panelists agreed with Marianne Burdison that even though legislators are perusing prior authorization statutes, “it is old school,” and that if the Affordable Care Act is correctly implemented and services are block funded, instead of fee-for-service, and based on outcomes, then prior authorization should become moot.

Charles Willis addressed a question about medication usage by stating that medication is a tool sometimes for the long-term, sometimes only for a limited time. He shared that he is “stepping down” his medications, and that practitioners should be paid to help people do so also if that is their choice. But he stressed that medication is very often the tool that allows people to “step into recovery.”

King Davis reiterated the importance of health literacy in changing policy from its present crisis-focused perspective. We pay a lot of money for the most expensive services, he explained, and costs are shifted into the criminal justice system and other social services rather than creating policies that promote healthy populations and save money. We need more health promotion and preemption services (intervening earlier and providing a full range of support services).

All the panelists agreed that there is an acute crisis in the behavioral health workforce that goes beyond just clinicians. In addition to a dearth of psychiatrists (especially for youth and older adults), there is a severe shortage of direct care workers in schools, hospitals and other institutional settings. Peers will help to mitigate some workforce issues, as will increased use of technological tools such as telemedicine. They also stressed the need to find ways to incentivize people to go into the mental health field. Lastly, all agreed that Medicaid and insurance plans in every state must be brought up to speed on the importance of quality of life outcomes and other social criteria and not base coverage upon the very limited perspective that is now used—medical necessity.

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