Implications/Impact of Healthcare Reform and Parity for Behavioral Health

MHSA Coordinators Call
May 28, 2010
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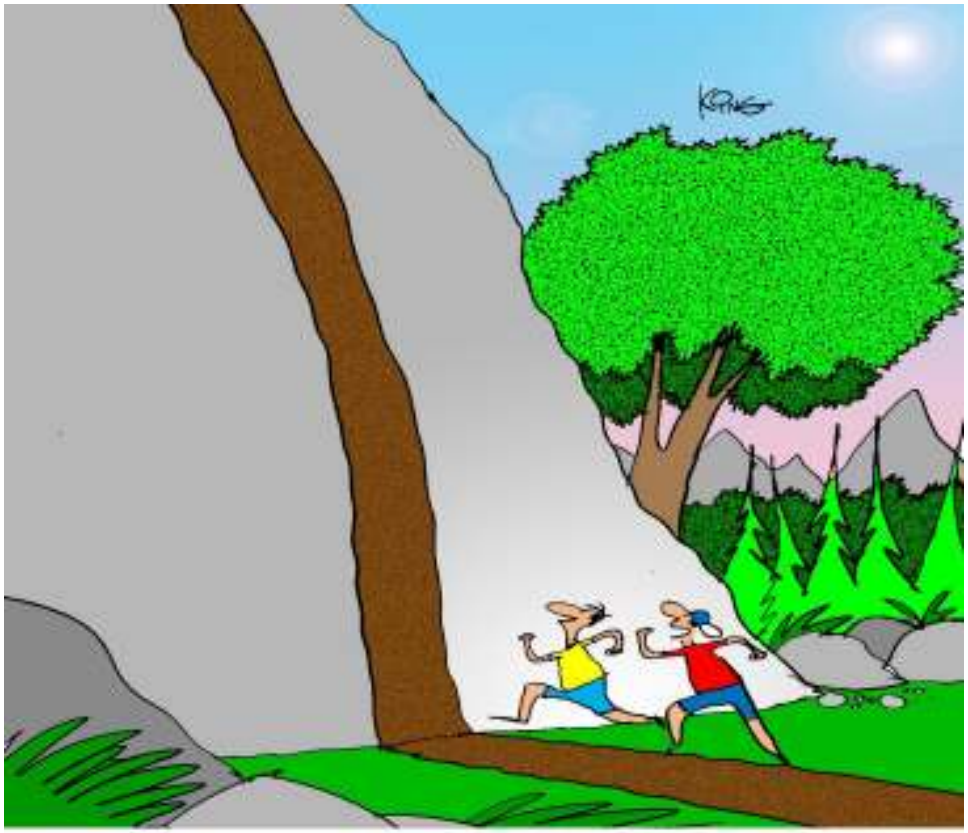
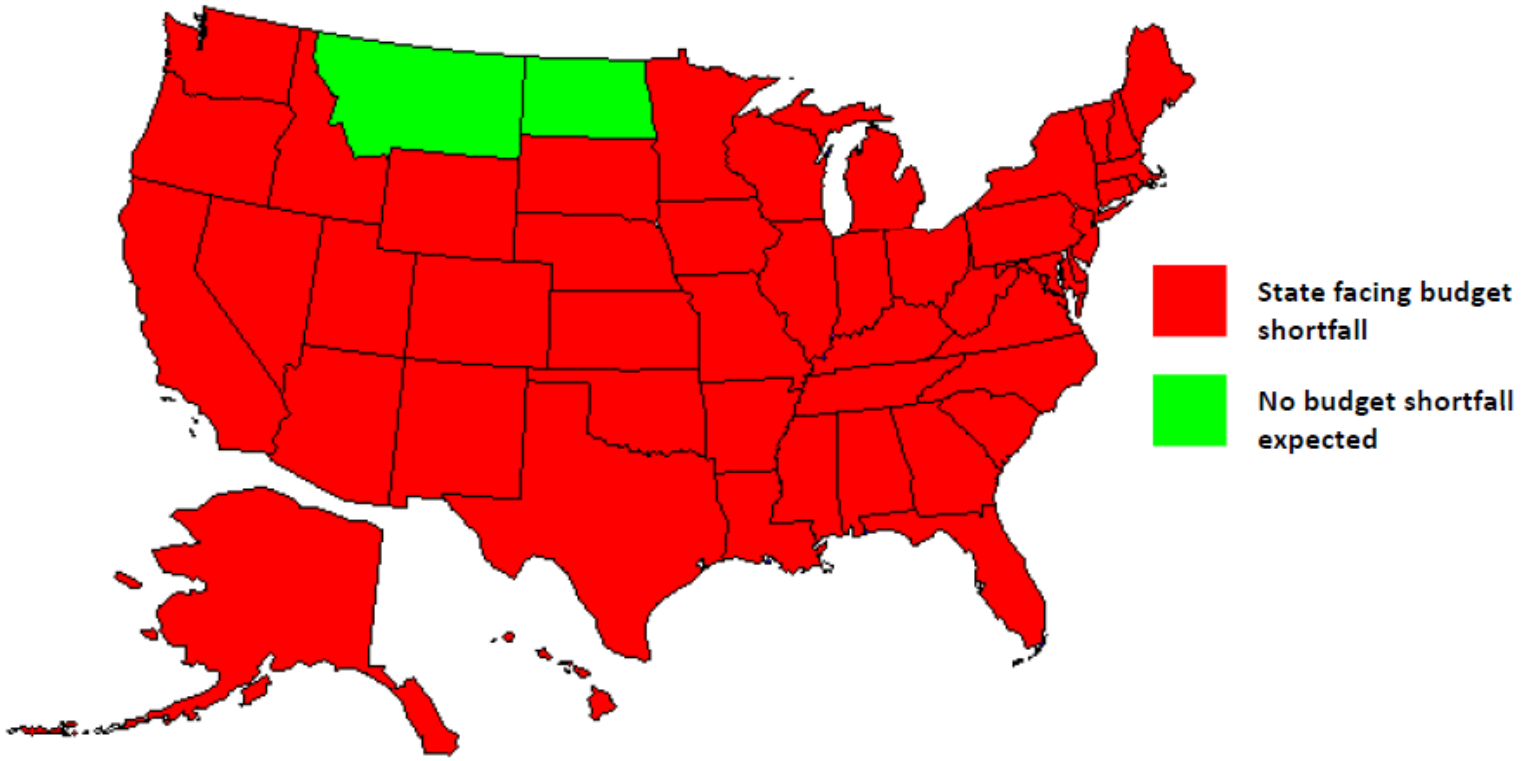
Healthcare Reform & Behavioral Health Overview



"This is where the trail gets a little more challenging."

48 States Face Budget Shortfalls

(Includes states with shortfalls in FY2010)



Map from the Center on Budget and Policy Priorities: McNichol, E., & Lav, I.J. (2009). State Budget Troubles Worsen.

The Behavioral Health "Tipping Point" Hypothesis

- We have reached the tipping point in understanding the importance of treating the ***healthcare needs of persons with SMI*** and the ***MH & SU of all Americans***
- Very important to managing ***Total Health Expenditures*** in the U.S. and *bending the cost curve*

Faces of Medicaid III: *Refining the Portrait of People with Multiple Chronic Conditions*

- New analysis includes pharmacy & 5 years data
- Fewer than 5% of beneficiaries account for more than 50% of overall Medicaid costs
- 75% of Medicaid costs = 3 or more chronic conditions
- Medicaid beneficiaries w disabilities w 3 or more chronic conditions ↑ from 35% to 45%
  - October 2009 Center for Healthcare Strategies

Faces of Medicaid III (cont)

- Psychiatric illness among Medicaid beneficiaries w disabilities ↑ from 29% to 49%
- Psychiatric illness is represented in 3 of the top 5 most prevalent pairs of diseases among the highest-cost 5% of Medicaid-only beneficiaries with disabilities

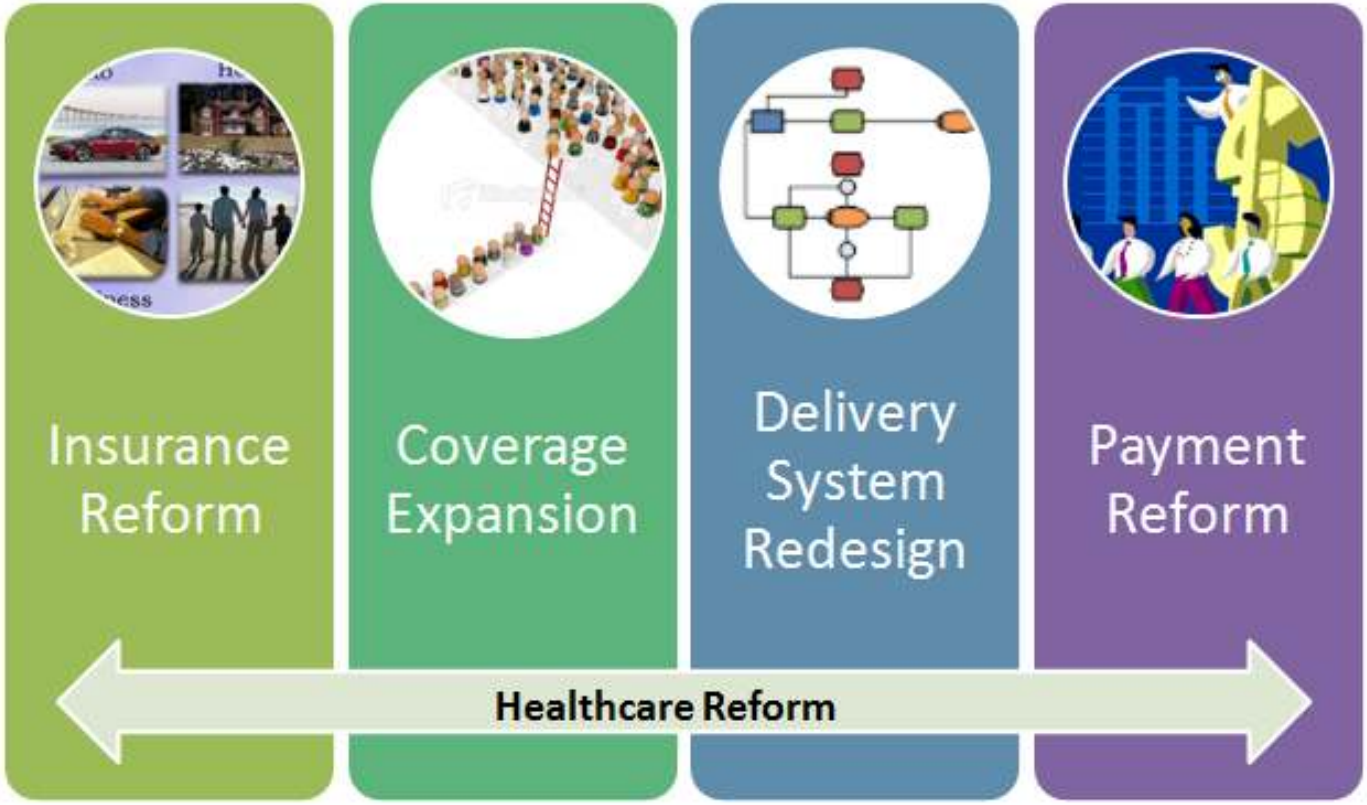
The Behavioral Health "Tipping Point" Hypothesis

- Changes will drive ***integration*** of Primary Care and Behavioral Health in the form of the ***Person-Centered Healthcare Home***
- And create ***greater demand*** for MH & SU treatment services
- Changes = enormous ***opportunities and threats*** to Community MH and SU Systems, which will:
  - need to demonstrate they can provide evidence-based, high quality care
  - Can ***produce outcomes and manage total health expenditures***

National Healthcare Reform
Root Cause Analysis

- Root Cause Analysis: Wrong incentives and many disincentives that lead to:
  - ***Lack of Access*** due 48 million citizens without insurance and resource misallocation
  - ***Overuse*** of unnecessary, high cost tests and procedures
  - ***Underuse*** of prevention, early intervention primary care and behavioral health services
  - ***Medical errors*** due to poor coordination among providers, poor communication with patients, etc
  - As much as 30 percent of health care costs (over $700 billion per year) could be eliminated without reducing quality
    - National Council

National Healthcare Reform
Four Key Strategies



U.S. health care reform is moving forward to address key issues

- Charles Ingoglia, National Council

Coverage Expansion: Federal Healthcare

- The New Health Care Reform Law:
  - Requires most individuals to have Coverage
  - Provides Credits & Subsidies up to 400% Poverty
  - Employer Coverage Requirements (>50 employees)
  - Small Business Tax Credits
  - Private Insurance policy costs include $1,000 per year of Uncompensated Care
  - Creates State Health Insurance Exchanges
  - Expands Medicaid to 133% of fed poverty level

Coverage Expansion – Parity Legislation

- Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Law: Mental Health and Substance Use Services must be provided at parity with general healthcare services (no discrimination)
  - Generally effective for plan years after October 3, 2009
- Interim Final Regs issued February 2, 2010 (75 Fed. Reg. 5410)
  - Agencies are requesting comments-- they may issue revisions
- Current lawsuit on procedural grounds by behavioral health managed care companies. Temporary injunction denied; outcome of rest uncertain

Coverage Expansion – Parity Legislation

- HCR builds on parity, and includes:
  - Large Employers (Parity Act)
  - Managed Medicaid Plans (Parity Act & Reform Legislation)
  - Health Insurance Exchanges for Individual and Small Group Policies (Health Reform Legislation)
  - Medicare: more to do (Medicare Improvements Act – MIPPA)
  - But a mandate that the mental health and substance use benefits that are required of plans offered through the Exchanges will apply to those newly eligible for Medicaid through the expansion.

    Key Question: will Insurance companies provide adequate "scope of services" needed for persons with SMI/SED?

Parity Requirements/Limitations

- **Financial requirements** – e.g., deductibles, copayments, coinsurance, out-of-pocket maximums
- **Treatment limitation requirements** – cannot limit benefits based on frequency of treatment, number of visits, days of coverage, days in a waiting period, and "**other similar limits on the scope and duration of treatment" unless same limits on other benefits**
  - **Quantitative treatment limitation** – expressed numerically, e.g., annual limit of 50 outpatient visits
  - **Nonquantitative treatment limitation** – not expressed numerically but otherwise limits the scope or duration of benefits

Coverage Expansion: Most Members of the Safety Net will have Coverage including MH/SU

- 15 M increase in Medicaid enrollees (43%)
- 16 M increase in privately insured (8%)

Impact of U.S. Health Reform on Coverage for Non-Elderly
Senate Finance Committee Reform Bill

	Current Law 2019 (Millions)	Reform Impact (Millions)	Reform Total (Millions)	Reform Impact %
Medicaid/CHIP	**35**	**15**	**50**	**43%**
Private/Other Insured	**193**	**16**	**209**	**8%**
Covered Non-Elderly	**228**	**31**	**259**	

Coverage Expansion: Most Members of the Safety Net will have Coverage including MH/SU

- $15 to $23 billion in added spending for MH/SU from insurance expansion
- No credible info yet on $ impact of Parity Act

Senate Healthcare Reform Bill	2019
Medicaid & SCHIP Expansion	$87,000,000,000
Healthcare Exchange Subsidies	$106,000,000,000
Total Expansion Funding	$193,000,000,000
Behavioral Health Spending @ 8%	$15,440,000,000
Behavioral Health Spending @ 10%	$19,300,000,000
Behavioral Health Spending @ 12%	$23,160,000,000

Coverage Expansion: Most Members of the Safety Net will have Coverage including MH/SU

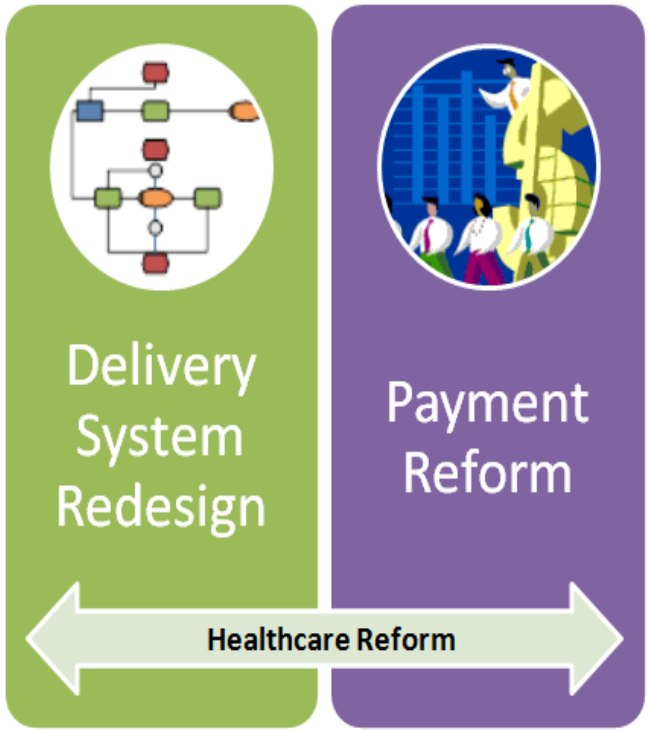
A much greater demand for service providers: these figures are based on closing the gap halfway for just the indigent & uninsured individuals with a SMI/SED

State	Added to Serve to close 50% of Gap	Additional FTE Demand
Alabama	11,421	266
Alaska	1,913	44
Arizona	55,564	1,292
Arkansas	16,391	381
California	235,148	5,468
Colorado	25,284	588
Connecticut	3,411	79
Delaware	2,730	63
District of Columbia	1,832	43
Florida	124,258	2,889
Georgia	49,170	1,143
Hawaii	1,365	32
Idaho	2,378	55
Illinois	80,312	1,867
Indiana	21,549	501
Iowa	1,073	25
Kansas	5,686	132
Kentucky	21,046	489
Louisiana	33,169	771
Maine	4,999	116
Maryland	31,415	730
Massachusetts	6,010	140
Michigan	38,266	890
Minnesota	7,065	164
Mississippi	13,922	324
Missouri	24,245	564
Montana	5,165	120
Nebraska	5,746	134
Nevada	16,295	379
New Hampshire	1,326	31
New Jersey	13,811	321
New Mexico	16,895	393
New York	12,346	287
North Carolina	48,403	1,125
North Dakota	313	7
Ohio	35,695	830
Oklahoma	18,845	438
Oregon	11,174	260
Pennsylvania	55,933	1,301
Rhode Island	833	19
South Carolina	18,104	421
South Dakota	2,422	56
Tennessee	29,542	687
Texas	228,586	5,315
Utah	11,427	266
Vermont	1,247	29
Virginia	28,445	661
Washington	24,264	564
West Virginia	2,143	50
Wisconsin	8,657	201
Wyoming	1,488	35
United States	**1,418,715**	**32,988**

Insurance Reform

- The New Healthcare Reform Law:
  - Requires guaranteed issue and renewal
  - Prohibits all annual and lifetime limits
  - Bans pre-existing condition exclusions
  - Create an essential health benefits package that provides comprehensive services *including MH/SU at Parity*
  - Requires health plans to spend 80%/85% of premiums on clinical services
  - Creates a new Health Insurance Rate Authority to provide oversight at the Federal level and help States determine how rate review will be enforced

Service Delivery Redesign and Payment Reform



- $700 Billion Question: Will the current legislative and regulatory *tools* at our disposal be enough to improve the health status of Americans and bend the cost curve?
- MH/SU Question: Is the answer to the above question the same for Americans with mental health and/or substance use disorders?

Other Relevant Service Delivery Redesign Opportunities

- New Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions or at least one serious mental health condition to designate a provider (which could be a community mental health center) as a health home – 90% federal funding for two years, effective Jan 2011.
- New grant program established to support co-location of primary and specialty care services in community-based mental and behavioral health settings.
- New grant program to fund community health teams to support primary care practices with interdisciplinary resources including access to mental health and addiction treatment specialists.
- New demonstration program to allow Medicaid coverage of private inpatient psychiatric facilities (i.e., IMDs) - $75 million available for 5 years.

Other Relevant Service Delivery Redesign Opportunities

- New program at HHS to develop, test, and disseminate shared decision-making tools to facilitate collaboration between patients, caregivers and clinicians, and incorporation of patient preferences and values into treatment decisions.
- New office within CMS to better integrate Medicare and Medicaid benefits for dual eligibles and improve coordination between the federal government and states.
- A new community transformation grant program will be established to support delivery of community-based prevention and wellness services.
- Home visitation will be promoted with $1.5 billion in grant funding for early childhood home visitation programs.

Variation in MH Funding Among States

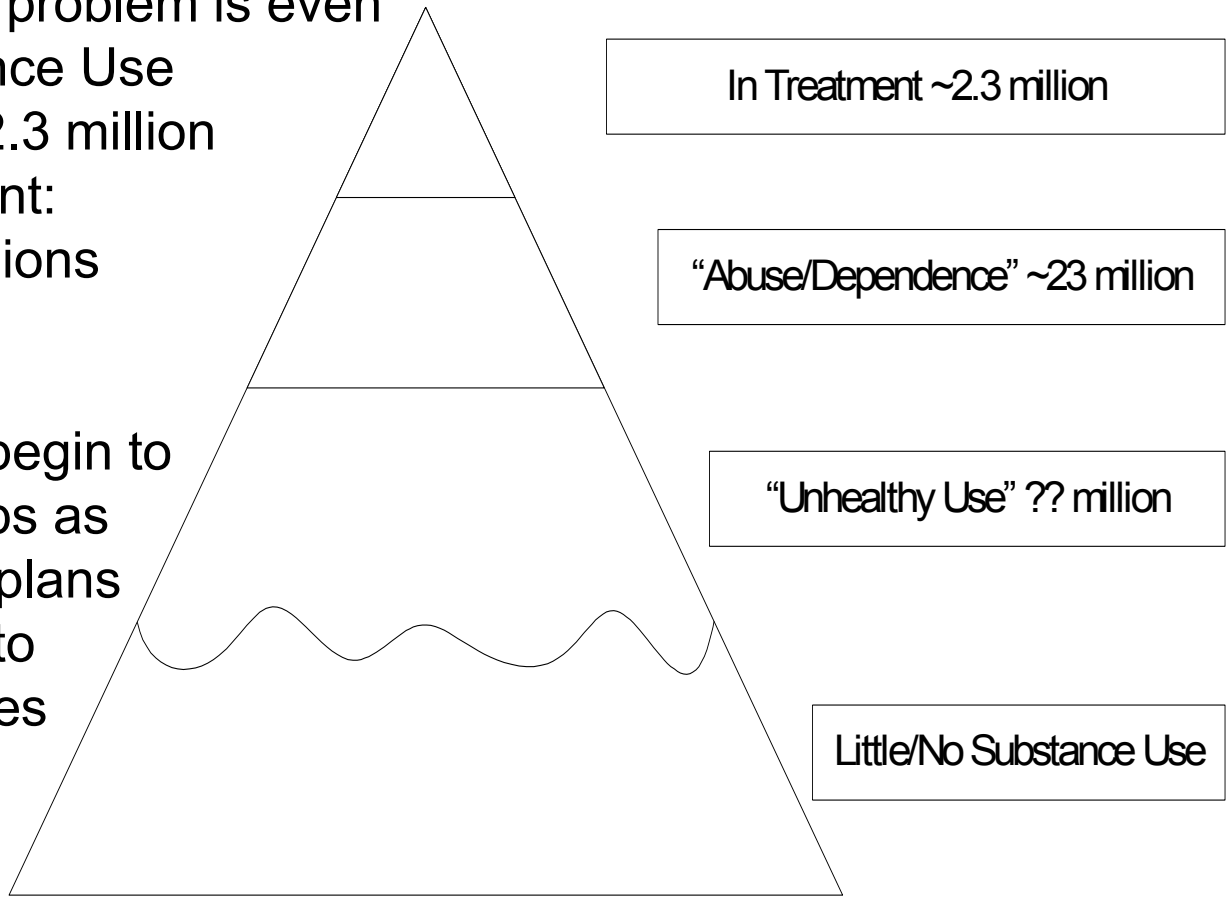
- How will HCR address variation in amount between states?
  - California is ranked 16th and 52% below average of top ten
- In CA, Counties Provide CPE: How will This Play Out?
  - Realignment
  - MHSA
  - SGF

National Healthcare Reform
Strategies and the MH/SU Safety Net

The underfunding problem is even greater in Substance Use

- In Treatment: 2.3 million
- Not in Treatment:
  - Tens of millions (McClellan)

How do we even begin to address these gaps as states and health plans realize they have to provide SU services at parity?



National Healthcare Reform Strategies and the MH/SU Safety Net

Relevance of:

- **Coverage Expansion**:
- **Insurance Reform**: this will become more important as Exchanges cover those between 134% and 400% Poverty Level
- **Service Delivery Redesign**:
  - Will the general healthcare system be willing to treat persons with > Mild MH/SUD?
  - Will Medical Home Prevention, Early Intervention and Care Management strategies get close to meeting the needs of persons with > Mild MH/SUD?
  - Will payors support embedding Primary Care in CBHOs to the extent needed to serve those with serious/severe MH/SU disorders?
  - Will the CBHO system be invited (late) to the $20B HIT Incentives “party”?

National Healthcare Reform
Strategies and the MH/SU Safety Net

- **Payment Reform:**
  - Will funding levels (beyond newly insured) come closer to matching need? What about In the states that are 1/3 or 1/4 of the average of the top 10?
  - Will new payment models be applied to MH/SU and will existing payment barriers be removed?

Emerging BH Safety Net Service Delivery Models

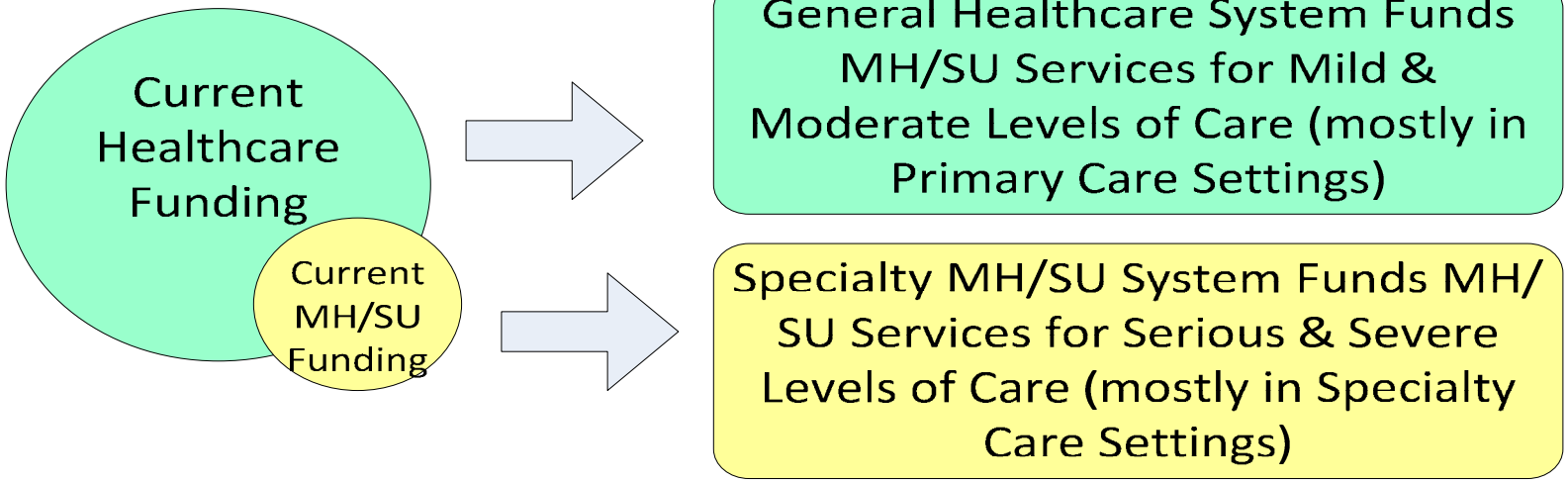
Safety Net BHOs will need to ensure that they meet a set core competencies in order to continue being an important part of the healthcare delivery system

1. A full Array of Specialty Behavioral Health Services
2. A well defined Assessment Process and Level of Care System
3. Measurement Systems and Tools that measure consumer improvement
4. Demonstrated use of Clinical Guidelines/Evidence Based Practices
5. A robust Electronic Health Record that includes Patient Registries
6. Quality Improvement Processes and supporting Data Systems
7. A solid approach to Prevention, Early Intervention, and Recovery
8. The ability to practice as a Team to Coordinate Care/Work with Primary Care
9. Financial Systems to manage Case Rate Payments & the FQBHC Prospective Payment System

Financing Flow Concept

- Assuming that parity will be embedded as a requirement for most health plans in the final healthcare reform legislation and a broader behavioral health benefit will be available for most people with coverage, and …
- Drawing on the California Integration Policy Initiative framework of Mild, Moderate, Serious and Severe Levels of Care, and …

Untangling the MH/SU Funding



What Does all of This Mean for California?

- County integration efforts
  - Los Angeles; Orange; Santa Clara; Shasta; Placer; San Bernardino; Riverside, Alameda, Sacramento, San Diego, San Francisco, etc.
- CalMEND integration pilots
  - IHI Breakthrough Change Model
  - Development of Registry
  - Tools for integration

What Does all of This Mean for California?

- DHCS 1115b Waiver: key opportunity to shape CA response
  - No new state funds
  - Populations for focus:
    - Adults & children w SMI/SED
    - CCS
    - Seniors & Persons w/ Disabilities
    - Healthcare Coverage Initiative

DHCS Behavioral Health Integration Technical Workgroup

- Assignments
  - Rethink current systems of care
  - Define models to pilot and test different strategies to integrate primary care and behavioral health services, including substance abuse
  - Define strategies and methods to facilitate implementation of models of integration

Behavioral Health Integration Technical Workgroup

- Assignments cont.
  - Recommend measurable performance goals associated with BHI integration into an organized system of care
  - Recommendations for testing the BHI model
  - Recommendations for approaches for a successful transition of individuals into an organized system of care

CMHDA Budget/Policy Issues

- What will be the impact of MOE provisions on EPSDT and Managed Care?
- What will be CA's definition of "essential benefits package" and what "benchmark" package will be selected?
- What will be the impact of sharing ratios on local government CPE and MOE protections?

CMHDA Budget/Policy Issues

- What will be the impact of the new Chronic Conditions state plan option (90% fed match) and how can we get involved?
- What opportunities do we have with the Home and Community state plan beginning October 2010?
- How can we ensure CA participates in the acute IMD Demonstration Project?

CMHDA Budget/Policy Issues

- What will be the role and structure of the Health Exchanges in CA and what benefit packages will be offered?
- How will federal parity play out in California, and what will be county MH/SA role in the short and long term?

CiMH Planning: Informing; Educating; Influencing

- Understand the early opportunities in the HRC package and educate people about them
- Bring all mental health advocacy organizations along in helping them understand impacts of parity and HCR
- Educate leaders/policy makers about the meaning of HCR
  - Behavioral health reforms
  - Include legislative staff
  - Facilitate understanding of priorities and principles
  - Commercial health plans/Accountable care organizations
  - what workforce competencies are needed
- Educate the health providers/plans about their responsibilities under parity/HCR

CiMH Planning: Think Tank for "What will Work"

- Accelerate CiMH's role as "convener" in integrating and bringing people and partners together
- Convene the conversations; Translate HCR and develop the "fact basis"
- Translate conversations into action
  - Build on what we're doing now
  - Build coalitions of counties and CBHOs
  - Work w counties and providers to Implement ideas without waiting for the state to sanction them
  - Do full-scale integration pilots
  - Move to statewide scale (not just small pilots).
  - Develop standards for EBPs that work across counties
  - Build something that "mimics a public option"
- Increase dialogue with ethnic-based organizations that are tracking HCR/parity legislation: These represent populations that are currently uninsured

CiMH Planning: Developing new models; competencies; training; TA

- Focus on “the nine competencies”
- Educate stakeholders about these competencies
  - “CBHOs will need to ensure that they meet a set of core competencies in order to be an important part of the healthcare delivery system:”
    - A full array of specialty behavioral health services
    - A well-defined assessment process and level of care system
    - Measurement systems and tools that measure consumer improvement
    - Demonstrated use of clinical guidelines
    - A robust electronic health record that includes patient registries
    - Quality improvement processes and supporting data systems
    - A solid approach to prevention, early intervention and recovery
    - The ability to practice as a team to coordinate care
    - Financial systems to manage case rate payments and the FQBHC Prospective Payment System
- CiMH should keep scanning the environment to see opportunities for MH transformation
- Stay focused on recovery
- Training, educate, advocate – “ensure true consumer leadership”