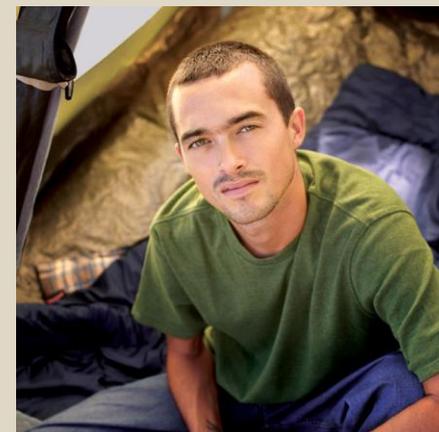




Federal Healthcare Reform and the Impact on Mental Health

Chuck Ingoglia

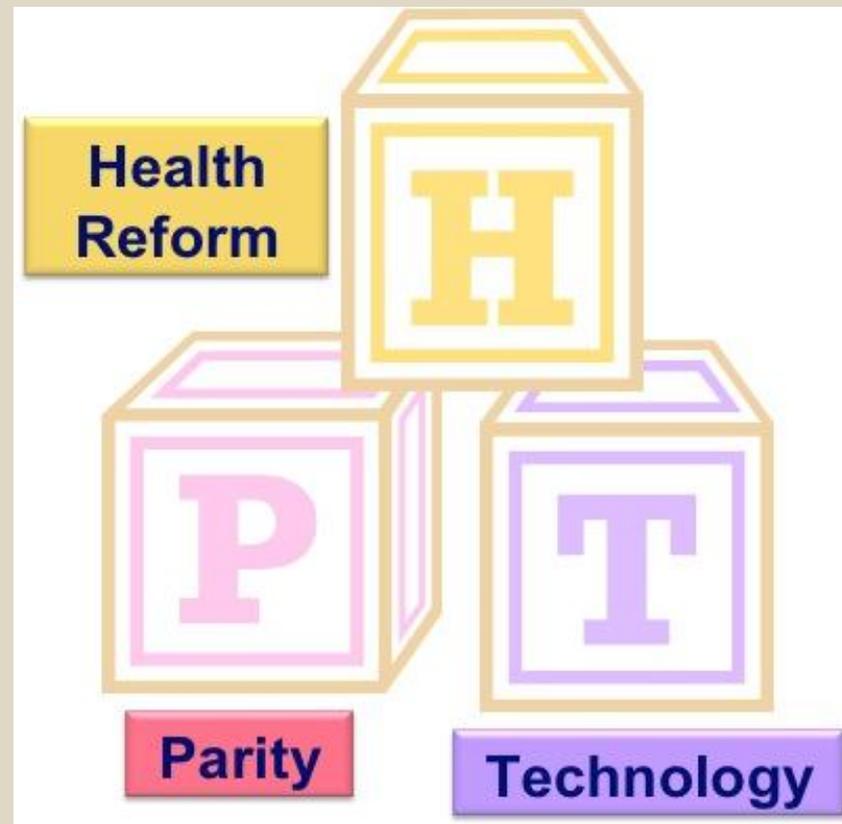
National Council for Community Behavioral Healthcare
February 15, 2011

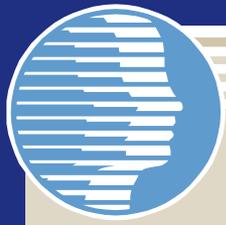




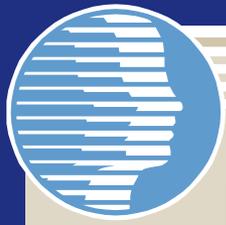
Changing Landscape for Behavioral Health

- > Parity, technology and reform will trigger dramatic changes in how health and MH/SU services are **organized**.
- > These changes will create a tipping point in how the **healthcare needs of persons with serious mental illness** and the **MH/SU healthcare needs of all Americans** are addressed.
- > Which will change the way MH/SU services are **funded and fit into the new healthcare ecosystem**.





Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act



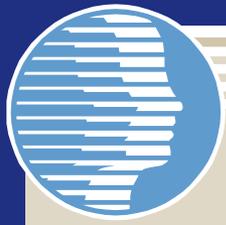
Parity – General Information on Interim Final Regulations

- > Apply for plan years beginning July 1, 2010
- > General rule – parity applies if a plan offers medical/surgical and MH/SUD benefits (> 50 employees)
 - Applies to Medicaid Managed Care
 - Will apply to Medicaid benchmark plans beginning in 2014
- > A plan may not apply any **financial requirement** or **treatment limitation** to MH/SUD benefits in any classification that is **more restrictive** than the **predominant** requirement or limitation for **substantially all** medical/surgical benefits in the same classification



Analyzing Plan Benefits

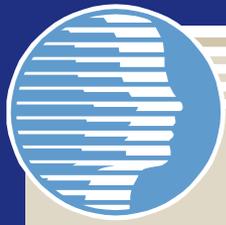
- > A requirement/limit applies to substantially all medical/surgical benefits in a classification if it applies to at least 2/3 of benefits in the classification — if not, it cannot be applied to MH/SUD benefits.
- > Example: If 70% of the projected payments for inpatient, in-network medical/surgical benefits were subject to a \$15 copay.... then... no inpatient, in-network MH/SUD could be subject to a copay greater than \$15.
- > MH/SUD and medical/surgical benefits must accumulate toward the same, combined deductible — separate but equal deductibles are not allowed.



Non Quantitative Treatment Limitations

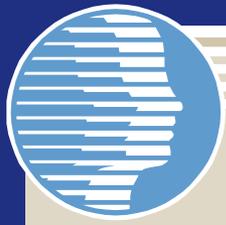
Definition – not expressed numerically – list of examples:

- > Medical management (e.g., utilization review, preauthorization, concurrent review, retrospective review, case management, etc.)
- > Prescription drug formulary design
- > Standards for provider participation in a network, including reimbursement rates
- > Fail-first or step therapy protocols
- > Conditioning benefits on completing a course of treatment

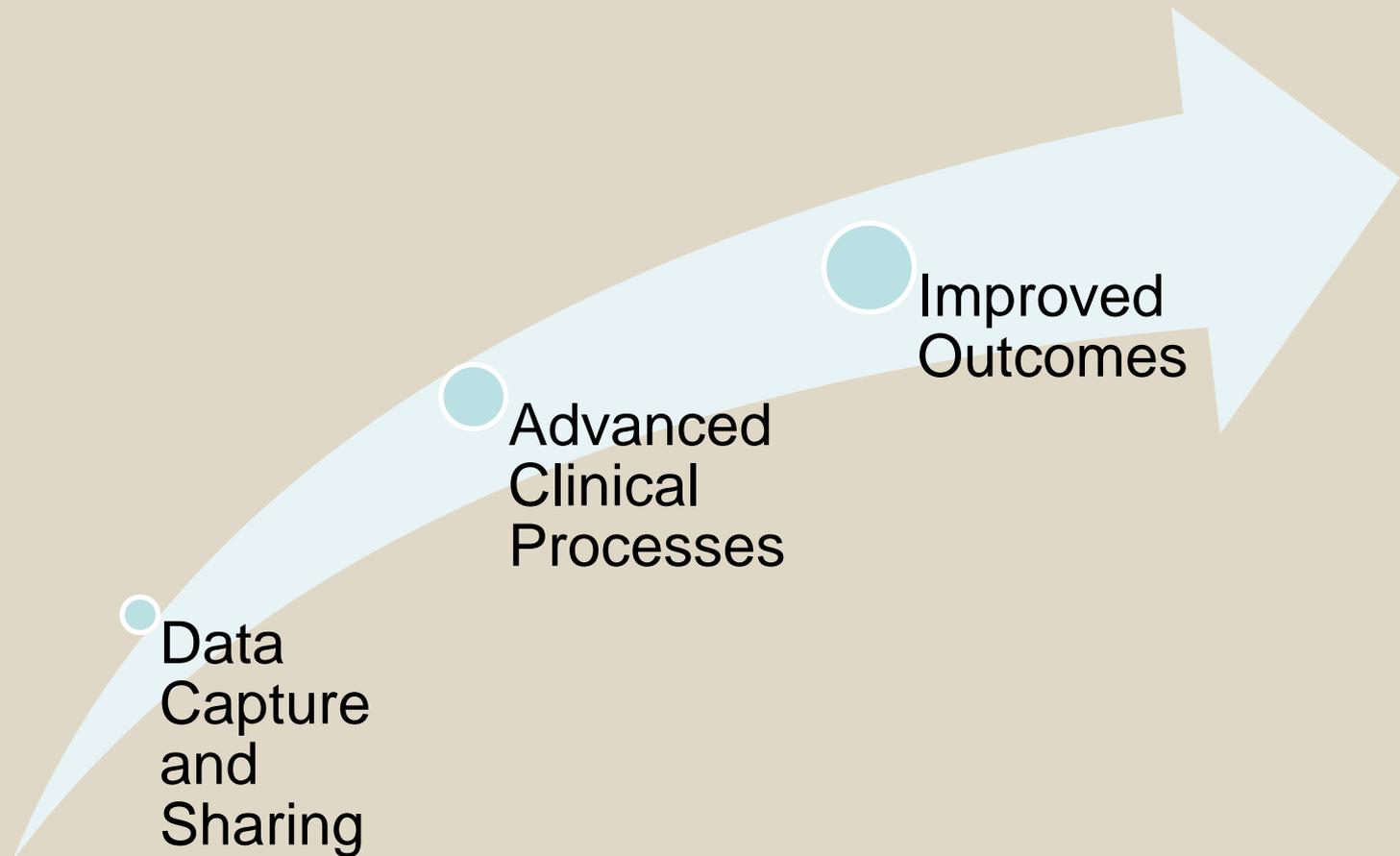


Health Information Technology

- > The Obama Administration made a “down payment” on healthcare reform with the passage of the HITECH Act in 2009.
- > Supports the adoption and meaningful use of Health Information Technology
- > State efforts should include behavioral health providers in HIT planning and implementation.



Conceptual Approach to Meaningful Use





Health Information Technology Requires

- > Shift to “measurement-based care” – adjusting treatment based on success of the intervention.
- > Ability to demonstrate that interventions improve health outcomes and/or save money.
- > Reporting of quality measures necessary for incentive payments.
- > New relationships with hospitals, community health centers and other parts of the healthcare delivery system.
- > All of these are supportive of California’s ongoing efforts to improve mental health care.



New Medicaid Options: Health Care Homes

- > State plan option allowing Medicaid beneficiaries with or at risk of two or more chronic conditions (including mental illness or substance abuse) to designate a “health home”
- > Community mental health organizations are included as eligible providers
- > Effective Jan. 2011
- > Additional guidance forthcoming from HHS



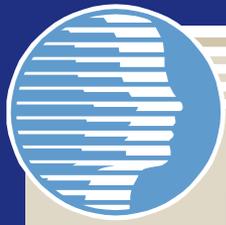
Medicaid Health Homes

- > 90% Federal match rate for the following services during the first 8 fiscal year quarters when the program is in effect:
 - Comprehensive care management
 - Care coordination and health promotion
 - Comprehensive transitional care from inpatient to other settings
 - Patient and family support
 - Referral to community and social support services
 - Use of health IT to link services (as feasible/appropriate)



Medicaid Reforms: Long Term Care Services & Supports

- Community First Choice Option
 - New state plan option through which states can offer community-based attendant services and supports to provide an expansive array of services to assist beneficiaries with incomes under 150% of poverty who would otherwise require an institutional level of care.
- 1915(i) State Option for Home and Community Based Services
 - Raises Income Level for Eligibility
 - Repeals Enrollment Cap Provision
 - Expands Range of Services
 - Allows for Target Populations
 - Permits Extension of Full Medicaid to HCBS eligible individuals
- Money Follows the Person Rebalancing Demonstration
 - Extended through 2016
 - Additional \$2.25 billion allocated for the extension



Medicaid Reforms

Dual Eligibles

- > Creates Office of Coordination for Dual Eligible Beneficiaries to align Medicare /Medicaid policies, integrate benefits, improve continuity of care, and enhance coordination of Federal and State governments.
- > Makes Rx co-pays for community living dual eligibles equal to those residing in long-term care facilities.

Health Care Homes

- > New Medicaid state plan option encourages greater coordination of and collaborative care by allowing Medicaid beneficiaries with or at risk of two or more chronic conditions to designate a “health home,” including CMHCs.
- > Includes \$25 million for planning grants made available to states for the planning and development of the state plan amendment.

Quality Demonstrations of Interest

- Medicaid Emergency Psychiatric Care Demo
 - 3 year, \$75,000,000 demo to fund 8 states to reimburse non-governmental freestanding psychiatric hospitals for emergency psychiatric stabilization for beneficiaries aged 21 to 65

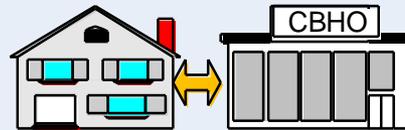
Maternal & Child Health

- Early Childhood Home Visitation Program
- Post-partum Depression Research and Support

New Paradigm – Primary Care in Behavioral Health Organizations

Funding starting to open up for embedding primary medical care into CBHOs, a critical component of meeting the needs of adults with serious mental illness

Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity



Primary Care Clinic with Behavioral Health Clinicians embedded, providing assessment, PCP consultation, care management and direct service

Partnership/Linkage with Specialty CBHO for persons who need their care stepped up to address increased risk and complexity with ability to step back to Primary Care

Clinical Design for Adults with Moderate to High BH Risk and Complexity



Community Behavioral Healthcare Organization with an **embedded Primary Care Medical Clinic** with ability to address the full range of primary healthcare needs of persons with moderate to high behavioral health risk and complexity



Care Management for Persons with SMI

- > Do you have the ability to identify patients with MH/SUD who represent the top 5% to 10% of high cost consumers of health care and provide effective care management services to help them manage their MH/SU disorders AND their chronic health conditions?

Aging and Disability Services Administration Chronic Care Management Project



A Look at National and State Data Tells Us

- Virtually all high-cost Medicaid beneficiaries have multiple physical and behavioral health conditions, disabilities, and or frailties associated with aging.
- In Washington State, 5% of Medicaid beneficiaries account for 50% of the costs, and many of them are also recipients of home and community based services. (Governor Memo 09/06)

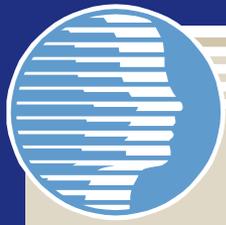
Project Overview

For the past three years, the Aging and Disability Services Administration (ADSA) has been providing the Chronic Care Management (CCM) Project. This model of chronic care management integrates acute (medical) and long-term care services using a service model of largely face-to-face care management for clients identified by the highest 20% cost predictive risk scoring (Predictive Risk Intelligence System - PRISM) and long-term care risk indicators (CARE).



Resources

- > *Behavioral Health/Primary Care Integration and The Person-Centered Healthcare Home*, April 2009, The National Council.
- > *Substance Use Disorders and the Person-Centered Healthcare Home*, March 2010, The National Council.
http://www.thenationalcouncil.org/cs/resources_services/resource_center_for_healthcare_collaboration/clinical/personcentered_healthcare_homes
- > California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative. Vols. I, II, and III. September 14, 2009.
- > *The Business Case for Bidirectional Integrated Care: Mental Health and Substance Use Services in Primary Care Settings and Primary Care Services in Specialty Mental Health and Substance Use Settings*. June 30, 2010. <http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx>
- > *Oregon Standards and Measures for Patient Centered Primary Care Homes*. February 2010. Office for Oregon Health Policy and Research. http://courts.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/docs/FinalReport_PCPCH.pdf



Questions?

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