

Oversight & Accountability Commission



June 19, 2013

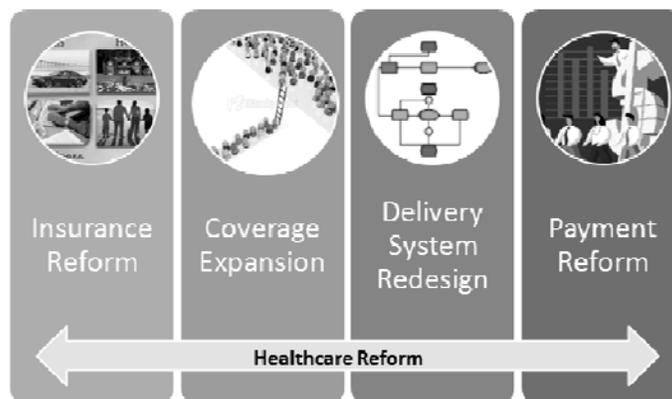
Sandra Naylor Goodwin, PhD, MSW
President and CEO

Agenda

- Basics of Healthcare Reform and Parity
- Planning for Bi-Directional Care
- California's Bridge to Healthcare Reform
- Covered California: Health Insurance Exchange

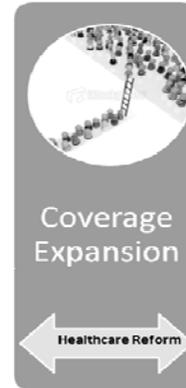
The Basics of Healthcare Reform and Parity

National Healthcare Reform Four Key Strategies



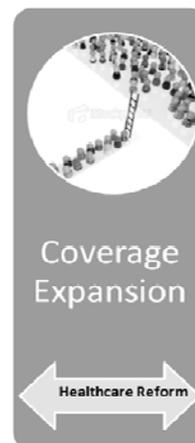
Coverage Expansion

- The New Health Care Reform Law:
 - Requires most individuals to have Coverage
 - Insurance Mandate was challenged as “unconstitutional”
 - Supreme Court ruled ACA constitutional
 - Creates State Health Insurance Exchange “Covered CA”
 - CA first state to pass legislation: now established
 - Employer Coverage Requirements (>50 employees)
 - Small Business Tax Credits



Coverage Expansion

- The New Health Care Reform Law:
 - Provides Credits & Subsidies up to 400% Poverty (FPL)
 - CA 1115 Waiver designed to move up to 200 % FPL (Healthcare Coverage Initiative HCCI)
 - Expands Medicaid to 133% of fed poverty level
 - CA 1115 Waiver designed to move to this benchmark (MediCal Expansion – MCE)



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)
 - Eliminates the practice of unequal health treatment.
 - Improves access to much needed mental health and substance use disorder treatment services
 - Generally effective for plan years after October 3, 2009
- Interim Final Regs issued February 2, 2010 (75 Fed. Reg. 5410)
- ACA builds on parity

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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

Insurance Reform



- The New Healthcare Reform Law:
 - Requires guaranteed issue and renewal
 - Prohibits all annual and lifetime limits
 - Bans pre-existing condition exclusions
 - Will create an essential health benefits package that provides comprehensive services *including MH/SUD 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

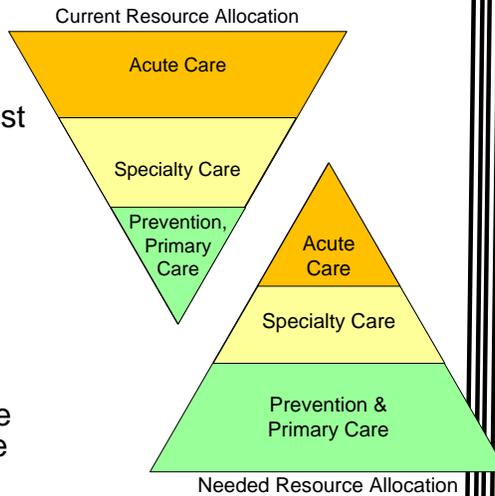
Service Delivery Redesign

- Institute for Healthcare Improvement's Triple Aim*
 - Improve the health of the population
 - Enhance the patient experience of care (including quality, access, and reliability)
 - Reduce, or at least control, the per capita cost of total healthcare
- California's ACA implementation

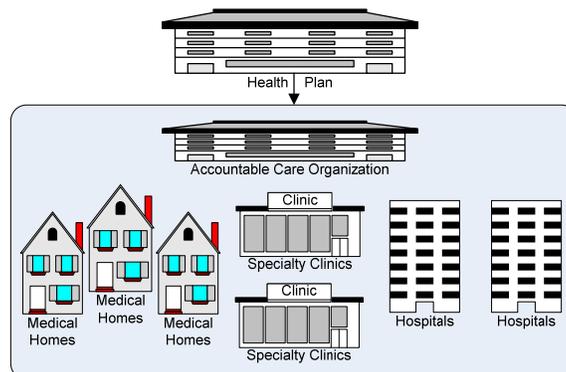
*Donald Burwick, MD, IHI Founder and former CMS Administrator

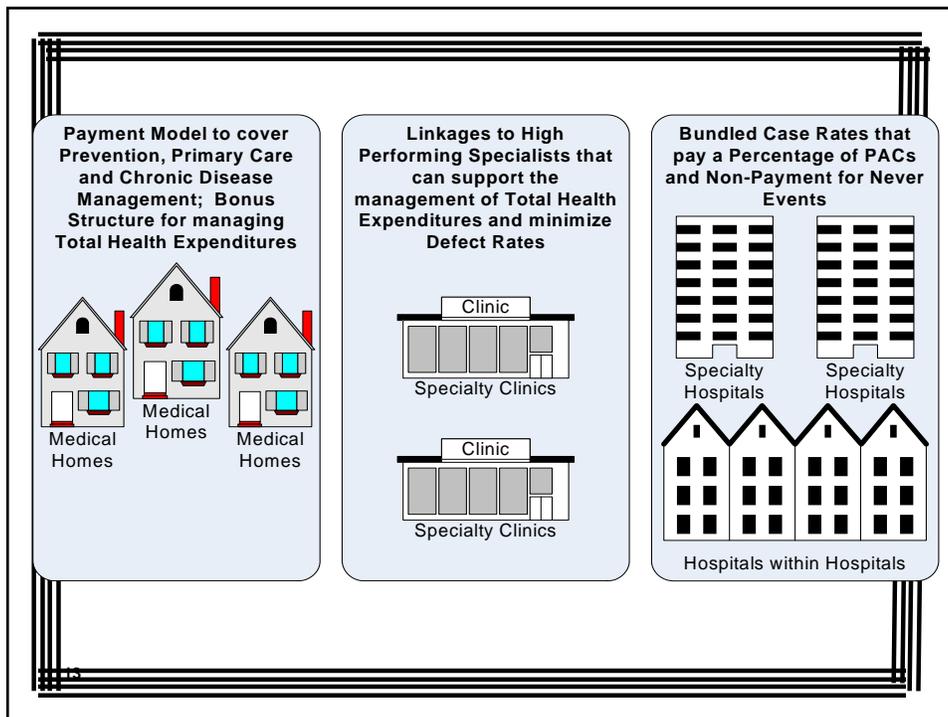
Achieving the Triple Aim

- Need to invert the Resource Allocation Triangle
- Prevention activities must be funded and widely deployed
- Primary Care must become a desirable occupation and...
- Services for MH/SU disorders must be integrated and robust
- Decrease demand in the specialty and acute care systems
- These are dramatic shifts



Healthcare Reform Model



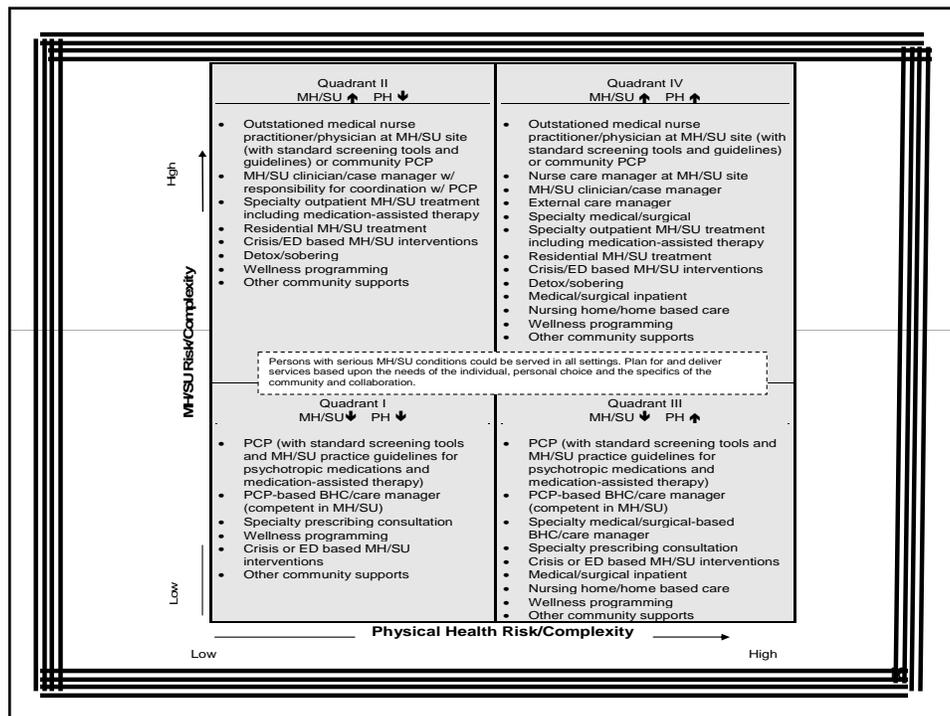


Payment Reform: from Volume to Value, Paying Based on Quality

- Shared savings
- "Episode-of-care payment"
- "Comprehensive care payment" (condition-adjusted capitation)
- Bundled payment
- Pay for performance
- Non-payment for: services required to treat complications, infections, etc.; for services that fail to meet minimum quality standards
- Quality-based tiers

Planning 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



The Affordable Care Act and California's "Bridge to Health Care Reform"

California

- 1115 Waiver "Bridge to HCR"
 - Low Income Health Plans
 - Seniors and Persons with Disabilities
- Demonstration Project
 - Dually Eligible (Medicare & Medi-Cal)
- Medi-Cal Expansion

California's Bridge to Health Care Reform 1115 Waiver & Demonstrations

- Key Programmatic Elements
 - Expand coverage to more uninsured adults;
 - Support uncompensated care costs;
 - Improve care coordination for vulnerable populations; and
 - Promote public hospital delivery system transformation.
- Managed Care: DHCS top priority

Low Income Health Program

- Low Income Health Program (LIHP) – two components
 - Medicaid Coverage Expansion (MCE)
 - Up to 133% FPL
 - ***Mental Health Minimum Benefit Required***
 - ***Substance Use Disorder Benefit Not Required***
 - Health Care Coverage Initiative (HCCI)
 - 134% to 200% FPL
 - ***MH & SUD Minimum Benefit Not Required***

LIHP Transitions

- Initiate Stakeholder Engagement
 - **June, 2013**
- Initial LIHP Transition Notice to Enrollees
 - **July, 2013**
- Transition HCCI enrollee contact info to Covered California for Outreach
 - **October, 2013**
- Administrative move of LIHP MCE to Medi-Cal
 - **December, 2013**

Managed Care for Seniors and Persons with Disabilities (SPDs)

- Medi-Cal enrollees who are Seniors or Persons with Disabilities (SPDs) into mandatory managed care
 - Goal to provide more coordinated care and contain costs.
- **49% of persons w disabilities**
- **36% of seniors have psychiatric illness**
- Behavioral Health not adequately addressed

Additional Federal Requirements Addressing Parity

- **Behavioral Health Services Assessment** - By March 1, 2012, State to submit CMS for approval an assessment that shall include information on available mental health and substance use service delivery infrastructure and other information necessary to determine the current state of behavioral service delivery in California.
- **Behavioral Health Services Plan** - By October 1, 2012, the State will submit to CMS for approval a detailed plan, outlining the steps and infrastructure necessary to meet requirements of a benchmark plan no later than 2014. **Final plan has been delayed.**

BH Service Plan

- October 2012 DHCS submitted an outline
 - Medi-Cal expansion still in development
- April 2013 DHCS submitted *Medicaid Alternative Benefit Plan (ABP) Options Analysis* prepared by Mercer
- October 2013 next Service Plan submission date
 - high-level overview of the selected benefit package, benefit delivery system(s), projected costs and levels of utilization

Dually Eligible: Medicare/Medi-Cal

- **Demonstration Project: Coordinate disparate, costly benefits, improve health**
 - All Medicare Part C and D Benefits
 - All Medi-Cal Services currently required in managed care coverage
 - Long-term supports and services
 - Nursing facilities, In-Home Supportive Services (IHSS), and Five home-and community-based waiver services.
 - ***Coordination with mental health and substance use disorder carved-out programs required by CMS***

Dual Eligibles

- **Now called Cal MediConnect**
- **8 counties – 3 year demonstration**
 - Los Angeles, Orange, Riverside, San Bernardino, San Diego, Alameda, Santa Clara, and San Mateo
- **Clients passively enrolled but may opt out**
- **June 2013** client and provider outreach
- **Aug 2013** readiness by CMS & DHCS
- **Sept 2013** contracts signed
- **January 2014** demonstration begins

Dual Eligibles

- 52% of individuals dually eligible for Medi-Cal and Medicare have a psychiatric disability
- CMS requires CA to address MH/SUD
 - Appendix 2 Framework for Shared Accountability: Coordination and Alignment Strategies for Integrated Delivery of Behavioral Health Services

Medi-Cal Expansion

Topic	Milestone
• State Legislation	Summer, 2013
• Establish Expansion Benefit Package	Summer, 2013
• CMS Approvals (State Plan Amendments, etc.)	Fall, 2013
• Open Enrollment Period	October – December, 2013
• Health Care Delivery Begins	January 1, 2014

Selected Medi-Cal ACA Implementation
Milestones

Covered California: California's Health Insurance Exchange Board

Covered California

- Primary individual health insurance marketplace
- New online tools to compare affordable coverage
- Low-income individuals and families qualify for free health insurance through Medi-Cal
- Moderate-income families will qualify for premium subsidies to purchase insurance

CA Mental Health System

- 1.6 M adults experience mental health distress in CA
 - Interferes with functions of daily living
- Approximately 600,000 currently served in public mental health system
- **1 M untreated**
- HCR & Medi-Cal expansion will add
 - 254,400 Medi-Cal eligible
 - 228,500 Exchange eligible
 - 58,600 Ineligible due to citizenship status

Questions?

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