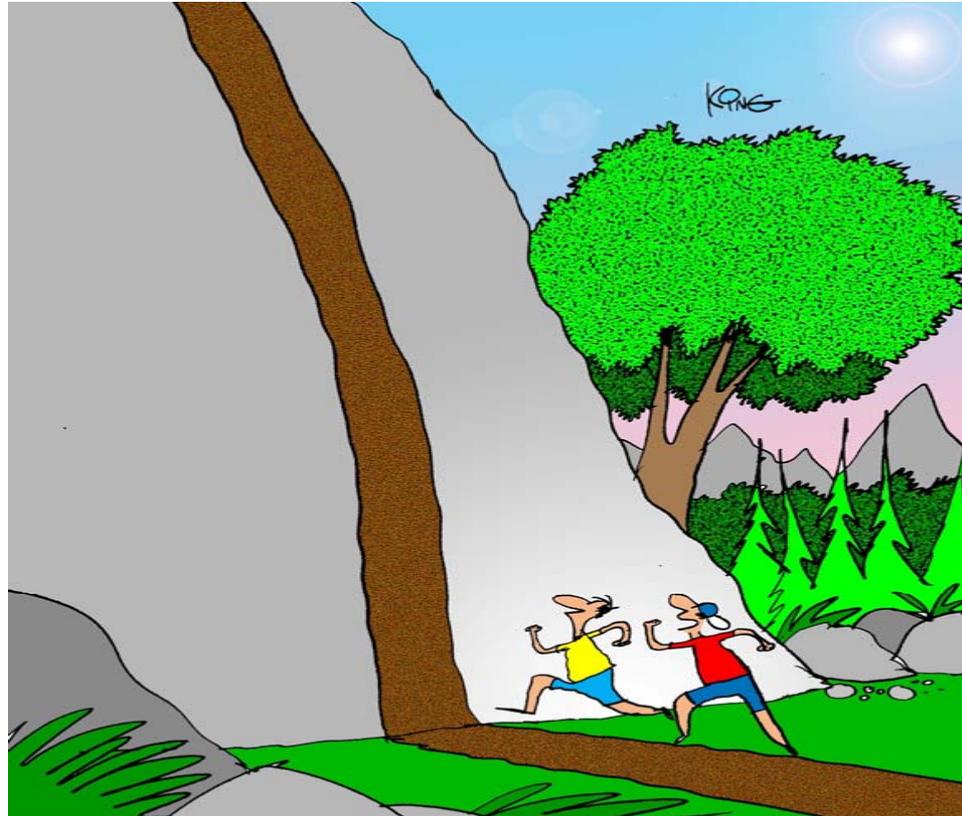


Implications/Impact of Healthcare Reform and Parity for Behavioral Health



Mental Health Services
Oversight & Accountability Commission
April 29, 2010

Healthcare Reform & Behavioral Health Overview



“This is where the trail gets a little more challenging.”

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***

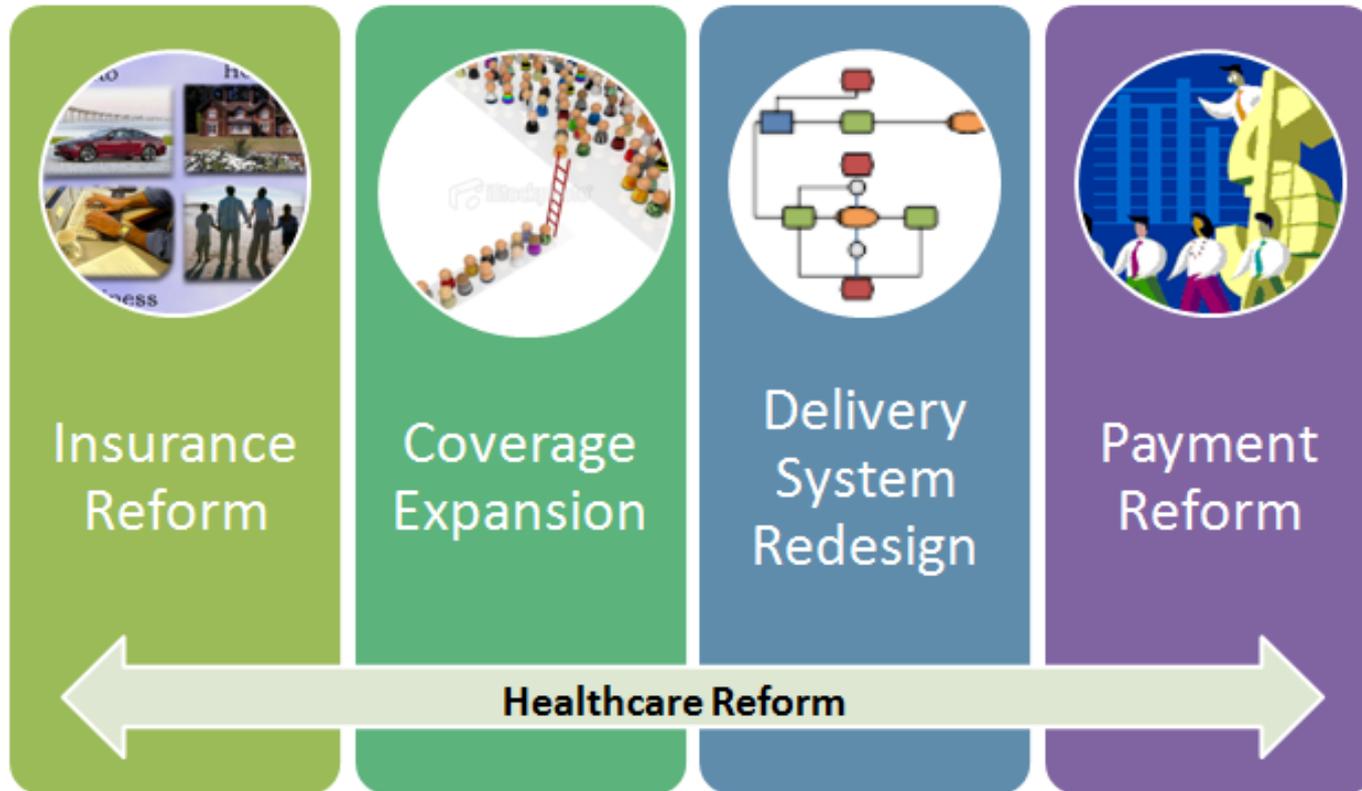
National Healthcare Reform

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

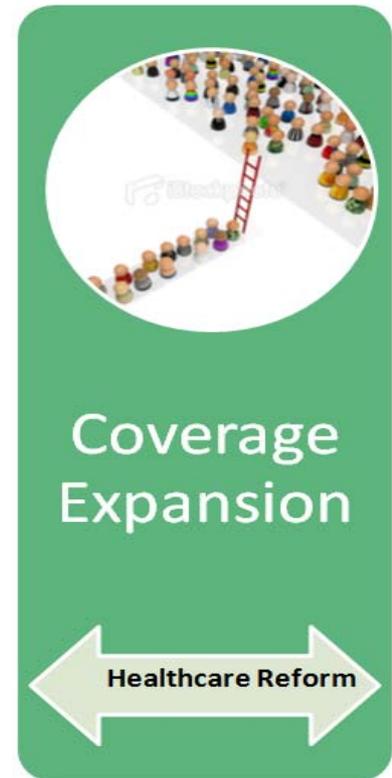
Four Key Strategies



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%)

	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

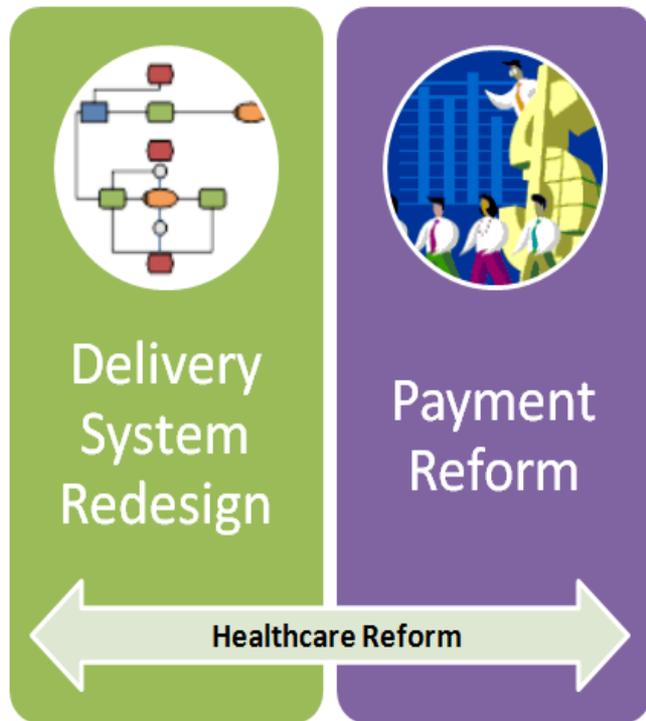
State	Added to Serve to close 50% of Gap	Additional FTE Demand	State	Added to Serve to close 50% of Gap	Additional FTE Demand
Alabama	11,421	266	Montana	5,165	120
Alaska	1,913	44	Nebraska	5,746	134
Arizona	55,564	1,292	Nevada	16,295	379
Arkansas	16,391	381	New Hampshire	1,326	31
California	235,148	5,468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

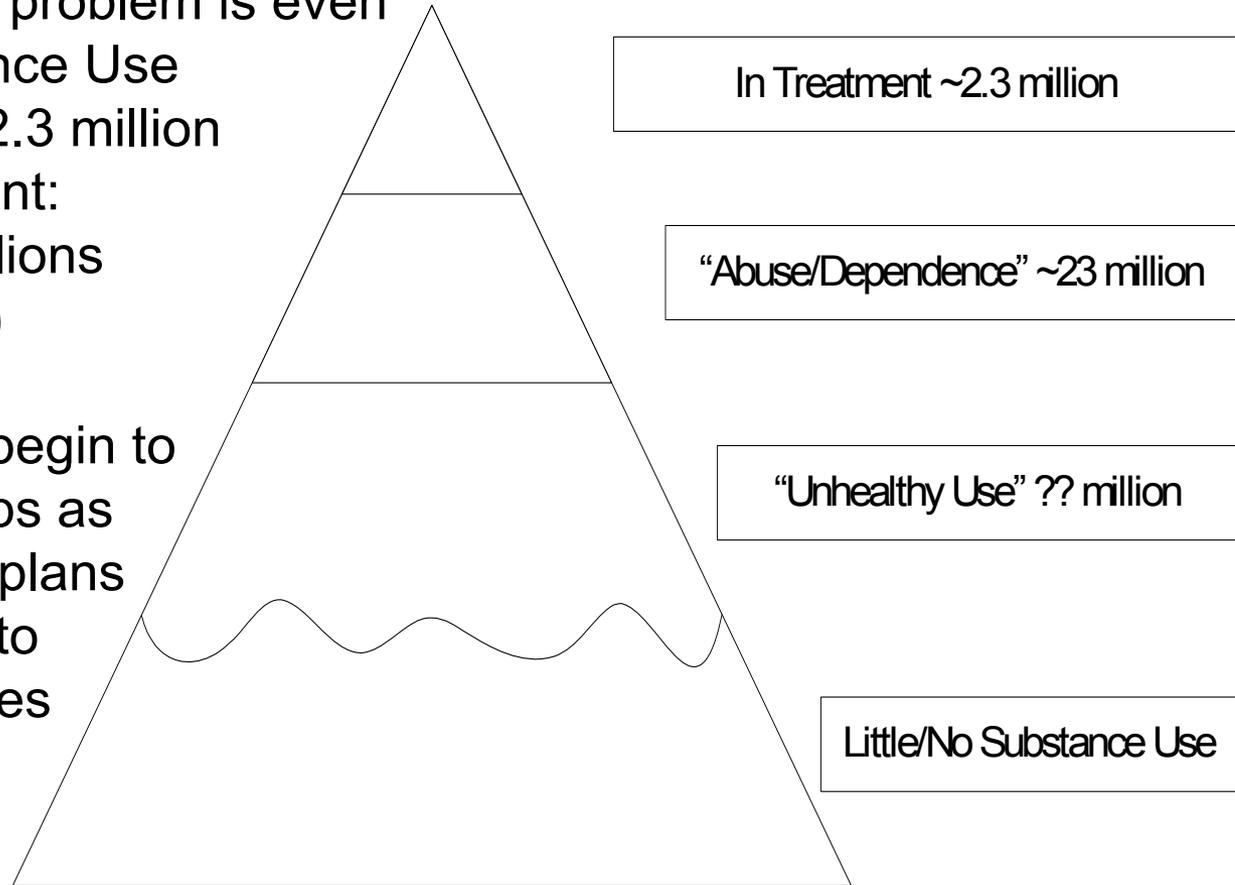
- New program at HHS to develop, test, and disseminate shared decision-making tools to facilitate collaboration between patients, caregivers and clinicians, and incorporation of patient preferences and values into treatment decisions.
- New office within CMS to better integrate Medicare and Medicaid 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.

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)

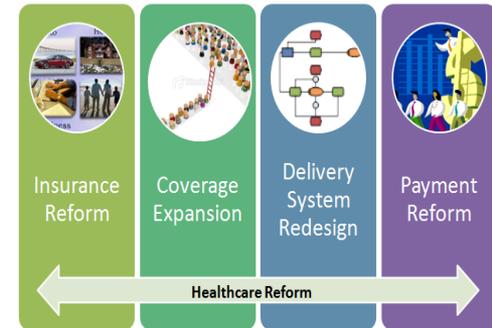
How do we even begin to address these gaps as states and health plans realize they have to provide SU services at parity?



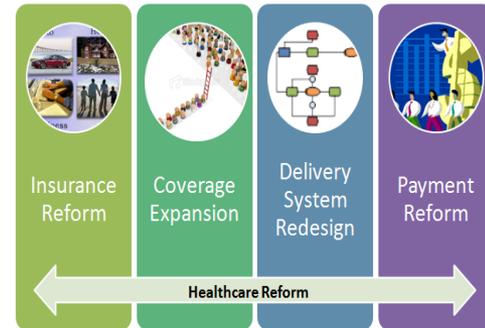
National Healthcare Reform Strategies and the MH/SU Safety Net

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

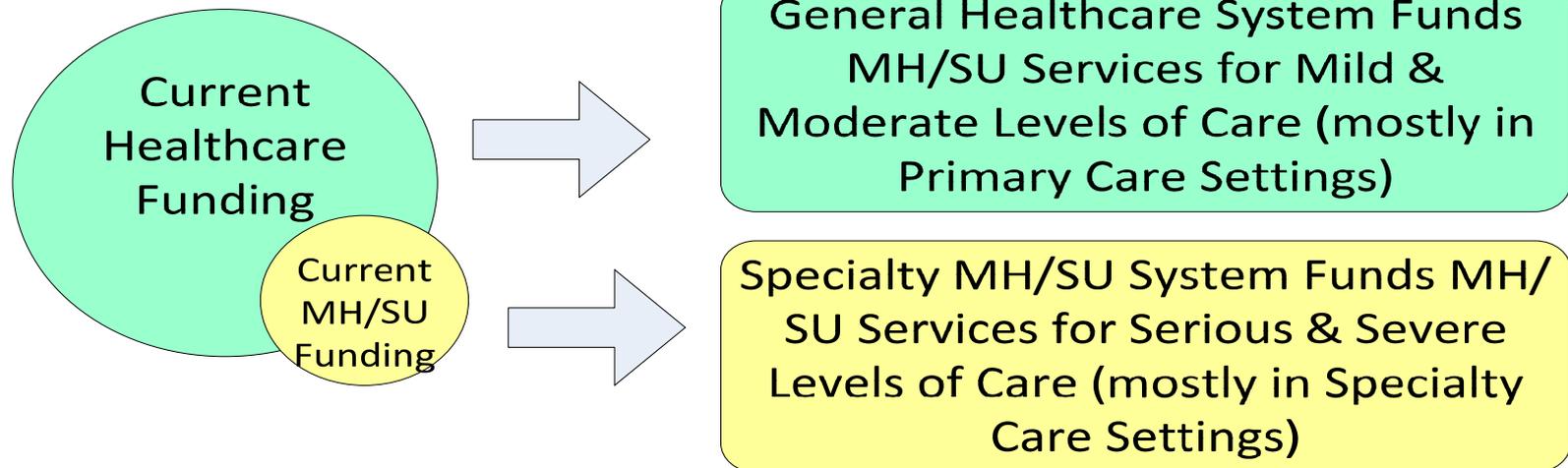
Safety Net BHOs will need to ensure that they meet a set core competencies in order to continue being an important part of the healthcare delivery system

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
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
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, etc.
- CalMEND integration pilots
- DHCS 1115b Waiver
 - Adults & children w SMI/SED
 - CCS
 - Seniors & Persons w/ Disabilities
 - Healthcare Coverage Initiative

Budget/Policy Issues

- What will be the impact of MOE provisions on Medicaid (including Specialty Mental Health)?
- What will be CA's definition of "essential benefits package" and what "benchmark" package will be selected?
- What will be impact of parity on both?

Budget/Policy Issues

- What will be the impact of the new Chronic Conditions state plan option (90% fed match) and will CA participate?
- 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?

Policy/Practice Issues

- How will commercial plans address new responsibilities under parity? What will be the role of safety net providers?
- Will there be opportunities for training and TA to assist safety net providers step up to new requirements & opportunities?
- Will recovery oriented services be retained in a more “medicalized” system?