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Substance Abuse and Mental Health Services Administration

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Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

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The Affordable Care Act: How It Expands Coverage for Those with Behavioral Health Conditions

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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Health Reform & BH Consumers

- Increased coverage
- Increased access to services
- Enrollment assistance
- Navigators

What Can Be The Role Of Statewide Consumer Network Organizations

- Gather information from Consumer Organizations around the state (what services they are providing, to how many people, how many of them do not have health insurance nor Medicaid, what percentage of consumers have medical problems that are not being dealt with because they are not covered by insurance or Medicaid, etc.)
- Be involved at the state level on the planning and implementation

What Can Be The Role Of Statewide Consumer Network Organizations

- Get information out to consumers throughout the state
- Assist consumer-run organizations in getting ready, some as providers, some as subcontractors with other provider agencies, and some individuals to be hired as staff within provider agencies

What Are The Services You Want To Sell

- What are the services that the consumer organizations in your state are very good at providing (peer support education, WRAP, peer support health and wellness, recovery centers, prevention activities, etc.)
- How do you assist your organizations in developing the marketing skills to sell these services

Behavioral Health Disorders are Common, Costly, Disabling, and Deadly

- Almost 50% of Medicaid beneficiaries will have diagnosable mental health and/or substance use disorder in any given year.
- Repeated studies of Medicaid enrollees with SUD demonstrate reduced medical cost after SA treatment & greater than the cost of SA treatment:
    - ER reduced by 39%
    - Hospital stay reduced by 35%
    - Total medical costs reduced by 26%
- Cost benefit ratio of 7:1—for every 1$ on treatment, save $7 in reduced crime, higher employment & productivity, lower medical bills. WA study:
    - Reduced likelihood of arrest: –16%
    - Reduced likelihood of convictions for any offense: –15%
    - Reduced likelihood of felony convictions: –34%

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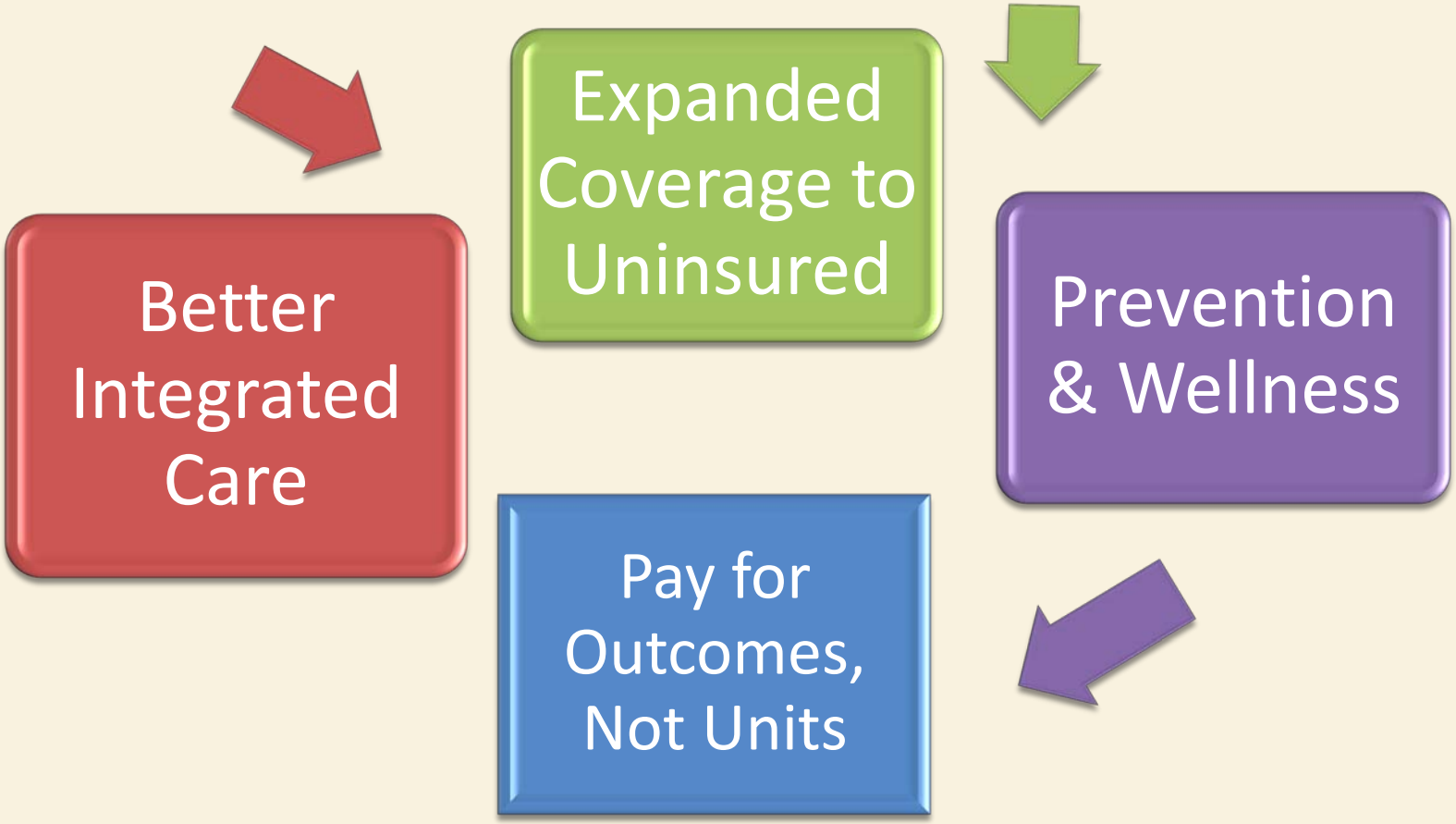
Bending the Cost Curve, Lowering Health Care Growth: Must Address Behavioral Health



2014 Coverage Expansion

- Up to $14,400 individual or $28,500 family of 4
- Feds pay 100% in first 3 year, down to 90%
- Cover foster kids up to age 26
- Un-sentenced in jails eligible

- Up to $43,300 individual or $88,000 for family of 4
- Small Employer & Individual covered
- Premium Tax Credits & Cost Sharing Subsidies
- Optional Basic Health Plan

133% FPL: CHILDLESS ADULTS

Essential MHSA Benefits at Parity & Prevention

Single Entry Portal via web, phone, in person; One card per family

Simplified documentation using internet verification

133 – 400% FPL: STATE EXCHANGES

- Shared Plans Across?
- Shared Providers Across?

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State Option for Basic Health Plan

Why?

- Concerns about those close to 133%, steep jump from Medicaid to employer premium : for family of 4:
  - Without BHP, 0 to $1098 annually
  - With BHP, 0 to $540
- States already providing basic health plan or expanded Medicaid
- Could cover legal immigrants

What?

- Basic health plan cover those 133% - 200% FPL; up to 95% federal premium subsidy
- BHP required to negotiate innovative plan features, like care management, incentives for prevention, and patient-centered decision making
- Promote “one card” for all family members

Coverage Expansion & Enrollment

- Challenges/Opportunities
  - Some States won't have exchanges—individuals will be enrolled with Federal exchange
  - The qualified health plans covering essential benefits must: equal to the scope of benefits provided under a typical employer plan but benefits also must be at parity
  - IOM on 10-07-11 releases recommendations to HHS Secretary on criteria for determining EHB:
    - Typical small employer plan
    - Not read to mean every service that is within one of the 10 categories must be covered
    - State mandated benefits should not receive any special treatment
    - Benefits should be a medical service or item, not serving primarily a social or educational function
    - Benefit should be built to a premium target, not first by services
- Additional Key Provisions (draft or shortly coming)
  - Essential Health Benefits (services)
  - Exchange Regulations (enrollment/network)
  - Eligibility Regulations (eligibility changes)

Current Grants for Consumer Assistance

- 33 states plus DC have received state consumer assistance grants will help to protect consumers from some of the worst insurance industry practices; yet many states not apply

Consumer Protections and Involvement

Consumer Protections

Sept 2010 Protections:
no lifetime limits, no rescissions, no pre-existing for children, must spend 80% of premium on services (85% for large group plans), reviewing premium increases

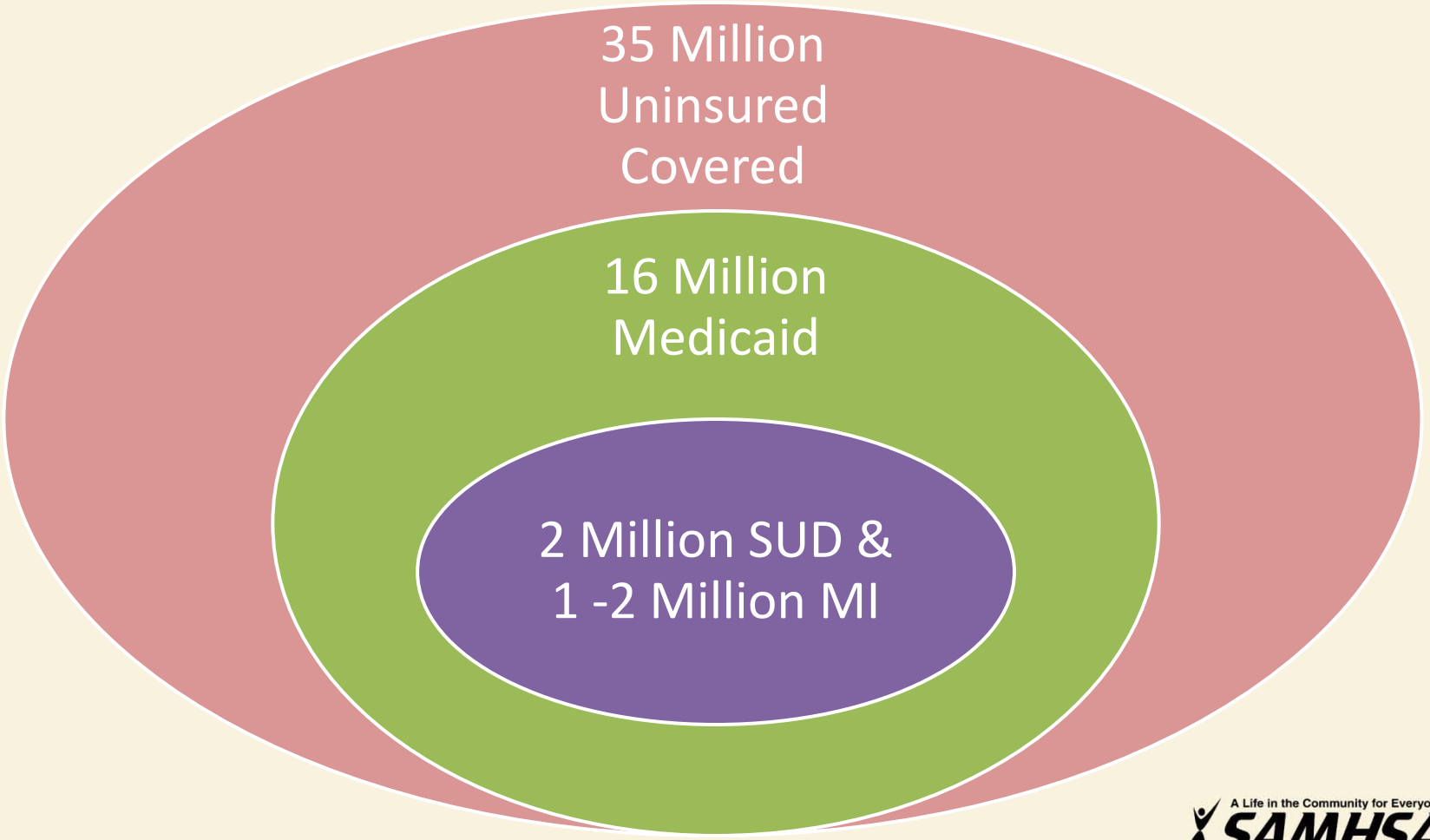
2014 Protections:
no pre-existing conditions, limit deductables, no annual limits, no discrimination in covering, guaranteed renewability, simplify premium rates

Consumer Friendly

Navigators in exchanges:
conduct public education, distribute culturally relevant enrollment and plan information, assist consumers selecting plans and act as ombudsman.

Medicaid enrollment outreach: provide additional assistance to enroll vulnerable populations, including those with MI and SUD

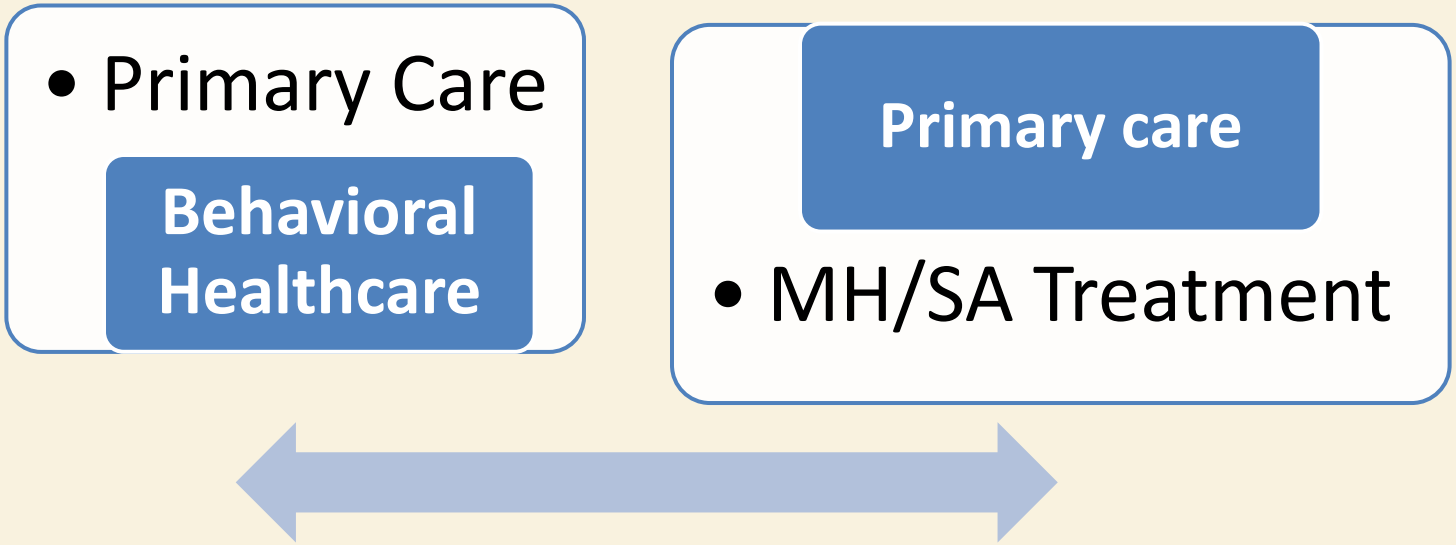
Who will be covered in 2014?



Re-Thinking Coverage

- Nationally, served under State Substance Abuse Authorities:
  - 61% of the individuals served have no insurance
  - 87% of these are estimated under 133% FPL
- 40% under age of 30: how to engage the Young Invincibles, SA treatment that appeals to the young.
- MA study:
  - although 95% have health insurance, only 84% of those coming to SA facilities have insurance
  - Beyond enrolling, churning on and off Medicaid from MA experience
  - Total dollars to providers not increased, but different payers
- Are SA facilities Medicaid ready? 2008 NSSATS: only 58% of SA facilities said accepted Medicaid
- Medicaid limits payment for non-medical residential SA treatment
- Enough capacity in SUD treatment for additional 4 million?

Bi-directional Integration



•Who belongs where, given high co-occurrence ?
•How can we have virtual integration using technology?
•How do we deal with confidentiality?

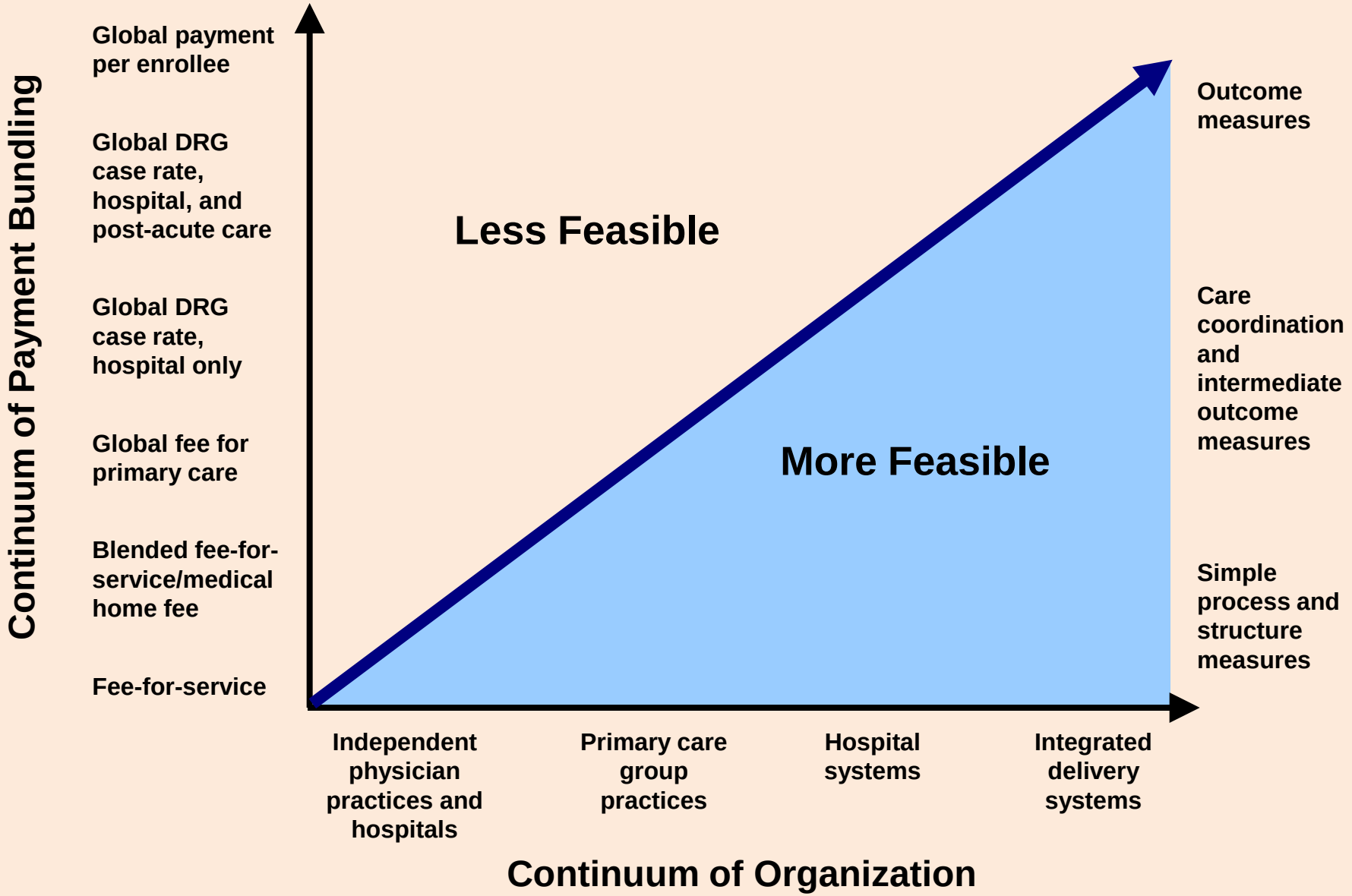
Integrated Care Models

Both emphasize team planning and care coordination, patient-centered treatment, support for transitions from hospitals, patient & caregiver support

- Service coordination focused
- Fee For Service payments
- Flexible team of providers or settings

- New financial incentives focused
- At risk/capitated payments
- Primary care MD providers in Medicare

Stop Paying for Widgets: Organization& Payment Methods



Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

ACA Section 2703: Medicaid Health Homes

➔ Health homes optional coverage: CMS SMD 11/16/10

- Includes those with chronic conditions (or at risk) in 6 diseases- includes those with MH and SUD conditions
- Medicaid state plan amendment- may do multiples, can limit geographically or target by diagnoses
- 90% match for initial 2 years—big incentives for states; also planning opportunities
- SAMSHA to consult with states on prevention and treatment of those with MH and SUD conditions

➔ **Several new services:**

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Patient and Family Support
- Comprehensive Transitional Care
- Referral to Community and Social Support Services

Many Other State Medicaid Flexibilities

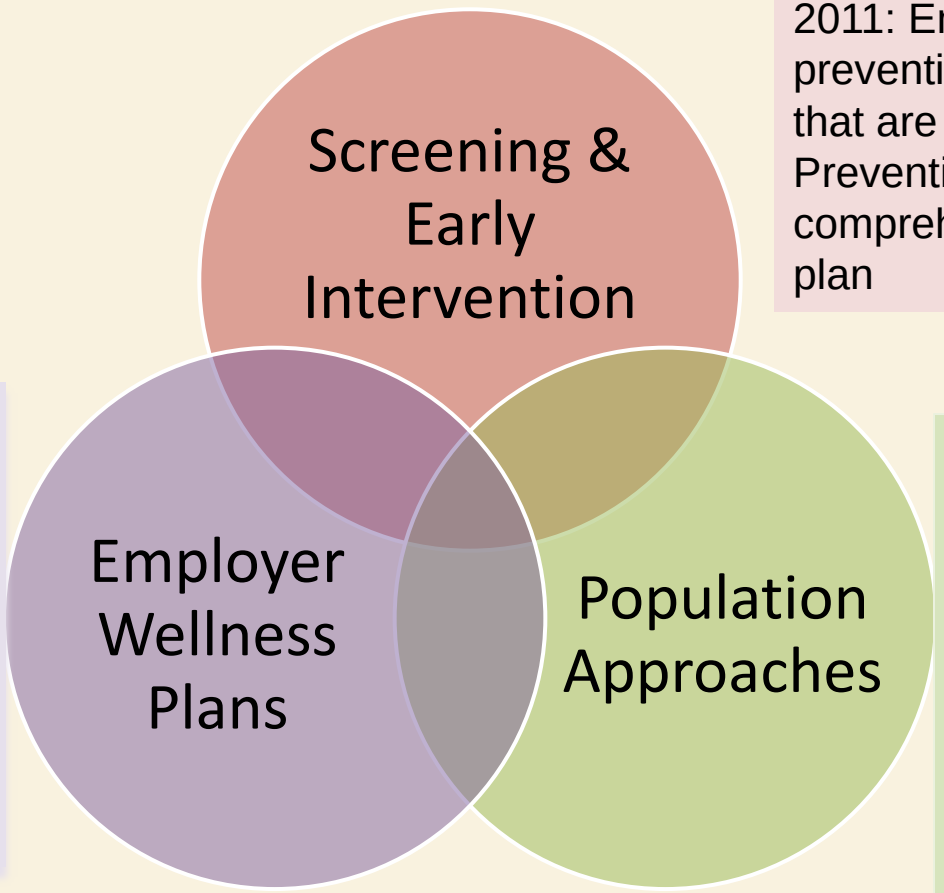
- **Smoking Cessation Guidelines** (SMD 6-24-11), includes pregnant women, adolescents (EPSDT). Encourages comprehensive smoking cessation, including warm lines
- **Medicaid Home and Community Based services** through State Plan Amendments, not waivers (SMD 8-06-10)
- **Medicaid Money Follows the Person** more flexible (SMD 6-22-10), can help cover deposits and home modifications
- Many **Dual Eligibles Demos**(eligible both Medicare & Medicaid), SMD (7-08-11) offered great financing flexibilities to integrate care
- **Medicaid Emergency Psychiatric Demo** for a few states to test Medicaid payments for psychiatric stabilization (SMD 8-09-11)
- **State Rebalancing Initiative Payments** to increase community long term care (SMD 9-03-11)

Position Yourself with Health Homes and ACOS (NCCBH: Partnering With Health Homes and ACOS)

Prepare to participate in larger healthcare field	• Build relationships with community partners, especially primary care • Develop team skills and flexibility to co-locate • Increase skills: wellness, prevention, disease managmt
Establish credentials as a high performer	• Adopt quality tools, train staff & use rapid cycle QA • Assess clients experience of care (pt centered) • Demonstrate the value and cost effectiveness of care
Ensure information technology readiness	• Use of data as routine part of clinical work • Exchange data within and outside your organization • Link payment to performance
Plan for extended period of change	• Identify key resources and support networks to stay current • Invest in educating the Board and staff

Prevention Strategies

2011: Employer and Medicare cover prevention services with no co-pays that are on A or B list of US Preventive Services Task Force; comprehensive Medicare wellness plan



2011 CDC grants to small employers for wellness programs
2014 incentives to employers for wellness programs

Public Health Fund supports interventions to prevent illnesses. SAMHSA given funds for smoking cessation and SBIRT.
2011 Community Transformation grants to states tackle root causes of chronic diseases

U.S. Preventive Behavioral Health Services A or B Endorsed Lists

- Alcohol Misuse (Drinking, Risky/Hazardous)
- Depression in Adults/
  Depression in Children and Adolescents
- Behavioral Interventions for Obesity
- Behavioral Interventions for Cardiac Conditions

National Quality Strategy

STRATEGIES

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that care engages each person and family as partners.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Major Drivers in the ACA

- More people will have insurance coverage
- Medicaid will play a bigger role in MH/SUD than ever before
- Emphasis on primary care and coordination with specialty care
- Encourages home and community based services and less reliance on institutional care
- Preventing diseases and promoting wellness is a huge theme
- Outcomes: improving the experience of care, improving the health of the population and reducing costs

As Medicaid Changes, So Must the SA Treatment Block Grant

Changes in Mission of Block Grant

➔ The "who" changes—more people are covered by insurance. Who is left uninsured:

- Individuals that lapse coverage
- Individuals not eligible for exchanges—too much income but cant afford private pay

➔ The "what" changes

- We need to buy what is "good and modern" - ACA requires "essential" MH/SUD
- Shift of dollars to recovery support services that Medicaid finds not "medical" enough

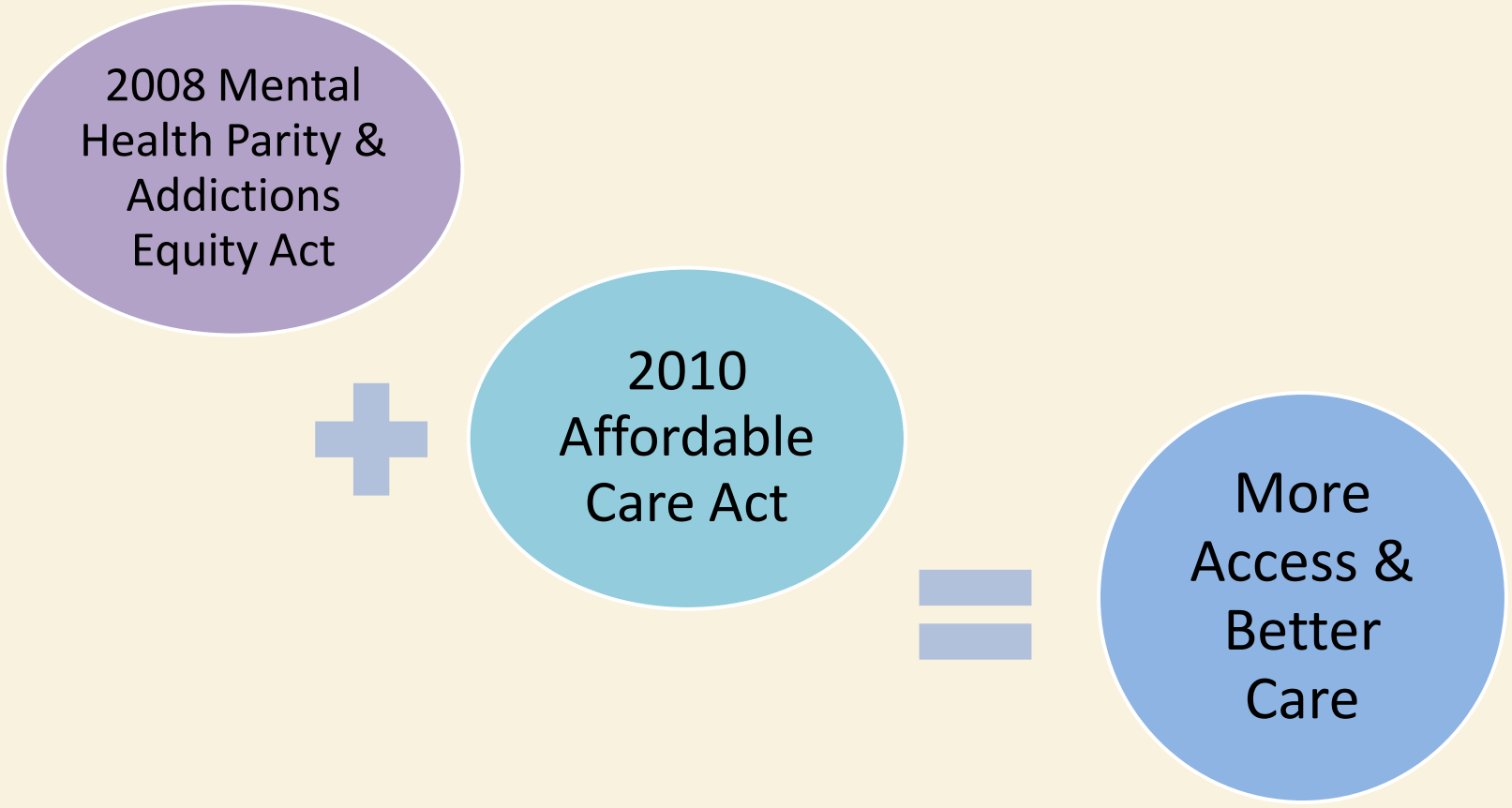
Block Grants

2011—Proposed Changes to BG Application and regulations

- Needs assessment for uninsured & Planning for FY 2014 Implementation
- Joint Planning Efforts between MH and SA: about ½ submitted this year
- Focus on Participant-Directed Care
- Increased Focus on Recovery Services—bring to scale demo efforts
- States Enhancing/Beginning Service Management Efforts
- Use of technology for service delivery
- Greater Accountability:
  - More specific information on what is purchased through BG dollars
  - Performance strategies that mirror National Quality Strategies

- 2014 and beyond
  - Services that are not covered by Medicaid/Medicare/insurance
  - Individuals that are not covered by 3rd party insurance
  - Enrollment challenges for those with MI and SUD

Opportunities for Substance Abuse Prevention, Treatment & Recovery



Wellstone/Domenici Mental Health Parity and Addiction Equity Act of 2008

- Requires **that IF** a plan includes MH/SUD, then it must do so with:
  - No greater financial burden (cost sharing, deductibles) than med/surg
  - No annual or lifetime limits unless also apply to med/surg benefits
  - Benefits not more limited than med/surg (number visits, frequency of treatment, etc) – Non-quantitative treatment limits
  - Out of network if med/surg out of network
  - Transparency in medical necessity & denials of care
- Exemptions from law
  - Employer with less than 50 employees
  - If costs go up (>2% first year, >1% after that)

Define MH/SUD Service Coverage: Good & Modern Behavioral Health Benefit

Within this world of coverage expansions

➔ Need clear, consistent and useful definitions for purchasers of what are good and modern MH and SUD services:

- Benchmark plans for Medicaid expansion (2014)
- Essential benefits for state exchanges (2014)
- Scope of services for Mental Health Parity and Addictions Equity Act
- Use block grant dollars in new world

- What Are Important Inputs Regarding Service Coverage?
  - What services do they need? –need more than a tea leaf exercise.
  - What's the modality/setting that will work?
  - What does the evidence say about what works for these populations?
  - How much will these individuals need?
  - What will it cost?
  - What are the cost offsets to the healthcare system?

Evidenced-Based "Good and Modern" Benefit Continuum of Services

Recovery Supports	• Peer support, peer coaching, self-directed care
Prevention & Wellness	• Screening, health promotion, wellness plans
Community Supports	• Case managemt, supported housing and employment
Other Living Supports	• Habilitation
Engagement Services	• Assessment, outreach
Medication Services	• Includes Medication-Assisted Treatment
Outpatient Services	• Multi-family therapy, other evidenced-based services
Intensive Support Svcs	• Ambulatory detox, intensive outpatient
Out of Home Residential	• Adults and youth
Acute Intensive Svcs	• Urgent and medically monitored

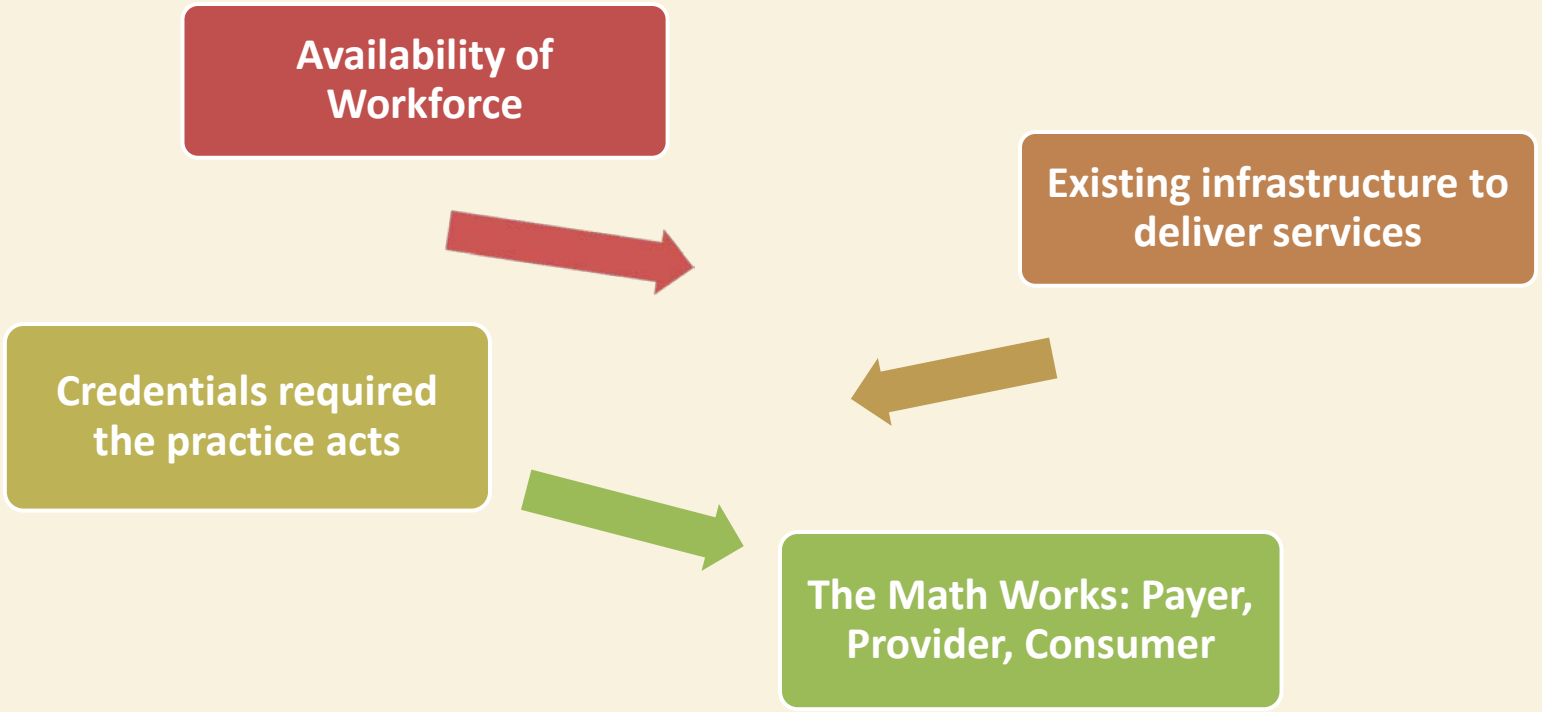
What do we know about MH/SA providers?

- Serve predominantly low-income and/or uninsured individuals.
- Mostly non-profit, state or county providers
- In certain States, more than 85 percent of the individuals served by these organization are enrolled in Medicaid, Medicare or are uninsured.
- According to the Health Resources and Services Administration, approximately 3,700 areas nationwide are designated as mental health professional shortage areas.
- These organizations are often licensed or certified by the State to offer mental health or substance abuse services.

Has Anyone Asked You?

- What do you think is your State's best approach to Health Homes?
- What Federally Qualified Health Centers (FQHCs) in your neighborhood?
- Do you know who runs your State's primary care organization or primary care association?
- Who is forming an ACO in your State and do they have a clue about SUD?
- What hospitals are participating in the federal Patient Safety Initiative?

What Will Drive Access to Services



The Systems Vision

- A benefit package, within available funding, that supports recovery and resilience.
- Promoting program standards, including common service definitions, system performance expectations, and consumer/family outcomes.
- Creation of an adequate number and distribution of appropriately credentialed and competent primary care and behavioral health care providers.
- Funding strategies that will be sufficiently flexible to promote a more efficient system of services and supports.

With More Questions?

- Trusted sources of information about Reform
  - www.Healthcare.gov
  - www.SAMHSA.gov/healthreform
  - www.kff.org/healthreform
  - http://nashp.org/health-reform
  - www.familiesusa.org/health-refrom-central