Financing Changes: How Health Reform, Parity And Recession Impact Use of Evidence Based Practices

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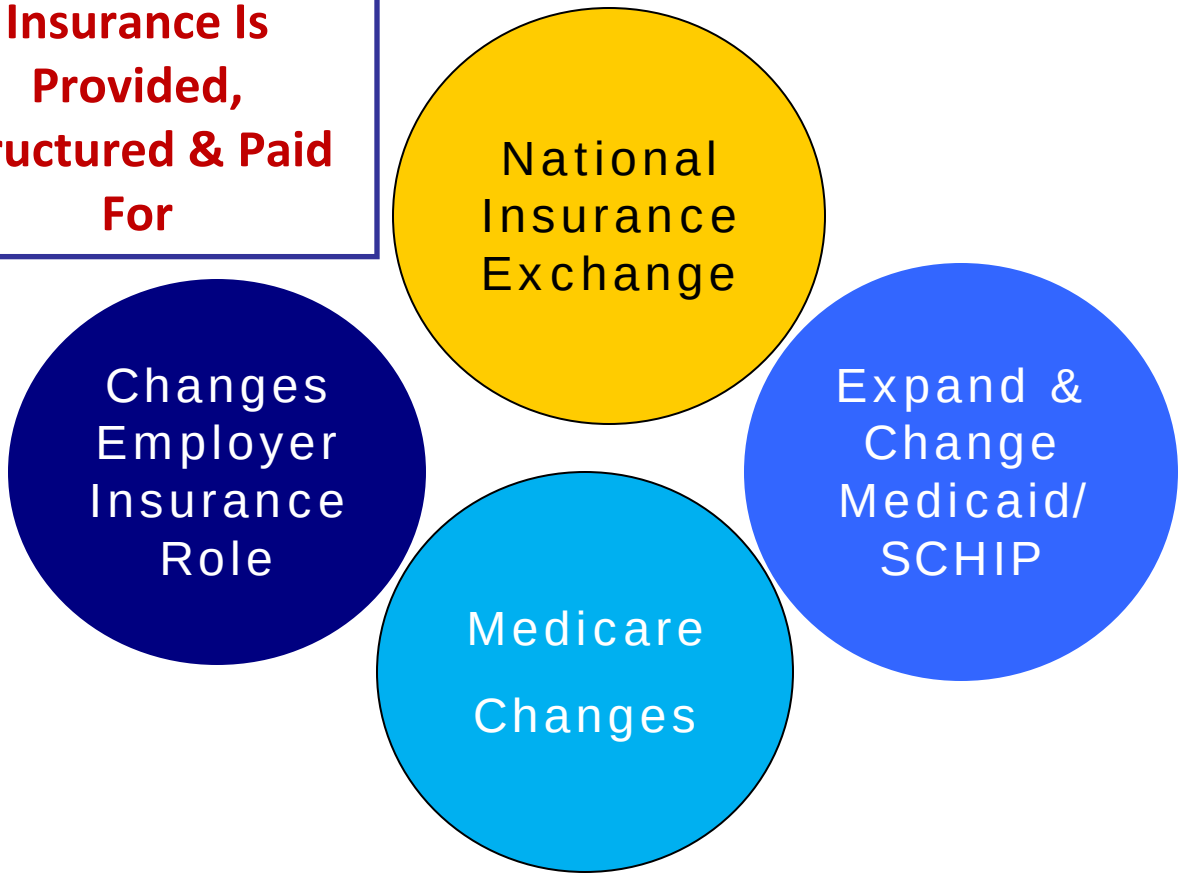
Topics To Cover

- Ground Setting:
  - What Do Health Reform Changes Mean To How Mental Health Financing Will Change?
  - What Health Reform Will Do To Supply and Demand for Services
  - What Changes in Organization and Financing Will Do To Provider Agencies
  - How Will Federal Changes Ripple Through To States
- How Does The Recession Impact Mental Health Now and What Changes Are Coming?
- How Does Parity Impact The Playing Field
- How Will Health Reform, Parity and the Impact of the Recession Jointly Shape The Future?

Health Care Reform By Incremental Efforts: Patient Protection and Affordable Care Act

Alter How Insurance Is Provided, Structured & Paid For



Change Benefits and Programs To Reform Care

Promote Prevention & Wellness

Standard Benefits & Insurance Reforms

Changes Specific to MH/SUD

All Americans Must Have Health Insurance by 2014
(Just as Every Car Owner Must Buy Insurance)

Changes to Employer Group Coverage

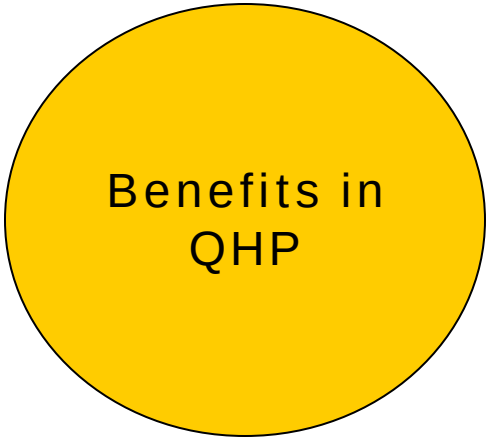
Employers:

- No requirement that employers provide insurance
- Employers may keep existing benefit plans, even if they are not comprehensive
- If an employee gets Gov't subsidy (tax credit or cost sharing subsidy), employers >50 employees pay penalty to the state exchange
- Small businesses tax credits begin in 2010 if under 25 employees and average annual wages <$50,000
- By 2014, small employers may purchase insurance through the exchange

Insurance Exchange: Adds QHP Plans & Manages

State Exchanges:

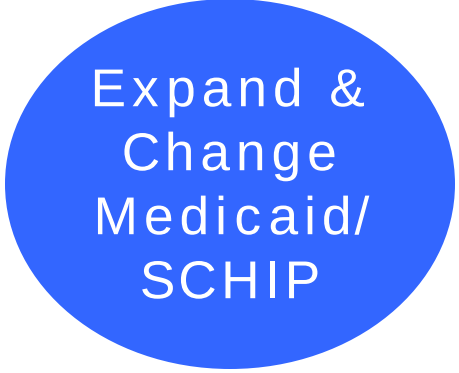
- By 2014 implement state exchanges through which individuals and small groups can purchase insurance
- By 2014 offer premium credits and cost sharing subsidies to individuals and families <400% of FPL
- Develop consumer friendly tools and require plain language insurance policies to aid in making choices
- Establish position of Ombudsman to assist consumers



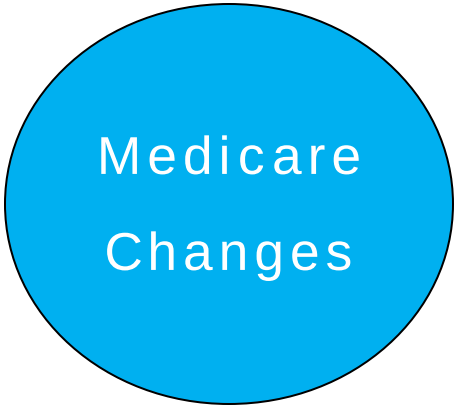
QHP benefit defines floor of coverage for Exchange, Medicaid expansion, SCHIP;

May opt to keep current plan which is grandfathered in; but must meet most insurance reforms in bill (cover adult children, no lifetime limits, no dropping for large medical bills)

- MH/SUD are essential benefits
- Parity for MH/SUD as in Wellstone Dominic Mental Health Parity and Addictions Equity Act
- Prevention services are essential benefits
- The Secretary will define and annually update what are essential benefits
- There are 4 level of employee cost share in exchange plans, but the benefits don’t vary within them



- Requires all states to maintain current eligibility under Medicaid and SCHIP
- By 2014, Medicaid expands to cover childless adults below 133.3% of the FPL
- Feds pay 100% of cost of eligibility expansion 2014-2016, then diminishing to a permanent floor of 90% federal dollars for expansion population in 2020
- Coverage for expansion population is at levels like QHP plans (with essential MH/SUD benefit at parity with medical/surgical benefits)
- New state plan option to have Health homes for the chronically ill. SAMHSA to be consulted on how each plan addresses the needs of populations with MH/SUD
- Expands and alters the structure of allowable home and community based services through the state plan amendments (1915(i))
- Changes structure of Rehabilitation Option to specifically include prevention
- Foster Care coverage extendable up to 25 years old if a person is in foster care at age 18
- SCHIP will receive enhanced match - up to 23% increase until 2019
- Medicaid and SCHIP enrollment simplification



- Medicare prescription coverage: for those in “donut hole” of no coverage, receive $250 rebate in 2010. Donut hole will be eliminated by 2020
- Creates CMS Office of Innovations to improve payment policies in Medicare, Medicaid and SCHIP to reduce cost while enhancing quality
- Reduces DSH payments (as does Medicaid) beginning 2014;
- Reduces Medicare Advantage payments that exceeded Medicare fee for service
- Creates Pilot Program on Bundled Payments for post-acute care from hospitalizations
- Payment decreases to hospitals for avoidable re-hospitalizations within 30 days
- Extends option to create Special Needs Plans (SNPs) to treat populations with complex needs, including mental illness
- Creates an Office for Dual Eligibles (those with both Medicare & Medicaid, the most costly group) to create programs to address acuity and costs
- Enhances Prevention Benefits (next slide)

Promote Prevention & Wellness

- Allows employers to give employee incentives to participate in wellness programs

- No co-pays for prevention services rated A or B by US Preventive Services Task Force (includes depression screening and SBIRT for Alcohol) under Medicare
- Covers development of an individualized wellness plan under Medicare
- Beginning 2011, states that provide prevention services under Medicaid without cost-sharing will get +1% FMAP for these services
- Requires Medicaid coverage for pregnant women to tobacco cessation drugs and counseling (by October 2010)
- Establishes a National Wellness & Prevention Strategy: expands AHRQ prevention research and CDC prevention services research
- Grants to Small Employers to develop Wellness Programs (2011);
- Provides technical assistance to employer wellness programs

Standard Benefits & Insurance Reforms

- No exclusions for pre-existing conditions; children 2010; all 2014
- Lifetime and Annual Limits Forbidden in 2014
- Guaranteed issue and renewability of insurance in 2014
- Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members
- Increases in premiums subject to review
- Large group plans must spend 85% of premium on medical services, small group plans must spend at least 80% - If this benchmark is not achieved the excess is paid back to enrollees
- Waiting periods for employer coverage limited to 90 days

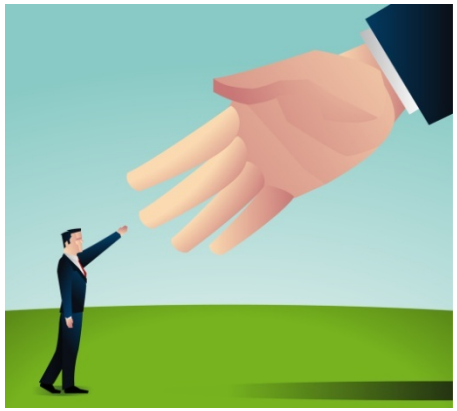
Changes Specific to MH/SUD

- Medicaid IMD Demonstration allowing payment to IMDs
- MH and BH Workforce grants to institutions; many other workforce programs include MH/BH workforce
- Grants for integration of behavioral health and Primary Care
- Authorized not yet funded: Centers of Excellence on Depression
- This year - grants for school based health centers that include MH/SUD prevention and treatment
- CMHC partial hospitalization programs must have at least 49% funding outside of Medicare patients

What Happens Immediately

Within the first year, the new Health Insurance Reform law:

- Establishes temporary risk pool for those unable to get coverage due to pre-existing conditions
- Establishes Temporary reinsurance program for early retirees (over 55 years old)
- Requires that individual and group insurance plans provide dependent coverage to adult children up to age 26
- Requires all health plans to report their medical loss ratio and report and justify premium increases
- Requires new plans to offer prevention services with no cost-share
- Establishes Workforce Advisory Committee for national plan
- Provides Medicaid coverage of smoking cessation for pregnant women



Health Reform Addresses Other Needed Infrastructure

(Some mandated in Stimulus Package)

QUALITY AND EHR

- Comparative Effectiveness research
- Payments to MD providers using EHR
- More fraud and abuse under both Medicare and Medicaid; greater transparency for provider reports
- Greater public input in Medicaid and SCHIP waivers and state plan amendments

WORKFORCE

- Training support for those in behavioral health programs
- Innovations in Interdisciplinary Care Training specifically includes mental and behavioral health professionals.
- HRSA administers most loan repayment and scholarship programs, most directed at primary care providers

Themes in Current Health Care Reform & How They Impact Our Field

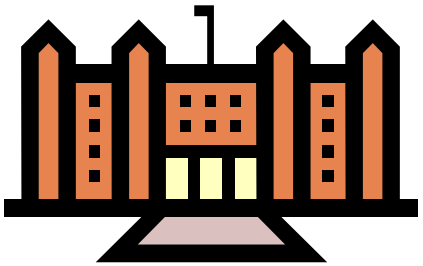
Emphasis on Primary Care:

- Medical homes for care management
- Payments to primary care management; even primary care provider who buys specialty care
- Push to global budgets that don't reward "piece work" as fee-for-service does

Impact on our field:

- Learn to be better consultants to primary care doctors while wrestling with confidentiality
- Build more relationships with safety net primary care providers like community health clinics
- Co-location Models: less stigma, better client engagement

Themes in Current Health Care Reform & How They Impact Our Field



Push Toward Large Providers:

- Can ask for more outcomes data
- Have deeper pockets so can put under global budgets, prospective payment, capitation – One payment per year based on diagnosis
- Economies of scale for electronic medical records, collaborative care models

Impact On Our Field:

- Many small facilities will look for opportunities to merge or be acquired
- Smaller providers may purchase services together or purchase from service bureaus
- Some states have build web based electronic health records
- Less service variability, greater emphasis on EBPs

Impact of Reform For Behavioral Health

- **COVERAGE**
  - Expands Medicaid to 133% FPL – an estimated 16 million new enrollees of which 1/3 are likely to have MI/SUD service needs. This further strains treatment capacity shortages
  - Focus of grant dollars will be for recovery support services not paid for through insurance benefit plans
  - Changes in Medicaid to assist youth to maintain coverage in times of transition will provide funding source, but still does not address other transition issues
  - Allows dependent coverage to age 26
  - Elimination of pre-existing condition exclusions & policy terminations; guaranteed renewability critical for populations that often have been excluded
  - Expanded options in home and community-based services for individuals with mental health and substance use disorders supports recovery orientation

Impact of Reform For Behavioral Health

- **SERVICES**
  - New home visiting programs for young children—with a focus on families with substance use disorders
  - Programs to expand “medical homes” to include behavioral health
  - School-based health clinics to provide mental health and substance use disorder assessments, crisis intervention, counseling, treatment
  - Begin closing Medicare “doughnut hole” for prescription drugs for seniors and disabled individuals
  - Establishes a “Medicaid Emergency Psychiatric Demonstration”

- **PARITY**
  - Parity required in essential benefits plans offered through exchanges
  - Employer mandate requires parity in private health plans

Impact of Reform For Behavioral Health

- **PREVENTION**
  - Prevention research programs and national prevention plans
  - Coverage of preventive services in benefits packages, including SBIRT, without cost-sharing
  - Allowing states to cover prevention services under Medicaid
  - Prevention Trust Fund

- **TRAINING & RESEARCH**
  - Increased patient-centered health research
  - Training grants for behavioral health workforce
  - Training on MH/SUD for Primary Care Extender

Impact of Reform For Behavioral Health

- **COSTS & FUNDING**
  - Tax credits for businesses offering coverage
  - Tax credits for individuals purchasing insurance
  - Vouchers for low-income individuals not eligible for Medicaid to purchase insurance through exchanges
  - Increased Medicaid and commercial insurance funding of mental health and substance abuse services
  - Allows SAMHSA block grant and grant dollars to be focused on recovery plans and support services not paid for through insurance benefit

Impact of Reform For Behavioral Health

- Support for Workforce Development:
  - Funding for residencies for behavioral health included with other disciplines
  - Loan repayment programs
  - Push towards more national certification standards
  - Push towards re-licensure and re-certification

Impact of Reform For Behavioral Health

Getting A Seat At The Table:

- SAMHSA consultation on regulations, demonstrations, implementation
- States that develop health homes must "consult and coordinate" with SAMHSA regarding the prevention and treatment of MH/SUD
- Demonstration initiatives within HHS at discretion of HHS Secretary allow for MH/SA inclusion

Implications of Near Universal Coverage

- Massachusetts Provides Insights
  - Inadequate Primary Care Access
  - Emergency Department Use Not Much Impacted
  - Cost Curve Not Greatly Impacted
  - Need for Carrots and Sticks To Get Everyone To Have Insurance
  - Employer Mandate – What Teeth Are Necessary

Why Changes Not Greater

- Health Insurance Reform Is Not Same As Health Reform
- Lead Time To Alter Provider Network
- Restructuring Takes Place Over Time
- Expectations and Cultural Change Evolve and React To Change Circumstances

How Behavioral Health Financing Will Change

- Initially, it won't change much
- Demonstration Projects and Pilots
- Bundled Rates and Shifted Risk
- Outcomes and Evidence Based Practice
- Common Coding
- Electronic Interfaces
- Expectation of Interoperability and Sharing

New Programs Planned

- **CMS To Run Many Pilots**
  - Medical Homes
  - Bundled Rates
    - Episodes of Care
    - Capitation
    - Case Rates
  - Money Follows The Person Expansion
  - Alternatives To In Patient
- **Pilots on Health Promotion, Prevention and Early Intervention**
- **Pilots on Integration of Behavioral and Primary Care**

Comparative Effectiveness Research

- **Goal Is For Science To Guide Practice**
  - Innovation and Exnovation
  - Advisory, Incentivized or Mandatory?
  - Priorities and Timeframes
    - 6 of top 10 IOM recommendations involve mental health
    - Increasing burden of disease will drive priorities

Accountable Care Organizations

- **Envisioned But Not Articulated Goal**
- **Medical Home on Steroids**
- **Risk Assuming – This Requires:**
  - Adequate Size
  - Full Range of Services
  - Integration of Information and Care
  - Acuity Adjustment

Federal Changes Ripple Through States

- Benefit Packages
- Medicaid Match – FMAP
- Minimum Benefit Packages
- State Exchanges
- Data Exchange
- Accountability

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Who Is Affected:

- Members of employer groups >50 lives that offer a mental health or substance use disorder (MH/SUD) benefit as part of their medical insurance plan

What The Law Says:

- financial requirements (e.g., co-pays, deductibles) and treatment limitations (e.g., visit limits) applicable to MH/SUD benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

What The Regulations Say:

- financial requirements (such as deductibles, copayments, coinsurance and out of pocket limitations) applicable to MH/SUD benefits can be no more restrictive than the "predominant" financial requirements applied to "substantially all" medical/surgical benefits. The regulations apply this test to six classifications of benefits on a classification-by-classification basis:
  - **In patient – in network**
  - **In patient – out of network**
  - **Out patient – in network**
  - **Out patient – out of network**
  - **Emergency care**
  - **Pharmacy**

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

What The Regulations Say:

- Treatment Limitations mean limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. The regulation clarifies that there may be both quantitative and non-quantitative treatment limitations, and provides rules for each. Since they are similar to financial requirements, quantitative treatment limitations are subject to the same general test as the financial requirements discussed above. Because non-quantitative treatment limitations (such as medical management standards, formulary design, and determination of usual/customary/reasonable amounts) apply differently, the regulation includes a separate parity requirement for them.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

What The Regulations Say:

- **Parity with respect to Out of Network Benefits.** If a plan or issuer that offers medical/surgical benefits on an out-of-network basis also offers MH/SUD benefits, it must offer the MH/SUD benefits on an out-of-network basis as well.
- MHPAEA requires that the criteria for medical necessity determinations with respect to MH/SUD benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request. MHPAEA also provides that the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits must be made available, upon request or as otherwise required, to the participant or beneficiary.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

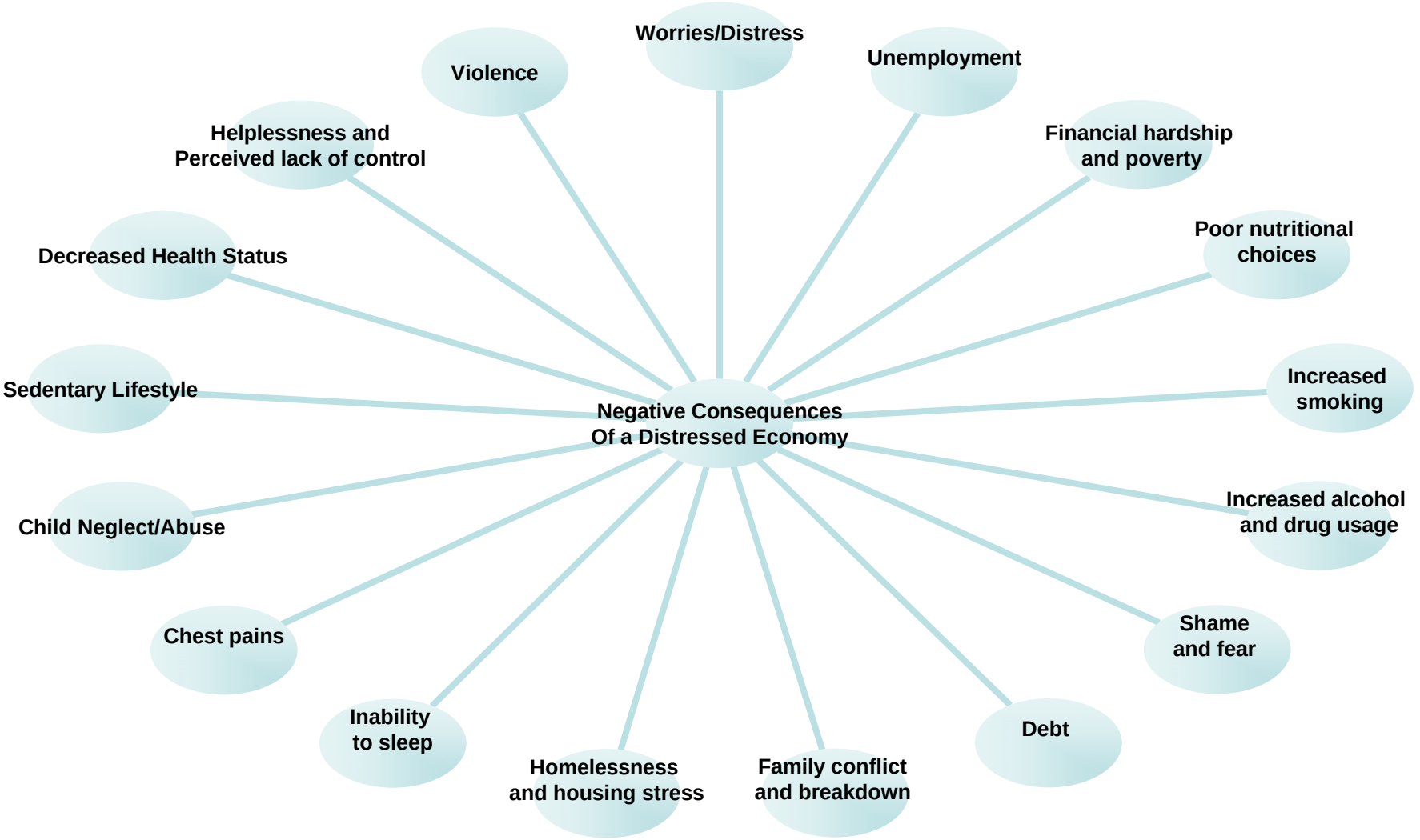
What The Regulations Say:

- Regulations are effective now and applicable to new business and renewals beginning 7/1/10
- The rules are issued as “interim final” which means they are in effect while comments are being solicited (through May 4, 2010). Additional guidance and final rules will follow
- Inquiries and Complaints can be directed to (866) 444-3272 or (877)267-2923, x 51565

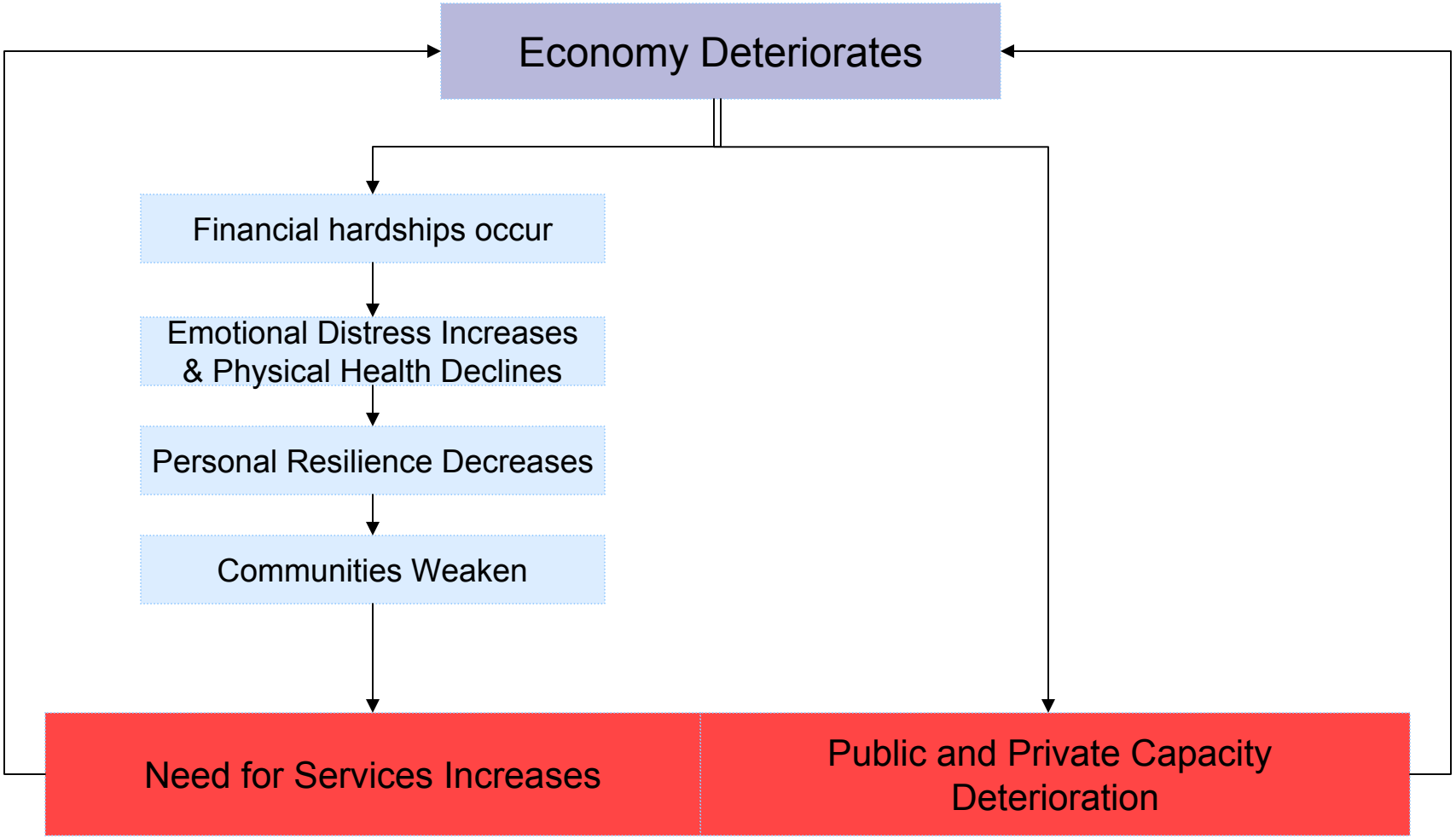
The Economic Recession Alters Starting Point For Health Reform

- Many Systems Impacted
- Infrastructure Being Dismantled
- More Unmet and Undermet Need
- Traditional Methods Being Questioned
- New Methods Being Tried?

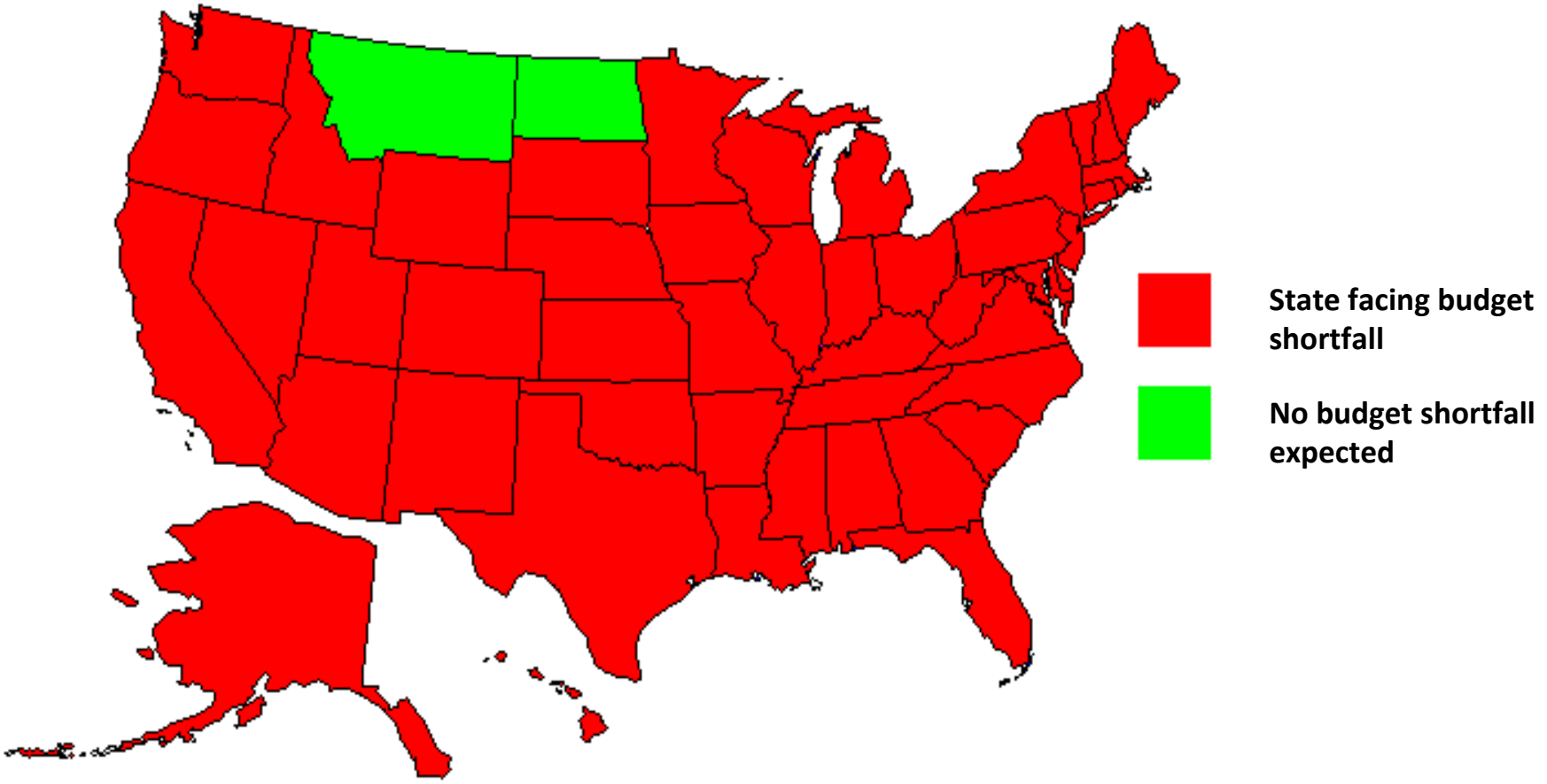
Economic Recession Alters Starting Point



Breaking the Downward Spiral



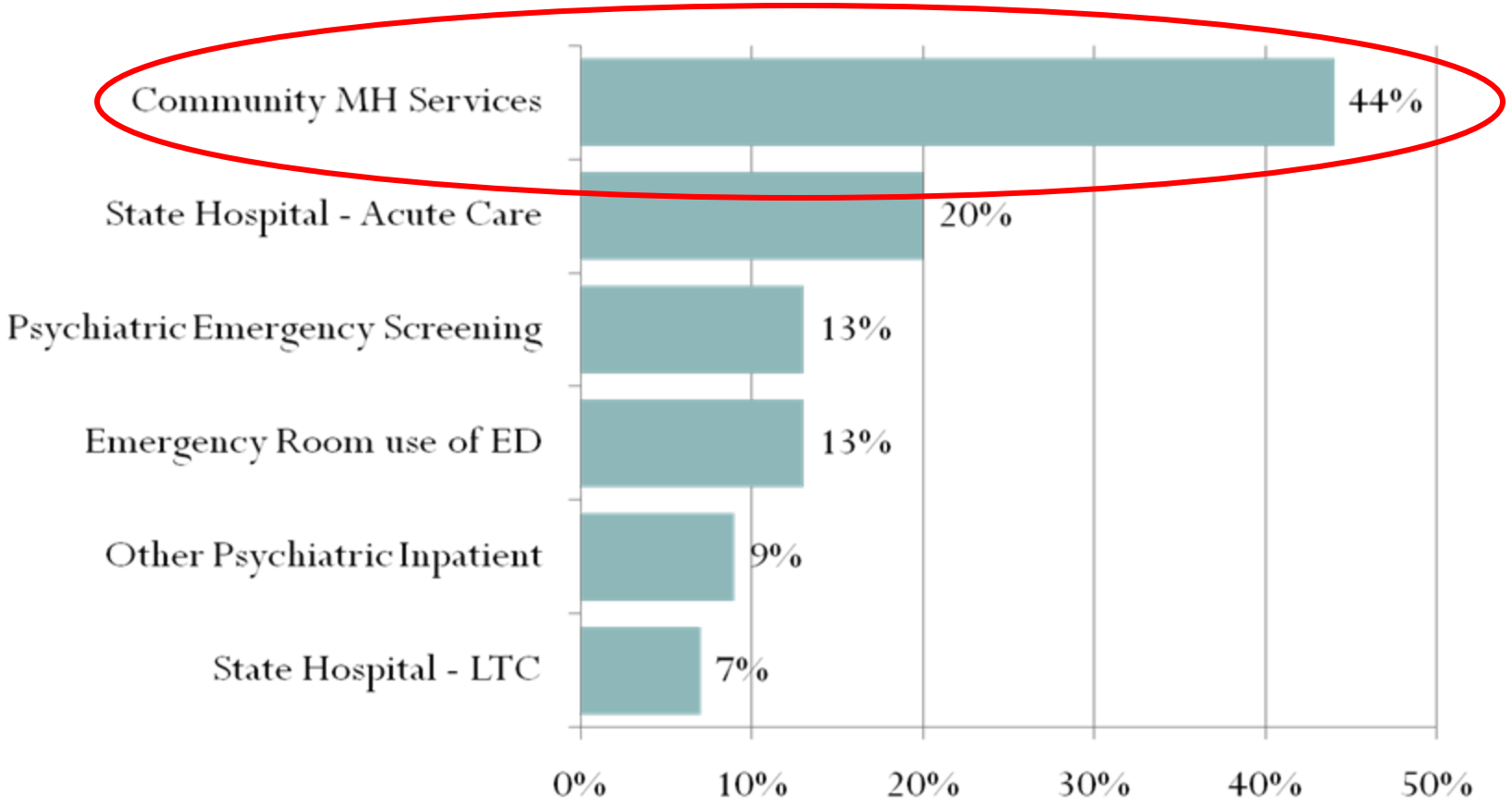
48 States Face Budget Shortfalls (Includes states with shortfalls in FY2011)



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

Increased Demand for Services

Percentage of States Experiencing Increased Demand for Services



As of July, 2009

Government and Private Payers Suffering

- Costs Are Skyrocketing And Are Not In Control
- Revenues Are Plummeting
- Lack Of Understanding/Belief In Efficacy
- Conflicting Priorities
- Lack of Understanding Of Need
- Lack Of Ownership Of The Problem
- Perceived Abuse Of The System

The Economics

- Revenue Drops Lead To Multiple Cycles of Cuts
- State Revenues Do Not Recover for 18+ Months After End of Recession
- Cost and Cost Increase Trends Are Too High
  - Insurance premiums doubled since 2000
  - 17% of GDP on healthcare, no other country spends more than 10%
  - 19%+ of government spending goes to healthcare
  - 50-75% of healthcare costs are attributed to 4-5% of individuals who have multiple, chronic illnesses
- System Results Are Not Good
  - 47 million without health insurance, typically receiving substandard and yet often expensive care. 1/3 of uninsured have mental illness, 1/3 of those with mental illness are uninsured
  - US 31st in life expectancy, 40th in child mortality
  - People With Mental Illness In Public Sector Die 25 Years Sooner
  - Size of Disabled Populations Are Growing
  - High Rates of Unemployment, Homelessness, Incarceration

What Happens When Needed Services Are Not Available/Accessible?

- The Need For Services Does Not Change
- Those In Need Will Gravitate To Easiest and/or Next Most Appropriate Available Service
  - Sometimes, This Is No Care
  - Sometimes, This Is An Emergency Department
  - Sometimes, This Is Criminal Justice
  - Sometimes, This Is Homelessness
  - Sometimes, This Is A Clinically Inappropriate Level Of Care
- This May Cost More Money In Total, But Costs May Be In Different Systems and Not Be Readily Visible
- This Further Distorts The Starting Point For Health Reform

Timing For Change

- Crisis Is Both Danger and Opportunity
- Incremental Versus Systemic Change
  - Managing The Moving Parts
  - Keeping The Dollars Flowing
  - Ensuring Access Is Not Compromised
- What Partners Are Ready To Move – Who Will Be Left Behind?
- How Change Will Be Explained & Perceived

What To Expect

- More to do with less – Proving Value Will Be Key
- Partnerships with other organizations and constituencies
- Simplified administration coupled with stronger requirements for accountability
- Changed expectations of outcomes and approaches to care
- Increased Focus of State Dollars Toward Funding of Medicaid Match
- More experimentation – need to win grants