

Health Care Reform, Substance Abuse Prevention and Treatment

DAS Professional Advisory
Committee Meeting

June 18, 2010



The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama in March 2010, reshapes the nation's health system. The law requires coverage of substance use disorders in the minimum benefit package and the new Medicaid expansion provision for childless adults up to 133% of Federal Poverty Level (FPL).

Medicaid Expansion

- Reform expands Medicaid eligibility to almost everyone up to 133% FPL, will extend coverage to a large number of uninsured adults.
- Prior to reform, Medicaid offered broad based coverage to children and pregnant women; coverage for parents was more limited and coverage for childless adults generally prohibited
- States can expand to all under 133% FPL now and will be required to by 2014
 - Early adopters can do so with state plan amendment and will receive current FFP
 - States can phase in expansion but must use same income eligibility level for all newly-eligible recipients and expand to lower income groups before higher-income groups
 - No asset tests and newly-eligible parents can enroll only if their children also have health insurance

Maximum Income Limits for Populations Applying for Medicaid as a Percentage of Federal Poverty Guidelines, NJ 2010

Population Segment	%
■ Infants (Ages 0 – 1)	200
■ Children (Ages 1 – 5)	133
■ Children (Ages 6 – 19)	133
■ Working Parents	200
■ Non-Working Parents	200
■ Pregnant Women	200
■ Aged and Disabled (OBRA '86), 2001	100
■ Supplemental Security Income, 2000	74
Medicaid expansion group (1115 waiver):	
■ Childless Adults	100



Medicaid Expansion

- States like New Jersey, with broader coverage levels for parents today, no coverage for childless adults and high uninsured rates, will see large reductions in the uninsured (45.3 %).
- States will receive 100% FFP for 2014-2016, 95-93% FFP for 2017-2019, and 90% FFP for 2020 and subsequent years

Key Provisions of Interest to Addictions and Mental Health Fields

Within the First 6 Months – 1 Year of Enactment

- Immediate access to insurance for uninsured individuals with pre-existing conditions (including MH/SUD)
- Provides small business tax credits including up to 25% credit for small not-for-profits
- Eliminates pre-existing condition exclusions for children
- Prohibits rescission (retroactively canceling a health insurance policy obtained in the individual market after the policyholder files a large claim)
- Covers first dollar of preventive health services – includes SBIRT
- **Allows states to cover prevention services under Medicaid**
- **Extends coverage to dependent children up to age 26 who are uninsured**

Key Provisions of Interest to Addictions and Mental Health Fields

- **Strengthens the health care workforce – expands and improves low-interest student loan programs, scholarships, and loan repayments**
- **Prohibits lifetime limits**
- Focus of grant dollars will be for community prevention, wellness, and support services not paid for through insurance benefits
- Requires MH/SUD as part of the essential benefits package in exchange plans
- Requires exchange plans to comply with the Wellstone Domenici parity law
- Prohibits insurers from excluding coverage for treatments based on pre-existing health conditions
- Limits the ability of insurance companies to charge higher rates due to health status, gender or other factors

Key Provisions of Interest to Addictions and Mental Health Fields

- Allows premiums to vary only on age (no more than 3:1), geography, family size, and tobacco use
- Newly eligible individuals (parents and childless adults otherwise ineligible for Medicaid) will be enrolled in a “benchmark” plan that includes MH/SUD at parity
- Prohibits annual limits
- Non-quantitative treatment limits (NQTLs) – Medical necessity criteria, utilization review, provider authorization may not be applied more restrictively to MH/SUD benefits than to the predominant med/surg benefits
- New home visiting program for young children – with a focus on families in which there is a SUD
- Programs to expand medical home to include behavioral health



Mental Health Parity and Addiction Equity Act

Mental health and substance use disorder benefits must be “no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan...” and “there are no separate cost sharing requirements than are applicable only with respect to mental health or substance use disorders benefits.”

Parity Issues

- Parity legislation does not automatically expand access to substance use disorder services.
- Even when insurers comply with parity regulations, co-pays and deductibles can restrict access to substance use disorder services, particularly for very low-income beneficiaries.
- Insurance plans often do not reimburse providers for the full continuum of care: residential treatment and social model detox are generally not covered by private plans, Medicaid, or Medicare, and the burden to fund these services falls on the State substance abuse agency.
- Administrative costs associated with billing multiple payment sources (especially multiple private insurers) represent a significant increase in costs for community based organizations (CBOs).
- Regulations apply for plan years beginning July 2, 2010
- General rule – parity applies if a plan offers medical/surgical and MH/SUD benefits (≥ 50 employees)



Health Information Exchange

- The electronic exchange of health information is both a statutory requirement for meaningful use and a critical component for enabling care coordination and other improvements to quality and efficiency.
- States play a critical leadership role in facilitating the exchange capacity of doctors and hospitals in their jurisdictions.
- In addition, states have the ability to facilitate payment reforms to support adoption and meaningful use of Health IT, such as bundling payments across providers and geographic regions.

Electronic Health Records

- Health information exchanges deal with the electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.
- The free movement of electronic health information challenges privacy and security rules when interoperable electronic information exchange systems are required to comply with patient confidentiality standards.
- Interoperability standards for electronic information exchange are under development. Yet the addiction treatment and behavioral healthcare fields are just beginning to review, discuss, and debate the effect of interoperable systems for electronic health record (EHR) exchange.
- Under a point-to-point interoperability model, some behavioral health software vendors believe that providing 42 CFR Part 2 support is attainable.
- 42 CFR Part 2 permits sharing information about a patient in health information exchanges as long as the regulations are followed. In addition, federal level discussions around modifications to 42 CFR Part 2 to facilitate this.
- A primary care delivery system operating on a web based platform will not be able to communicate with a behavioral health delivery system operating on a paper and pen platform.



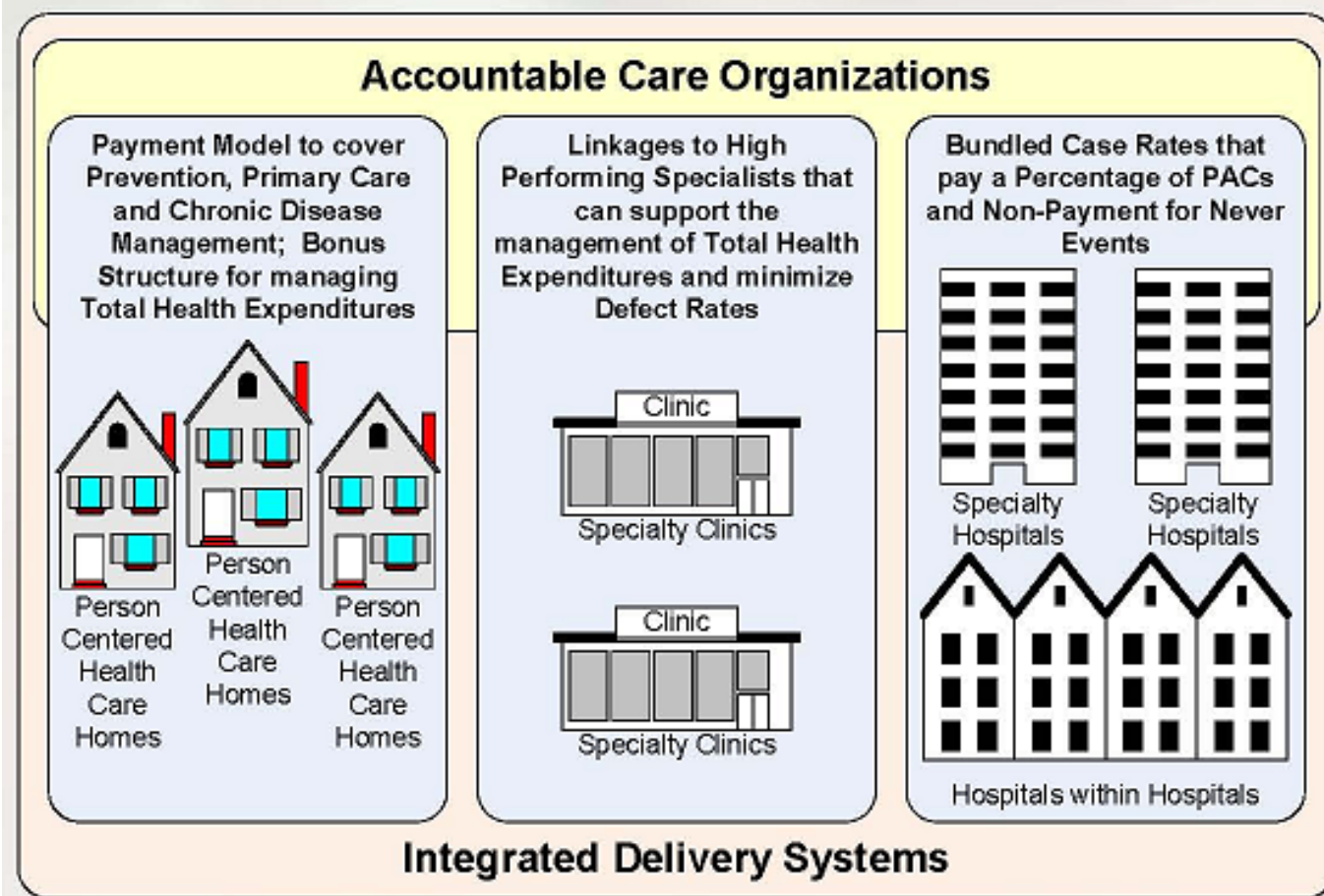
Accountable Care Organizations

Accountable Care Organizations are entities that contract to provide services for a defined population of Medicare patients in a delivery model that allows successful exemplars to share in savings if certain medical care quality objectives are achieved. PPACA calls for the ACO model to be in effect January 1, 2012.

Accountable Care Organizations

- Part of larger effort to improve the delivery system
- Dual purpose:
 - Organizational structure for managing bundled payments for inpatient care
 - Vehicle for small to mid-size primary care practices that want to become Person-Centered Medical Homes
- Would receive incentive payments/penalties for meeting quality goals
- Medicaid Demos (2010-2016) to encourage state Medicaid programs to move to global capitated payment systems from fee for service by incentivizing safety net hospitals (facilities that provide a significant level of care to low-income, uninsured, and vulnerable populations)
- Structure
 - Must have at least 1 hospital, 50 physicians (primary care and specialists), in business for at least 3 to 5 years, & serve at least 5,000 patients

How Does MH/SUD Fit Within ACOs?



- Initiatives are underway in Massachusetts (1115 Waiver Amendment submitted 3/1/10) & Minnesota (H.F. No. 3709, as introduced 86th legislative session. Posted 3/18/10)

Opportunities

- Less cost shifting from the private to public sector
- Increased payment from commercial insurance and Medicaid
- States' experience with "frequent flyers" may prove to be invaluable disease management model to plans; states should develop consulting models for integrated health plans
- Appropriate enforcement of federal parity and non-quantitative treatment limitations will provide access to benefits and yield savings; savings can be used for other state priorities; "Parity Dividend"
- Use the SAPT block grant for innovative models packaging treatment and recovery supports for the chronically addicted

Prevention

- In a section authorizing community health team grants aimed at supporting medical homes, the bill includes a provision to include SUD prevention, treatment and MH service providers as eligible grantees
- Substance use disorders are listed as a national priority in the report to be provided to Congress and the President by 7/1/10 by the National Prevention, Health Promotion and Public Health Council
- Requires SUD/MH services be provided at school-based community health centers
- Preference will be given to applicants who demonstrate the ability to serve communities that have evidenced barriers to primary health care & mental health & substance use disorder prevention services for children & adolescents; as well as populations of children & adolescents that have historically demonstrated difficulty in accessing health & mental health & substance use disorder prevention services

Prevention

- Permits state or local health departments receiving grant funds through a Department of Health and Human Services (HHS) public health grant program, administered through the Centers for Disease Control and Prevention, to enter into contracts with MH/SUD providers and screening activities may include MH/SUD
- The new Prevention-Prepared Communities Program (PPC) supplements existing community-based efforts such as SPF-SIG and focuses on youth ages 9-25. Grantees will conduct epidemiologic needs assessments, create a comprehensive strategic plan, implement evidence-based prevention services, and address common risk factors for mental, emotional, and behavioral problems
- The Successful, Safe, and Healthy Students program replaces the Safe and Drug Free Schools program and provides support for school based prevention programs.

SUD/MH Workforce Development Funds

- Includes a loan repayment program for individuals practicing pediatrics, child and adolescent MH/SUD services
- Authorizes grants to higher education institutions for MH/SUD professionals
- Priority will be given to institutions in which the training focuses on the needs of vulnerable groups, including individuals with MH & SUD and where applicants have demonstrated familiarity with evidence based methods in child and adolescent mental health services including SUD prevention & treatment
- \$8M is authorized for social work
- \$12M for graduate psychology
- \$10M for professional child and adolescent MH/SUD
- \$5M for training in paraprofessional child and adolescent work at state-licensed not-for-profit and for-profit organizations



Final Points

- Legislation includes an HHS education and outreach campaign on the benefits of prevention; section contains a requirement that the campaign disseminate information about the preventive work done by the Substance Abuse and Mental Health Services Administration (SAMHSA)
- As part of the Medicaid “State Plan Option Promoting Health Homes for Enrollees with Chronic Conditions” program, directs states to consult and coordinate with SAMHSA in addressing prevention & treatment of MH/SUD
- Includes SAMHSA as an agency in the “Interagency Working Group on Health Care Quality”



For Discussion

- How do you see the future for addictions under healthcare?
- How do you envision preparing our clients for healthcare reform?
- What do you envision is required to prepare your agency for healthcare reform?
- Would you consider joining an ACO?
- What are the core services that should be a part of the benefit package?
- How should reimbursement be structured?