The Landscape of the Affordable Care Act: Impacts and Challenges for Policy and Practice/Workforce Development

June 6, 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
- Implications for workforce development
The Basics of Healthcare Reform and Parity
National Healthcare Reform
Four Key Strategies

Insurance Reform
Coverage Expansion
Delivery System Redesign
Payment Reform
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
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

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
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
Bundled Case Rates that pay a Percentage of PACs and Non-Payment for Never Events

Payment Model to cover Prevention, Primary Care and Chronic Disease Management; Bonus Structure for managing Total Health Expenditures

Linkages to High Performing Specialists that can support the management of Total Health Expenditures and minimize Defect Rates

Specialty Hospitals

Specialty Clinics

Medical Homes

Medical Homes

Clinic

Clinic

Specialty Clinics

Hospitals within Hospitals
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
The Business Case and 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
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 = 45%
- Psychiatric illness among Medicaid beneficiaries w disabilities = 49%
  - October 2009 Center for Healthcare Strategies, Todd Gilmore, PhD, et al
## Faces of Medicaid III

**Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data**

<table>
<thead>
<tr>
<th>Diagnosis 1</th>
<th>Diagnosis 2</th>
<th>Frequency among all beneficiaries</th>
<th>Frequency among most expensive 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>Cardiovascular</td>
<td>24.5%</td>
<td>40.4%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Central Nervous System</td>
<td>18.9%</td>
<td>39.8%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Pulmonary</td>
<td>12.5%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Central Nervous System</td>
<td>13.1%</td>
<td>32.9%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Pulmonary</td>
<td>11.2%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Gastrointestinal</td>
<td>10.2%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>Pulmonary</td>
<td>7.0%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Renal</td>
<td>7.1%</td>
<td>24.6%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Gastrointestinal</td>
<td>5.9%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Gastrointestinal</td>
<td>9.5%</td>
<td>24.0%</td>
</tr>
</tbody>
</table>
Kaiser SU Study: Approach and Rationale

- Context of a health plan
  - Employers are primary purchasers
- Alcohol and drug problems as primary problems and as risk factors for other health conditions
- Treatment can be effective
- Not treating them causes lack of improvement in other health conditions (and problems in work productivity)
- Not treating them causes more ER and inpatient utilization
- Not treating them causes health problems and cost for family members
Prevalence in Substance Abuse Patients Vs. Matched Controls

Conditional Logistic Regression Results: $p<0.01$ for all conditions shown

Bi-Directional Care Planning Based on the Four Quadrant Model
Persons with serious MH/SU conditions could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.
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.
  – Integration of MH/SUD/PC not mentioned
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.**
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
Dually Eligible: Medicare/Medi-Cal

California Data:

- 1.1 million dual eligibles
- Roughly 14% of Medi-Cal population but are 25% of cost
- 20% enrolled in Medi-Cal managed care
- $7.6 billion in state Medi-Cal costs ($20 billion with Medicare)
- $3.2 billion in LTC costs = 75% of Medi-Cal total LTC spending
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

• Alameda MHS – 3,488 rec’g services
## Medi-Cal Expansion

<table>
<thead>
<tr>
<th>Topic</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Legislation</td>
<td>Summer, 2013</td>
</tr>
<tr>
<td>Establish Expansion Benefit Package</td>
<td>Summer, 2013</td>
</tr>
<tr>
<td>CMS Approvals (State Plan Amendments, etc.)</td>
<td>Fall, 2013</td>
</tr>
<tr>
<td>Open Enrollment Period</td>
<td>October – December, 2013</td>
</tr>
<tr>
<td>Health Care Delivery Begins</td>
<td>January 1, 2014</td>
</tr>
</tbody>
</table>
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
Implications for Workforce
Workforce

• More!
  – Newly covered: 235,148 (50% of gap)
    • 470,296 – 100%
  – Additional FTE need = 5,468 (50%)
    • 10,936 – 100%

• Working to Top of Licensure
• BH as hi-performance specialty care partner
• Working in teams
Workforce

- Peer & Family Partner Certification
  - WWT Summit
  - Steinberg Mental Health Initiative
- Ethnic and Racial Workforce Needs
- Health Homes with BH integrated into Primary Care
- Integrated Care Competencies
- BH in primary care settings
Workforce

• Care Coordination and Care Management for individuals w/multiple (complex) conditions
• Emphasize client's central role in managing their health