Health Care Reform

EBP Symposium
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Topics

• Context
• Health care reform basics
• Accountable care organizations
• Person centered homes
• Behavioral health organizations
• 1115 Waiver
• Case for behavioral health integration
Context (County Lens)

- County mental health is responsible for a range of mental health services
  - SED/SMI (W&I Code) including individuals without insurance or means (indigent)
  - Specialty mental health Mental Health Plans (medical necessity for Medi-Cal beneficiaries)
  - EPSDT
  - MHSA FSP including individuals without insurance or means
  - MHSA PEI including individuals without medical necessity
• There are different levels of mental health services
  – Specialty mental health (chronic care) for severe and persistent disorders
  – Specialty mental health (episodic care) for discrete episodes of a disorder
  – Treatment for routine conditions (by primary care physician)
  – Behavioral interventions that enhance physical health care
  – Promotion and prevention (wellness) interventions
Context

• There are different settings in which mental health services are organized
  – Mental health clinics
  – Primary care (health care) clinics
  – Federally Qualified Health Centers
  – School based clinics
  – ???
Context

• **Key health care reform impacts**
  – Increase enrollment in health insurance (and Medicaid and CHIP)
  – Reform payment provisions
  – Reform service delivery structures

• **Key health care reform goals**
  – Improve quality of care
  – Reduce health care costs

• **Key strategies**
  – Flip the cost triangle (promotion, prevention, early intervention in lieu of emergency, late stage, hospital interventions)
Big Questions

• What will be the new mental health benefit?
• How will payment provisions incentivize quality of care and cost savings?
• What will behavioral health organizations need to be able to do?
• What role will county mental health have in provision of services to new enrollees?
• What role will organizational providers have in provision of service to new enrollees?
• How will counties/providers fit into or be a part of Accountable Care Organizations?
• Where will substance abuse treatment fit in?
National Healthcare Reform

- Insurance Reform
- Coverage Expansion
- Delivery System Redesign
- Payment Reform
Coverage Expansion

• 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
  – Creates State Health Insurance Exchanges
  – Expands Medicaid to 133% of federal poverty level
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)
Coverage Impact

• **Increase in enrollees**
  – Individuals without insurance or means today (indigent) will have health insurance with mental health and substance abuse benefit
  – Some will have Medi-Cal
  – Some will have SCHIP
  – Some will be covered through the exchange

• **Funding currently being spent on care for indigent individuals will be reimbursed**
  – Savings to county mental health
  – Large savings for physical health hospital care
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*
Insurance Reform

– Requires health plans to spend at least 80% 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

- Accountable Care Organizations (ACO)
- Payment structures with incentives for quality of care and cost savings
Flip the Cost Triangle

- Need to invert the resource allocation triangle
- Prevention activities must be funded and widely deployed
- Primary care budgets must increase
- Mental health and substance use disorder services must be available to all
- In order to decrease demand in the specialty and acute care systems
System Redesign

**OPPORTUNITIES FOR HEALTHCARE COST REDUCTION**

- Improved Inpatient Care Efficiency
- Use of Lower-Cost Treatments
- Reduction in Adverse Events
- Improved Management of Complex Patients
- Use of Lower-Cost Settings & Providers

- Reduction in Preventable Readmissions
- Reduced Management of Health Care Cost
- Improved Unnecessary Testing & Referrals
- Reduction in Preventable ER Visits & Admissions

**FIGURE 1**
ACOs

• A local health care organization & related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost & quality of care delivered to a defined population

• Goal: to deliver coordinated and efficient care
ACOs

- ACOs are *provider groups* that accept responsibility for the cost and quality of care delivered to a group of patients that are cared for by ACO clinicians.
- ACOs: the *organizing infrastructure* to help health homes coordinate care with specialists, hospitals and other parts of the healthcare delivery system.
- ACOs will also *manage new payment models* that incentivize prevention, early intervention and supports for persons with complex and costly health conditions.
Person Centered Healthcare Home

- **Person (patient) Centered Medical Home**
  - Each patient has a personal physician who provides first contact, continuous and comprehensive care
  - Physician leads a team who take responsibility for the ongoing care of patients
  - The physician provides for all care needs or arranges care including all stages of life; acute care; chronic care; preventive services; and end of life care
  - Care is coordinated and/or integrated across all health (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the pt’s community (e.g., family, public and private community-based services)
Person Centered Healthcare Home

• Care is facilitated by registries, IT, & other means to assure that patients get care when & where needed and wanted, in a culturally & linguistically appropriate manner

• Quality and safety are hallmarks
  – Practices support patient-centered outcomes defined by care planning driven by a partnership between physicians, patients, and the patient’s family.
  – Evidence-based medicine and clinical decision-support tools guide decision making
  – Physicians accept accountability for CQI thru performance measurement and improvement.

• NCQA recently published standards emphasizing behavioral health
Person Centered Healthcare Home

• **Quality and safety are hallmarks**
  
  • Patients participate in decision-making & feedback is sought to ensure patients’ expectations are met
  
  • IT supports optimal patient care, performance measurement, patient ed, enhanced communication
  
  • Practices go thru a voluntary process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level.
  
  • [http://www.acponline.org/advocacy/where_we_stand/medical_home/](http://www.acponline.org/advocacy/where_we_stand/medical_home/)
The PCMH-Neighbor

• A specialty/subspecialty practice recognized as a Patient-Centered Medical Home Neighbor (PCMH-N) engages in processes that
  – Ensure effective communication, coordination, and integration with PCMH practices in a bidirectional manner to provide high-quality and efficient care
  – Ensure appropriate and timely consultations and referrals that complement the aims of the PCMH practice
  – Ensure the efficient, appropriate, and effective flow of necessary patient and care information
The PCMH-Neighbor

- Effectively guide determination of responsibility in co-management situations
- Support patient-centered care, enhanced care access and high levels of care quality and safety
- Support the PCMH practice as the provider of whole-person primary care to the patient and as having overall responsibility for ensuring the coordination and integration of the care provided by all involved physicians and other health care professionals.

- [http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf)
Next Generation Vision

• Healthcare homes are critical for safety net/vulnerable populations…

• But they must also be connected to public health and the community
Healthcare Neighborhood

- The Fulton County Georgia (Atlanta area) Neighborhood Union Primary Care Partnership’s One Stop Shopping:
  - Well patient care
  - Sick-patient care
  - OB/GYN services
  - Travel immunization services
  - Communicable disease intervention
  - WIC/nutrition education
  - Oral health services
  - Behavioral health services
  - A day center for parents receiving services
  - Employment assistance
  - Disability and vocation rehabilitation services
  - Foreclosure prevention services
  - Housing assistance
  - A reading room/information center that offers ESL classes
  - A farmer’s market
  - A community garden
  - A walking trail
Behavioral Health Organizations

Safety Net BHOs will need to become “high performing Behavioral health organizations” by meeting core competencies - to continue being an important part of the healthcare delivery system & to ensure appropriate care for people with SMI & children with SED
Behavioral Health Organizations

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/evidence based practices
5. A robust electronic health record that includes patient registries
Behavioral Health Organizations

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/work with primary care
9. Financial systems to manage case rate payments
Payment Reform

• 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
Federal Reform

- **April 2010**: FMAP available for MIAs up to 133% FPL
- **November 2010**: Target for new §1115 Waiver (CA)
- **2014-2016**: Federal government will pay 100% of the Medicaid cost of covering MIAs for three years, 95% in 2017, 94% in 2018, 93% in 2019 and 90% thereafter
- **2014**: Exchange opens for MIAs above 133% of FPL (100% FFP)
1115 Demonstration Waiver

• By January 2014, California will have made significant strides in implementing key components of the Patient Protection and Affordable Care Act, including:
  – Coverage expansion to newly eligible Medicaid populations
  – Expansion of Medicaid benefits for new and existing populations
  – Delivery system reform
  – Administration simplification
  – Payment reform
Low Income Health Program (LIHP)

• Consists of Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI) programs
  – MCE: 0-133% of FPL; broader range of services and no cap on Federal reimbursement
  – HCCI: 133% - 200% of FPL: narrower range of services and cap on Federal reimbursement
LIHP Demonstrations

• Terms and Conditions for LIHP Demonstrations specify core mental health benefits required for Medicaid Coverage Expansion (MCE) but no requirement to provide for HCCI

• Option to provide benefits beyond the minimum for MCE with prior CMS approval

• Must promote evidence-based care in community settings; promote prevention and early intervention

• Permits counties to continue to carve out mental health benefits as separate system until 2014
MCE Requirements

• Benchmark-like benefits
• Due Process for eligibility and benefit access
• Network adequacy standards; must contract with at least one FQHC
• Out of network hospital emergency care
• Mental Health and Substance abuse parity rules will apply according to forthcoming Medicaid rules
MCE Mental Health Benefit

• Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric facility
• Psychiatric pharmaceuticals
• Up to 12 outpatient encounters per year (Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment)
• If medically necessary need to extend treatment exists, plan can optionally expand the services
Bending the Cost Curve

• Lack of Access leads to late stage treatment
• 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
Bending the Cost Curve

• A small number of people receive a high level of treatment
• Individuals with co-occurring chronic conditions use considerably more health care services
• Mental health is a common co-occurring disorder associated with increased health care costs
• Substance abuse is a common co-occurring disorder associated with increased health care costs
• Bending the cost curve will certainly involve addressing mental health (and substance abuse) disorders
Bending the Cost Curve
Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions

• New analysis includes pharmacy and 5 years data
• Just 5% of beneficiaries account for more than 50% of overall Medicaid costs
49% of Medicaid beneficiaries with disabilities have a psychiatric illness.

52% of those who have both Medicare and Medicaid have a psychiatric illness.
People with Mental Illness Die Younger

• Adults w serious mental illness have a life expectancy about 25 years less than Americans overall.*
  – Primarily from natural causes or preventable diseases, including heart disease, cancer, lung disease or complications from HIV/AIDS
  – Average life span: 53 years old

• Substance Use loses 5 more years: average life span 48 years old

* NASMHPD 2006: Morbidity and Mortality in People w Serious Mental Illness
Four Quadrants

• Low PH Low BH
  – Behavioral health integrated into primary care

• High PH Low BH
  – Behavioral health integrated into primary care

• Low PH High BH
  – Primary care outstationed in mental health clinic

• High PH High BH
  – Primary care outstationed in mental health clinic
  – Medical case manager outstationed in mental health clinic
### Four Quadrants

#### Quadrant I
**MH/SU** < PH <
- PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
- PCP-based BHC/care manager (competent in MH/SU)
- Specialty prescribing consultation
- Wellness programming
- Crisis or ED based MH/SU interventions
- Other community supports

#### Quadrant II
**MH/SU** < PH <
- Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- MH/SU clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Wellness programming
- Other community supports

#### Quadrant III
**MH/SU** < PH <
- PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
- PCP-based BHC/care manager (competent in MH/SU)
- Specialty prescribing consultation
- Crisis or ED based MH/SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

#### Quadrant IV
**MH/SU** < PH <
- Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- Nurse care manager at MH/SU site
- MH/SU clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

**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.**
Impact on CA’s Children: Reference

- Information on the impact of the ACA on California’s children obtained from *The New Health Care Law: Just What the Doctor Ordered for California’s Children!* and *The First Anniversary of the Affordable Care Act: Expanding & Improving Health Coverage for Children and Youth*, summary documents prepared by the 100% Campaign, a collaborative effort between The Children’s Partnership, Children Now, and Children’s Defense Fund-California
  - [www.100percentcampaign.org](http://www.100percentcampaign.org)
Impact on CA’s Children: Reference

• Information on the impact of the ACA on children with mental health needs obtained from the Bazelon Center for Mental Health Law and can be found at
Integrated Service Models

Reference

• *Integrating Behavioral Health and Primary Care for Youth and Young Adults: Recommendations and Resources for Providers in California and Beyond*, a policy brief co-authored by the Adolescent Health Working Group and the California Adolescent Health Collaborative
  – [www.ahwg.net](http://www.ahwg.net)

• The National Institute for Health Care Management 2009 Issue Paper *Strategies to Support the Integration of Mental Health into Pediatric Primary Care*
Medical Home Model
Reference

• Measuring Medical Homes: Tools to Evaluate the Pediatric Patient- and Family-Centered Medical Home, monograph authored by Rebecca A. Malouin, PhD, MPH and Sarah L. Merten, MPH, funded by the AAP’s National Center for Medical Home Implementation

• AAP National Center for Medical Home Implementation – California
Medical Home Model

Reference

• Originally developed to address the complex set of services needed by children with special health care needs

• Innovative programs in other states provide lessons learned for California’s CYSCHN
  
    
    • [http://www.amchp.org/publications/ChildrenandYouthwithSpecialHealthCareNeeds/Documents/Models%20of%20Care%20for%20CYSCHCN.pdf](http://www.amchp.org/publications/ChildrenandYouthwithSpecialHealthCareNeeds/Documents/Models%20of%20Care%20for%20CYSCHCN.pdf)
Safety Net Clinics and Integration

Reference

• CHCF publications:
  – Designing Safety-Net Clinics for Innovative Care Delivery Models
  – Designing Safety-Net Clinics for Flexibility
  – Designing Safety-Net Clinics for Cultural Sensitivity

• http://www.chcf.org/publications/2011/03/promising-practices-clinic-design
Safety Net Clinics and Integration Reference

- CA clinics referenced by CHCF as examples that support innovative care delivery
  - Clinicas Sierra Vista, Bakersfield
    - www.clinicasierravista.org
  - Hill County Health and Wellness Center, Round Mountain
    - www.hillcountryclinic.org
  - La Maestra Community Health Centers, San Diego
    - www.lamaestra.org
Safety Net Clinics and Integration

Reference

- CA Clinics (cont’d)
  - Native American Health Center, Seven Directions Health Center, Oakland
    - www.nativehealth.org
  - Open Door Community Health Centers, Arcata
    - www.opendoorhealth.com
  - Shasta Community Health Center, Redding
    - www.shastahealth.org
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