Major National Developments and County Responses

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Our hats are off to:

MARV SOUTHDARD

- Humanitarian
- Innovator
- Manager
Key National Contexts

- **Mental Health Parity and Addiction Equity Act of 2008**
  - Leveled the playing field on benefits and management

- **Patient Protection and Affordable Care Act of 2010**
  - Moved the agenda
  - **11.4 million** Marketplace Enrollees (16 state operated marketplaces)
  - **6.4 million** Medicaid Expansion Enrollees (30 states currently participating)
68% of previously uninsured Californians now have coverage, but 23% report recent problems in paying medical bills.

1.4 million Marketplace enrollees; 88% receive subsidies, and 51% receive cost-sharing reductions.

3.3 million new Medicaid enrollees compared with pre-ACA.
Insurance Issues to Consider

- For lower incomes, deductibles, co-pays, and coinsurance costs are too high. Example:
  - 150% FPL 11% of gross
  - 400% FPL 17% of gross
- In 2016, Essential Health Benefit will be reconsidered. Consideration:
  Pharmacy benefit is inadequate
  Prevention benefit needs to be populated
National Trend 1: System Reform

- System Reform = Integration with a Primary Care Focus.
- ACA provides financial incentives (Section 2703)—2 years, 90% FFP.
- Delivery System Reform Incentive Payment (DSRIP) Program—to reduce hospital use and achieve defined goals. Money used for system reform under a Medicaid waiver. NY example: $6.8 billion in DSRIP payments.
National Trend 1: System Reform

- Full integration means integrated service delivery teams and integrated funding (Manderscheid and Kathol, 2014).
- Behavioral healthcare has not been in synchrony with other health entities to undertake this reform.
- *Progress in this area is the most urgent problem facing behavioral healthcare.*
Value Purchasing = Moving to case/capitation rates from traditional fee for service, and attaching performance measures to adjust payments.

HHS Secretary Burwell has set aggressive targets for Medicare; 50% by end of 2016 and 90% by end of 2018.

Good electronic financial data systems will be essential to make this transition successfully.
National Trend 2: Value Purchasing

- Value purchasing will move benefit management (managed care) from an external to an internal activity; you will manage yourself.
- Value purchasing will move the focus of care from “more care” to “quality care”.
- Value purchasing will promote “population health” approaches.
Using 1115 Waivers to build systems of care and remove some of the Medicaid IMD restrictions on community residential care for substance use. Can mental health be far behind (Representative Tonko–NY)?

Home and Community Based Services Waivers now only have a 5 year horizon to achieve “full community integration”. This is especially important for the ID/DD population.
National Trend 3: More Flexibility

- Federally Qualified Health Centers continue to ramp up integrated care. Can these changes be traced to your local county?
- Federally Certified Community Behavioral Health Clinics are under development. Planning grants have been awarded. We will need to develop an understanding how these facilities will mesh with the integrated care model.
Some Assumptions for You

- Implementation of the **ACA will quicken** over the next year.

- **Counties will confront** the issue of developing **integrated care** systems and engaging in self management.

- The CA **carve-out will end** in favor of integrated funding. Counties will have a 5 year planning horizon to consider modes of adaptation.
# A Table to Determine Where You Are

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Discrete and non-overlapping medical and BH provider groups &amp; treatment settings; frequent delays</td>
<td>Non-network cross disciplinary providers at primary service delivery site; selective access</td>
<td>Integrated medical and BH network providers uniformly present in service locations; ready access</td>
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<tr>
<td>Integrated Care Delivery</td>
<td>Clinician documentation information firewalls; crisis dictated communication and care coordination; non-existent continuity</td>
<td>Site specific cross disciplinary information access, communication, and care coordination; partial continuity</td>
<td>Full integrated medical and BH network provider information access, communication, care coordination, and continuity</td>
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<td>Payment</td>
<td>Separate medical and BH benefits, claims adjudication procedures, and coding and billing rules</td>
<td>Separate medical and BH benefits, claims adjudication procedures, and coding and billing rules; subsidized cross disciplinary services</td>
<td>Consolidated medical and BH benefit set, claims adjudication procedures, and coding and billing rules</td>
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<tr>
<td>Outcomes</td>
<td>Discipline-specific clinical and cost/saving accountability</td>
<td>Discipline-specific clinical and cross disciplinary cost/saving accountability</td>
<td>Medical and BH clinical and cost/saving accountability</td>
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Resources We Bring to Integrated Care

- **Recovery** Goal
- **Trauma** Informed Service Delivery
- Peer Support
Key Qs for You in the New Terrain

- How can I extend my limited human resource capacity?
- How can I show that behavioral healthcare contributes to the value of services delivered?
- How can I integrate prevention and promotion services?
- How can I work with my local community to implement community interventions?
Key Planning Questions for You

- What are some of your fears about integrating behavioral health and primary care?
- What steps are you and your organization planning to take to prepare for integration? Any new partnerships?
- What vision/strategy/tactics do you think will be necessary to accomplish integration? Short-term? Longer-term?
- How do you plan to do work with your Health Insurance Exchange? Medical Expansion? Specifically?
Outcomes

- We would expect:
  - **Longevity** to improve
  - **Recovery** to improve disability and community tenure
  - **Community tenure** to improve full community participation

- We also would expect the implementation of prevention and promotion protocols to improve personal and population health over the longer run.
Community Life

We would expect:
- Greater attention to the social and physical determinants of health
- More community participation in addressing local health issues
- Less stigma in the community
- Much greater recognition that:

All health and health care is local!
Take Aways

- We **are** on the **right side** of the issue.

- We **do have** services that can **decrease health disparities** and promote equity.

- Our clients **can and will** become **productive citizens** in a global economy.
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