Update from the Beltway:

National Policy Trends and Expected Impact on MH/SUD

Chuck Ingoglia, National Council for Community Behavioral Healthcare

October 1, 2011

The National Council: Serving and Leading

- Represent over 1,950 community organizations that provide **safety net mental health and substance abuse treatment services** to over six million adults, children and families
- National voice for **legislation, regulations, policies, and practices that protect and expand access** to effective mental health and addictions services

Current National Policy Trends

- Health reform rollout: challenges & opportunities
  - State budget pressures and the influx of new federal dollars
  - Medicaid/Exchange enrollment
  - Care coordination, accountability, and payment reform
- Impact of the deficit debate on MH/SUD
- Proposals for overhauling Medicaid
- Taking advantage of health IT incentive payments

ACA Rollout: Most of the Heavy Lifting is Being Done by the States

- Most have very little connection to Congressional action, should the Senate turn "R" in 2012
- Most are critical to states avoiding bankruptcy, irrespective of the 2012 presidential election

Seven Key State-Level Components of Healthcare Reform

- Medicaid Expansion
- Implementation of Federal Parity
- Health Insurance Exchanges
- Accountable Care Organization Design and Standards
- Medical/Health Home Design and Standards and Payment Models
- Medicaid Home and Community-Based Services (HCBS) Option (1915i)
- Dual Eligible and Special Needs Plan Design

Budget Shortfalls Are Putting Pressure on Medicaid & MH/SUD Programs

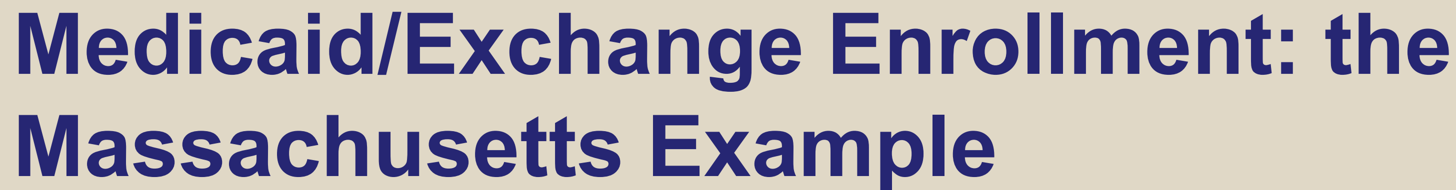
- States have cut $2.2 billion from mental health agency budgets over the course of the recession
- Medicaid cost-saving measures in Colorado in 2011:
  - Reduce provider payments
  - Limit benefits
  - Strategies to reduce spending for prescription drugs
  - Delivery system reforms

Sources: NASMHPD (2011): http://www.thenationalcouncil.org/galleries/policy-file/2-16-11%20Kevin%20Martone%20Remarks.pdf; National Association of State Budget Officers (2011): http://nasbo.org/LinkClick.aspx?fileticket=yNV8Jv3X7Is%3d&tabid=38

New Dollars… and New Challenges

- When the ACA is fully implemented, Medicaid coverage is expected to increase from 12.4% of individuals with mental illness to 23.3%
- Medicaid's MH spending projected to rise by 49.7%; additional increases for Medicaid SUD spending
- National Council analysis: $15 to $23 billion more spending for MH/SUDs from insurance expansion → **potential new revenue sources for BH providers**
- **The vast majority of the new spending will be federal dollars**
- BUT... Many people served by state MH/SUD agencies will continue to be uninsured

Sources: Jeffrey Buck, "The Looming Expansion & Transformation of Public Substance Abuse Treatment under the Affordable Care Act" *Health Affairs* 30.8 (2011); The Urban Institute/RWJF, "Consider Savings as Well as Costs" (July 2011) http://www.urban.org/uploadedpdf/412361-consider-savings.pdf



Medicaid/Exchange Enrollment: the Massachusetts Example

- **Half** of focus group participants with MH/SUD conditions were disenrolled from their health insurance in the past year
- According to CEOs of MH/SUD treatment programs, **20-30% of patients seeking acute services are uninsured** (in a state where 97% of population as a whole is insured)
- Patients report difficulty with enrollment process (complicated, time-consuming, lack of information)
- Providers report difficulties (both financial and time burden) in providing the support and assistance to enroll eligible patients

Reaching the “Eligible but Unenrolled”

- Navigator support at key locations for the most vulnerable populations
- Outreach and enrollment efforts that target these populations
- Clear, concise, simple instructions disseminated through multiple media
- Presumptive eligibility for acute and emergency episodes for those previously enrolled
- Exempt children, chronic or long term illness diagnoses, from disenrollment consequence of random verification checks

Key Components of a "Reformed" Health Care System

1. Prevention/Wellness Focused Care
2. Integrated "Horizontal" Care Delivery System
3. Accountable Care Organizations
4. Medical Homes/Healthcare Homes
5. **Payment Reform – Primarily shared Risk models with incentive payments to providers for meeting quality outcome indicators**

Payment Models – Highest to Lowest Provider/Payer Risk

1. Full Risk Capitation/Sub-Capitation Rates (Per Member per Month)
2. Partial Risk Outpatient Only Capitation/Sub-Capitation Rates
3. Bundled Rates/Episodes of Care Rates – Shared Risk
4. Stratified Case Rates – Shared Risk
5. Case Rates – Shared Risk
6. Capped Grant Funding – Shared Risk
7. Performance Based Fee for Service – Shared Risk
8. Fee for Service – Payer Risk

Payment Reform: Specialty Care moving to Case Rate Payment Models

U.S. Population with Serious Mental Health and Substance Use Disorders

Payment Models to cover the Medical and Behavioral Health Prevention, Primary Care and Chronic Disease Management including Dedicated Funding for Uninsured; Bonus Structure for managing Total Health Expenditures

Fully Integrated Medical/BH Health Care Home

Medical/BH Health Care Home Partner-ship

CBHO with links to multiple Medical Homes

Linkages to High Performing Specialists that can support the management of Total Health Expenditures and minimize Error Rates; Case Rates with a Bonus Structure

Clinic

CBHOs working with Health Care Homes through Partnerships or Linkages

Clinic

Other Specialty CBHOs

Linkages to Hospitals, Long Term Care Facilities & Supported Housing serving persons with MH/SU Disorders; Bundled Payments, Case Rates and Bonus Sharing Arrangements for management of Total Health Expenditures and minimize Error Rates

A Population Health Approach

- Need to think differently about health: move from a focus on **providing services** to a **single individual**… to **measurably improving outcomes** for the **populations** in our communities
- Key strategies/elements:
  - Prevention
  - Care management
  - Partnerships with primary care providers and others in the healthcare system
  - Data collection & continuous quality improvement
  - Clinical accountability

Accountability

- Compliance
  - Not going away!
- Clinical accountability
  - New responsibility for meeting clinical quality measures
  - National Quality Strategy
  - Meaningful Use requirements
- Infrastructure
  - What quality measures do we use?
  - What do we want to be held accountable for?

New Medicaid State Option for Healthcare Homes

- To be eligible, individuals must have:
  - Two or more chronic conditions, OR
  - One condition and the risk of developing another, OR
  - **At least one serious and persistent mental health condition**
- The ***chronic conditions*** listed in statute **include a mental health condition, a substance abuse disorder,** asthma, diabetes, heart disease, and obesity (as evidenced by a BMI of > 25).
- States may add other conditions subject to CMS approval

Designated Provider Types/Functions

- Community MH/SUD organizations included as eligible providers
- Provider organizations may work alone or as a team
- Functions include (but are not limited to):
  - Providing quality-driven, cost-effective, culturally appropriate, and person-centered care;
  - Coordinating and providing access to high-quality services informed by evidence-based guidelines;
  - **Coordinating and providing access to mental health and substance abuse services;**
  - Coordinating and providing access to long-term care supports and services.

Health Home Services

- 90% Federal match rate for the following services during the first 8 fiscal year quarters when the program is in effect:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care from inpatient to other settings
  - Patient and family support
  - Referral to community and social support services
  - Use of health IT to link services (as feasible/appropriate)

States to Date

- 9 States have planning grants: AR, AZ, CA, MS, NC, NJ, NM, NV, WV
- SAMHSA Discussions: MO, MN, NC, NH, NY, RI
- SPAs submitted: MO, RI
- Quite a few states seem to be considering this option for populations with serious mental illness —no substance abuse proposals yet

The Health Home Neighbor

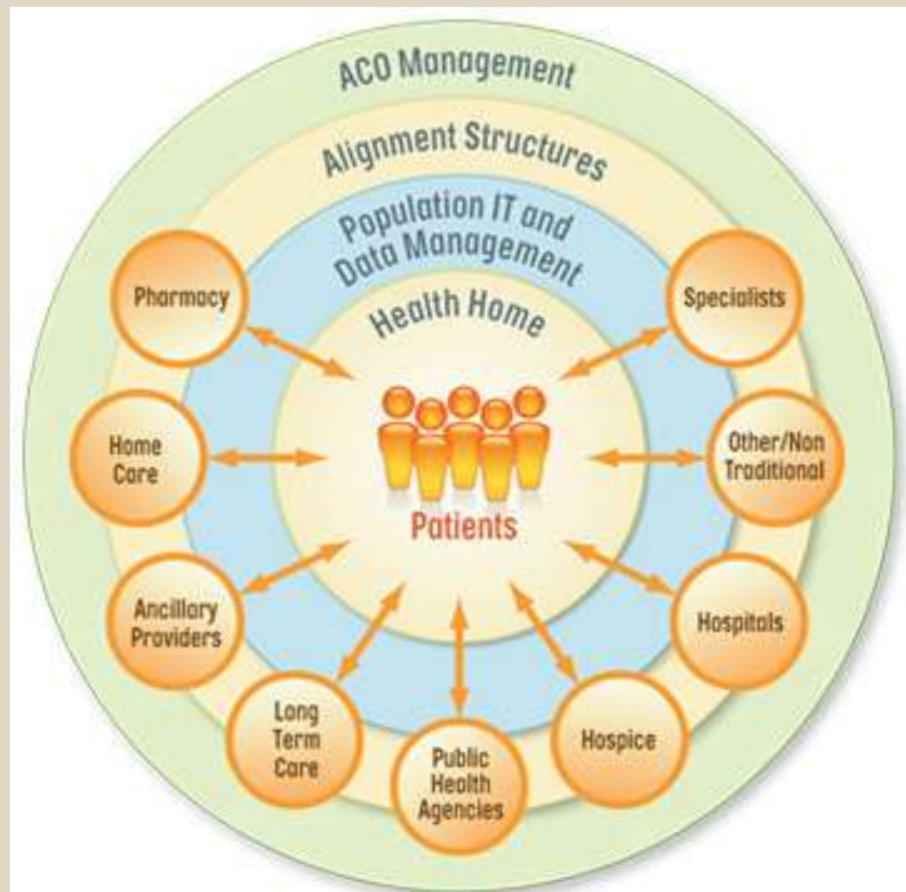
To be recognized as a neighbor, specialists must demonstrate competency around:

- Communication, coordination, & integration
- Timely consultations & referrals
- Timely, effective exchange of clinical data
- Effective participation in co-management situations
- Patient-centered care, enhanced care access, and high levels of care quality and safety
- Supporting the health home practice's work

Source: American College of Physicians, Patient Centered Medical Home Neighbor Principles

On Your Mark, Get Set, ACO…

Accountable Care Organizations bring together healthcare homes, specialty care, and ancillary services



ACOs and the Safety Net

- **Coverage expansions:** The massive expansion of coverage in 2014 will require new models to assure access and control costs – particularly for serving Medicaid patients, who will make up 14 million of the newly insured
- **Care management:** Individuals served by the safety net experience higher rates of serious mental illness, substance use disorders, and poorly controlled multiple chronic conditions
- Community behavioral health organizations have **expertise and experience** in caring for these populations, making them valuable partners in an ACO

Partnering with Health Homes and Accountable Care Organizations

- National Council report
  http://www.thenationalcouncil.org/cs/acos_and_health_homes
- Webinar with Dale Jarvis & Laurie Alexander
  http://www.thenationalcouncil.org/cs/recordings_presentations
- Live Blogchat
  http://mentalhealthcarereform.org/aco-webchat/

Conceptual Approach to Meaningful Use

Data Capture and Sharing

Advanced Clinical Processes

Improved Outcomes

Taking Advantage of Health IT Incentive Payments

Blog

Home | About | Contact Us | Subscribe to RSS

Behavioral Health Organizations Begin Receiving Incentive Payments for Health IT

Friday, September 9th, 2011

Guest Post: Chuck Ingoglia, Vice President, Public Policy, National Council for Community Behavioral Healthcare

Throughout 2011, states have begun disbursing Medicaid incentive payments to healthcare providers for the meaningful use of health information technology. Among the many providers receiving these payments are several behavioral health organizations, who qualify for the program by having "eligible professionals" (physicians and/or nurse practitioners) on staff.

Grand Lake Mental Health Center in Nowata, Oklahoma - a member of the National Council - was the first behavioral health center in the country to receive incentive payments for its electronic health record. GLMHC received $189,000 in April in the first installment of its payments by attesting to meeting the meaningful use requirements outlined in federal law. Most recently, D&E Counseling Center in Youngstown, Ohio, Unison Behavioral Health in Toledo, and Regional Mental Health in Lake County, Indiana also received incentive payments.

Grand Lake
Mental Health Center, Inc.

REGIONAL
MENTAL HEALTH CENTER
Helping. Healing. Building a Strong Community.

D&E Counseling Center
Because Kids Matter

Meaningful Use Step by Step

1. Determine how many eligible professionals (EPs) you have on staff (physicians, nurse practitioners).
2. 30% of your organization's caseload must be from Medicaid.
3. Determine whether your EHR is fully certified.
4. Register at the CMS website.
5. Attest that your eligible professionals are meeting meaningful use criteria.
6. Receive payments! (up to $63,750 per EP over 6 years)

More information:
http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage

Behavioral Health IT Act of 2011 (S. 539)

112TH CONGRESS
1ST SESSION

S. 539

To amend the Public Health Services Act and the Social Security Act to extend health information technology assistance eligibility to behavioral health, mental health, and substance abuse professionals and facilities, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 10, 2011

Mr. WHITEHOUSE introduced the following bill; which was read twice and referred to the Committee on Finance

---

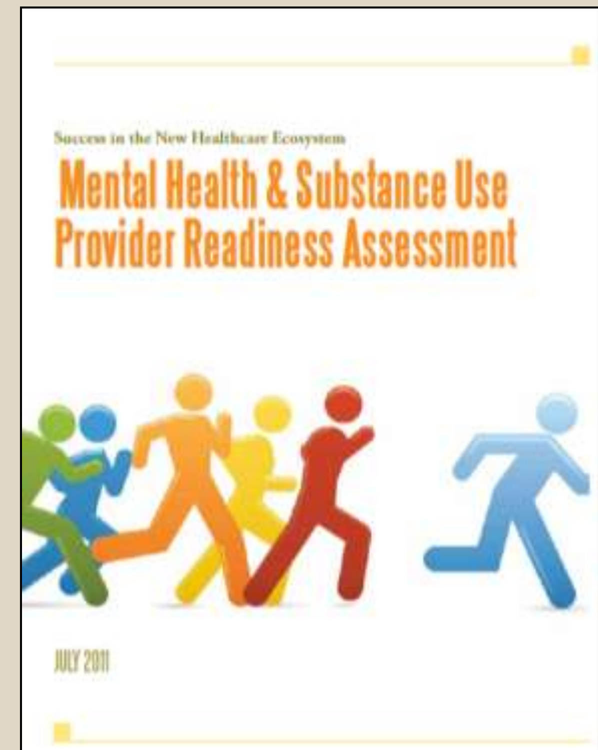
A BILL

To amend the Public Health Services Act and the Social Security Act to extend health information technology assistance eligibility to behavioral health, mental health, and substance abuse professionals and facilities, and for

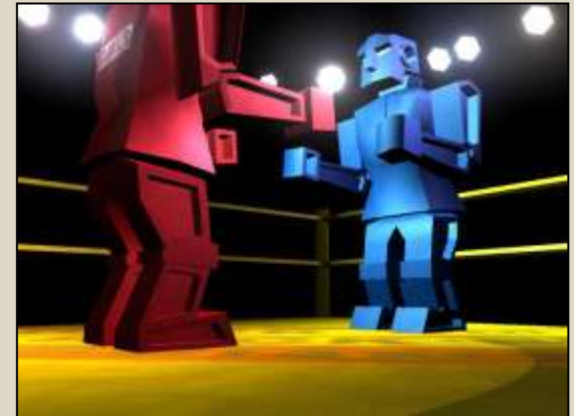
- Extends federal health IT incentive payments to CBHOs and certain behavioral health providers
- Currently 14 Senate co-sponsors
- Working on House introduction

Provider Readiness Assessment

- Describes 23 important competencies and strategies necessary to succeed in the new healthcare ecosystem
- Points to how you can assess and redesign internal operations to better align with healthcare reform and demonstrate to consumers, healthcare providers, and state policymakers that your organization is high-performing, quality-focused, and efficient.



The Federal Deficit Debate



- Debt ceiling increase
- Balanced Budget Amendment
- Discretionary spending caps: $917 billion in spending reductions
- Joint Select Committee on Deficit Reduction: Goal: $1.2-1.5 trillion in deficit reduction
- Timeline: a deficit reduction plan must be approved by the end of the year…
- …Or automatic, across-the-board cuts will be triggered beginning in 2013

Medicaid, MH/SUD, and the Supercommittee Negotiations

- At least $1.2 trillion in cuts to be identified
  - All federal programs are fair game
  - Potential for sweeping cuts to discretionary programs
  - Medicaid faces an even greater risk
  - ACA prevention, integration programs under fire
- Should the supercommittee fail: Medicaid, CHIP, SSI protected from automatic cuts

Sen. Patty Murray & Rep. Jeb Hensarling, supercommittee co-chairs

Medicaid Reform Proposals

- Establishing a single, “blended” FMAP rate for each state
- Converting Medicaid to a block grant
- Additional proposals for state “flexibility” & “freedom”
  - Republican Governors’ Association Medicaid policy proposals (heavy focus on decreased federal regulation of Medicaid and state autonomy in achieving healthy outcomes)
  - ARRA/ACA Maintenance of Effort repeal

Take Action!

- To protect Medicaid and behavioral health in debt limit negotiations
- To extend health IT incentive payments to behavioral health organizations

Visit the National Council's Policy Action Center at http://capwiz.com/thenationalcouncil/home/

Your Opinion Matters!

Blog with us at

www.mentalhealthcarereform.org

Mental health and addictions services are at the core of healthcare reform

Join us on our blog to

- >>> **Hear from the leaders**
- >>> **Keep up with the latest**
- >>> **Understand the implications**
- >>> **See what's coming**
- >>> **Download PowerPoints, timelines, maps, and more**
- >>> **Add YOUR voice**

Find material to share on your social media sites and subscribe to our email and RSS feeds for live updates.

Questions?

- Chuck Ingoglia

  Chucki@thenationalcouncil.org