Update on Federal Policy and Legislation Impacting Community Mental Health

February 9, 2017

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Where we've come…

- **2010:** Affordable Care Act
- **2013:** Final commercial parity rules
- **2014:** Excellence in Mental Health Act
- **2015:** MACRA
- **2016:** Final Medicaid parity rules
- **2016:** Comprehensive Addiction & Recovery Act
- **2016:** 21st Century Cures Act

On the eve of 2017…

Checking the Box Score

House of Representatives	
Republican	239
Democrat	193
Independent	1

Senate	
Republican	51
Democrat	48

Trump's Health Care Team

Rep. Tom Price (R-GA) nominated as next Secretary of Health and Human Services

Seema Verma, Indiana-based health care consultant, nominated as next Administrator of CMS

What does it mean?

- **President Trump** has little history on health care issues.
- **GOP congressional majorities** will look to undo policies from last 8 years…maybe more.
- **HHS/CMS leadership** has a history of support for sweeping Medicaid reforms

A new health care agenda

- ACA repeal / replace / repair / ?
- Medicaid restructuring
  - Block grant
  - Per-capita cap
- Medicaid waivers
- 2017 & 2018 funding:
  - CARA
  - Sequestration, potential cuts to non-defense programs
- Implementation of CCBHCs, 21st Century Cures

Key provisions at risk if ACA is repealed in its entirety

(100% repeal is unlikely)

- Medicaid expansion & health insurance marketplaces
  - 560,000 Indianans could lose coverage
  - Indiana would lose about $610 million in federal Medicaid dollars
- Essential health benefits & parity

“Winning is easy, young man. Governing’s harder.”

Different Republican schools of thought on ACA repeal

- "This law **cannot be fixed**. Its knot of regulations, taxes, and mandates cannot be untangled. We need a clean start…" –Speaker Paul Ryan, June 2016

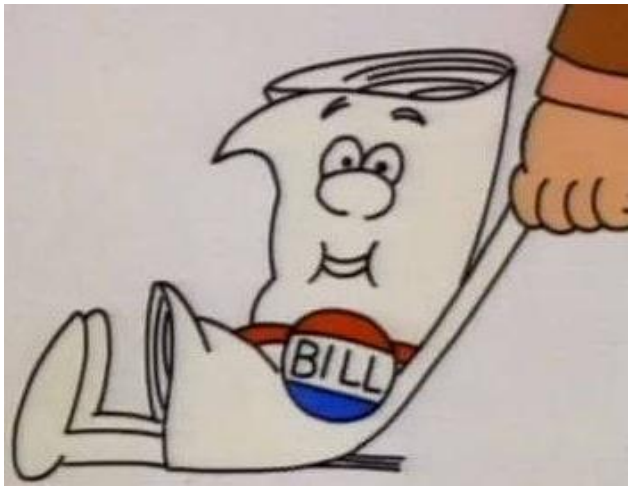
- "We can **repair** the individual market, which is a good place to start" –Sen. Lamar Alexander, Feb. 2017

Timeline:

- **Currently underway:**
  - **ACA "repeal" and partial "replace" or "repair"**
  - Will be a partial repeal through budget reconciliation
- Timing TBD:
  - Additional ACA "replacement" bills
- Looking ahead (spring or summer 2017?):
  - Medicaid, Medicare, tax reform
  - Will also be done through budget reconciliation

ACA "repeal" begins…

- ☑ **Step One**: House and Senate chamber each introduce and adopt a budget resolution with spending instructions. (Simple majority needed.)
- ☐ **Step Two**: Each chamber makes changes to federal mandatory spending or revenue policies per instructions. (Ex. Reducing enhanced Medicaid match)
- ☐ **Step Three**: Specified debate time, filibuster-proof, simple majority vote to approve.
- ☐ **Step Four**: Approved bill sent to President for approval.



ACA replacement plans

Universal "access" to health insurance

"Health care for everybody"… "Medicaid block grants"… and… ?

3 options for states to choose

If coverage expansions are repealed…

- **2.8 million** Americans with a MH or substance use disorder will lose coverage.
- **222,000** of these newly uninsured individuals have an opioid disorder.
- **$5.5 billion** fewer dollars would be available for treatment for low-income Americans

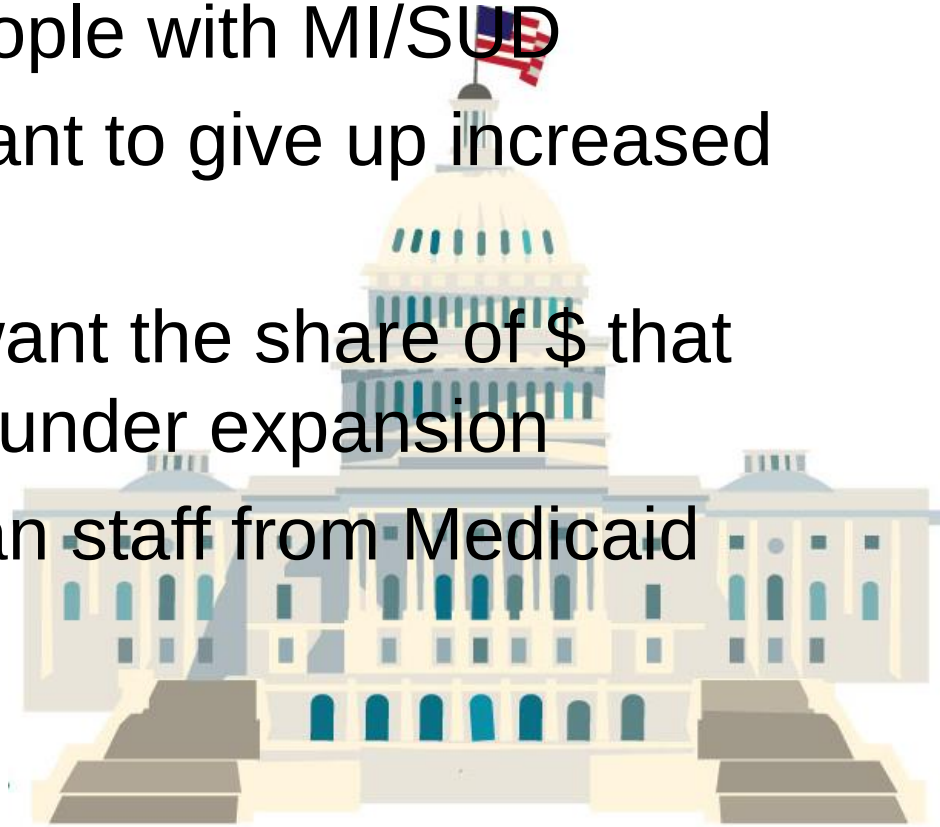
Source: Richard G. Frank and Sherry A. Glied, *To sustain progress on treating opioid disorders and serious mental illnesses keep the ACA.*

Other sources of prevention & treatment funding cannot fill the gap

- Substance Abuse Prevention & Treatment Block Grant
  - **$1.8 billion** each year
- 21st Century Cures opioid block grant
  - **$500 million**/year for 2 years
- State/local general funds for behavioral health
  - **Cut by ~$4.5 billion** during the course of the recession

Medicaid expansion: latest update from the Hill

- Growing awareness of the ripple effects of expansion repeal on people with MI/SUD
- Expansion states reluctant to give up increased federal $
- Non-expansion states want the share of $ that would have been theirs under expansion
- Workgroup of Republican staff from Medicaid expansion states



What will happen next?

Preservation of key programs will require consistent, engaged advocacy.

What will happen to states' Medicaid waivers?

For now, nothing.

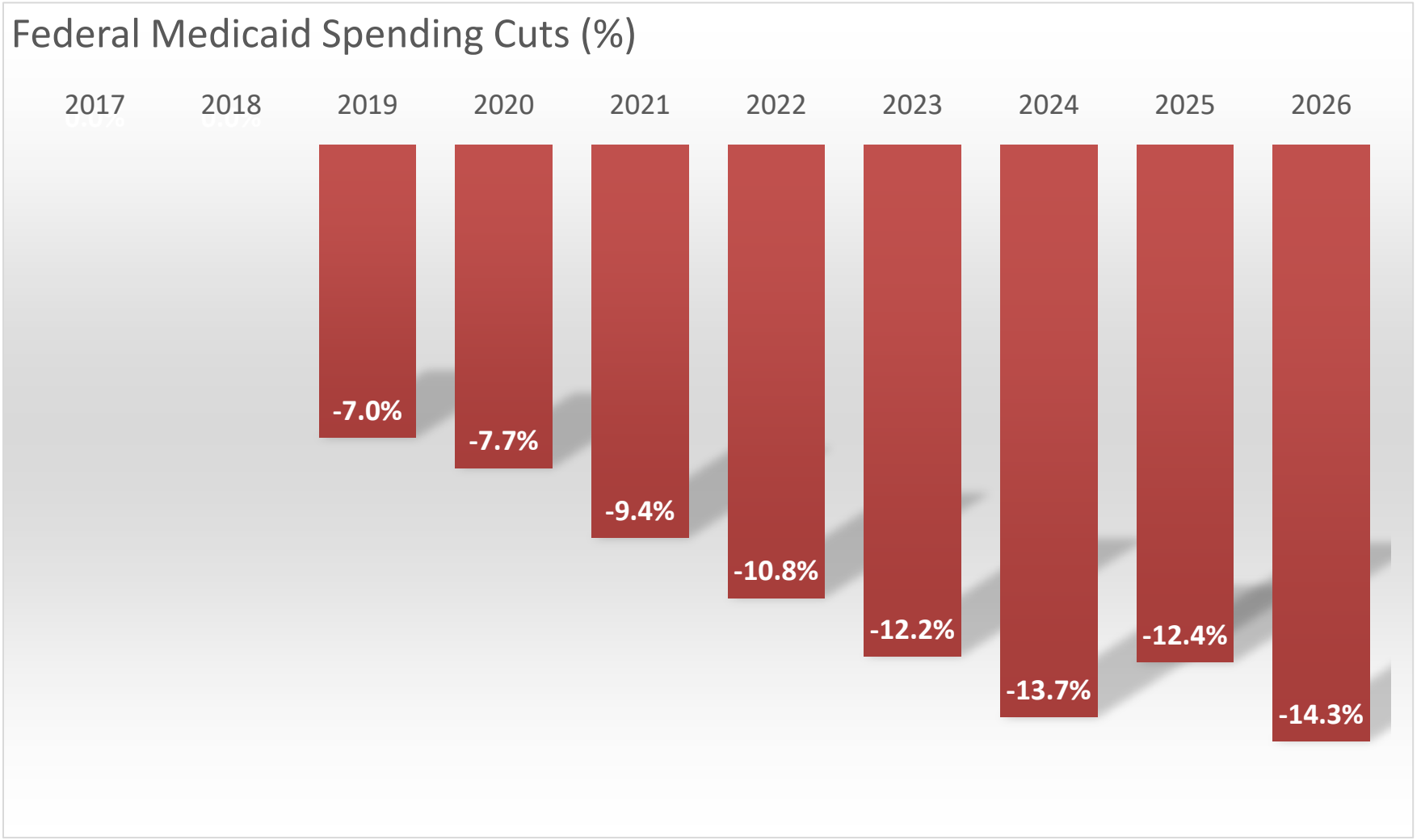
- Incoming HHS/CMS leadership likely to be much more amenable to waiver proposals like:
  - Employment incentives/requirements
  - Premiums for low-income enrollees
  - Rating
  - Open enrollment periods
- Remember the ACA's Section 1332 waivers…

Medicaid Block Grants or Per-Capita Cap: Cut Federal Funding and Shift Costs to States

- Explicit cuts in funding based on structure of the cap:
  - Baseline funding cap per beneficiary is set too low
  - Rate of growth in spending per enrollee doesn't keep pace with health costs

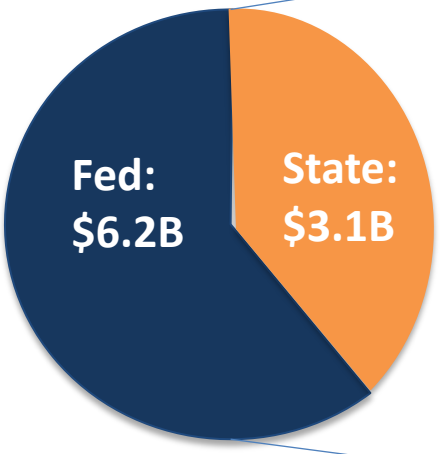
- Shifts costs to states for :
  - Unanticipated **increases in expected state Medicaid costs**
  - **Increases in health care costs** that will likely occur, but are not factored into the established growth rate

End goal: cut federal Medicaid spending by $1 Trillion



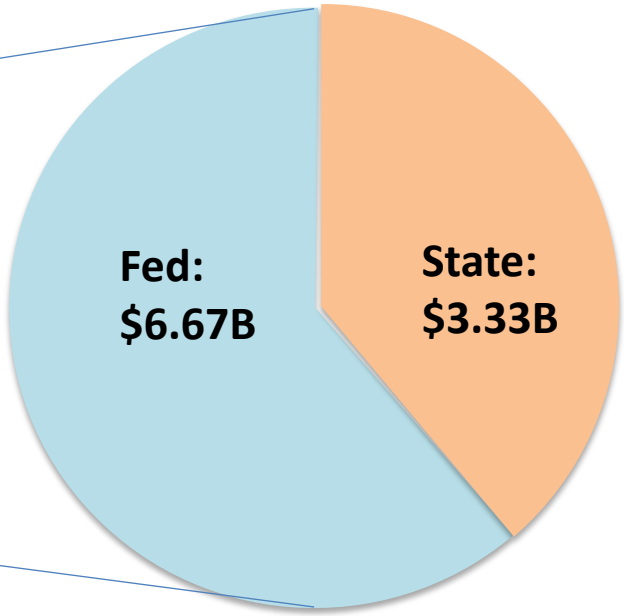
Impact of Medicaid caps on states

Baseline



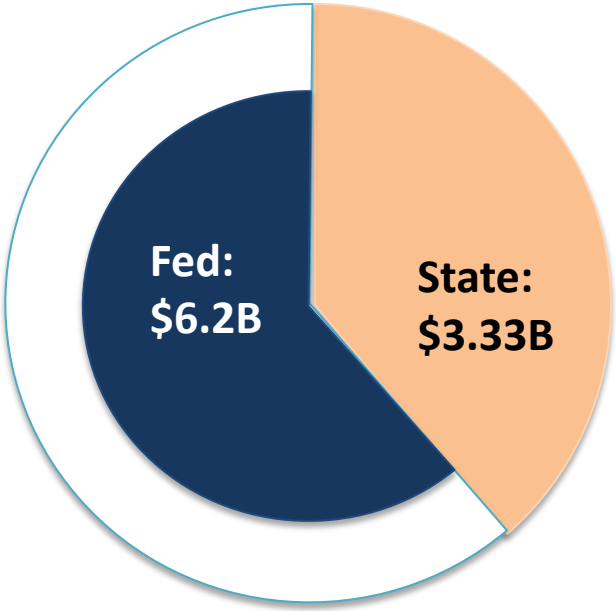
Total: $9.3 billion

Program growth, currently



Total: $10 billion

Program growth, capped scenario



Total: $10 billion

Shortfall: $470 million

Medicaid is largely a BH funding program

- Medicaid accounts for:
  - 21% of all SUD spending
  - 25% of all mental health spending
- People with a BH diagnosis account for:
  - 20% of all Medicaid beneficiaries
  - 29% of the Medicaid expansion

Medicaid reform proposals further crunch states… and providers

- Indiana general fund revenues below projections
  - Last 6 months of FY 2017
  - Initial months of FY 2017
- Common cost-cutting actions by states include:
  - Provider pay cuts
  - Coverage rollbacks/limitations
  - Benefit reductions

THE TIME IS NOW

What can you do to protect Medicaid?

Visit the National Council's Act NOW page for the latest call to action and tips for how to get involved.

https://www.thenationalcouncil.org/policy-action/national-council-act-now/

Our message (at this stage)

- Medicaid is a key coverage source for people living with mental illness or addiction
- Please preserve Americans' access to mental health & addiction coverage

Today's advocacy goals:

- ***Raise awareness of the importance of Medicaid for this population***
- ***Highlight broad support for Medicaid***
- ***Make lots of noise!***

Discretionary spending

- FY 2017 under a continuing resolution through 4/28 (7 months into fiscal year)
- FY 2018 marks return of sequestration
  - Previous cuts split evenly between defense & non-defense
  - President Trump expressed desire to raise defense spending… at the cost of what?
- Spending decisions affect CARA, 21st Century Cures, SAMHSA block grants & more…

In July 2016 Congress Passed…

The most comprehensive federal effort to address the opioid epidemic.


Senators Sheldon Whitehouse and Rob Portman


Representatives James Sensenbrenner and Tim Ryan

Funding 21st Century Cures

- Signed into law in December, 2016
- **Authorized $1 billion** in state grants to combat the opioid epidemic.
- $500 million appropriated in FY2017… **appropriation for FY2018 still TBD.**

Opportunities ahead

- Continued focus on opioid epidemic
  - CARA & Cures funding?
- CCBHC implementation and expansion?
- Investing in the MH/addiction workforce?
- Other?

"After months of partisan bickering, Congress has finally agreed to put a Slinky on an escalator and see if it goes forever."

Questions?


I think it's time for a break.

Community Mental Health Best Practices and National Trends

Where are we today?

CCBHC Demonstration strengthens capacity in the safety net

Billing code revisions support integrated, coordinated care.

Performance pay is permeating more payment models.

Growing need is increasing the pressure on the workforce.

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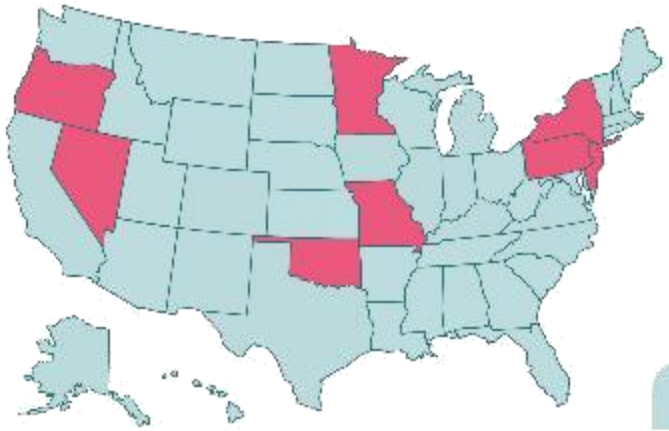
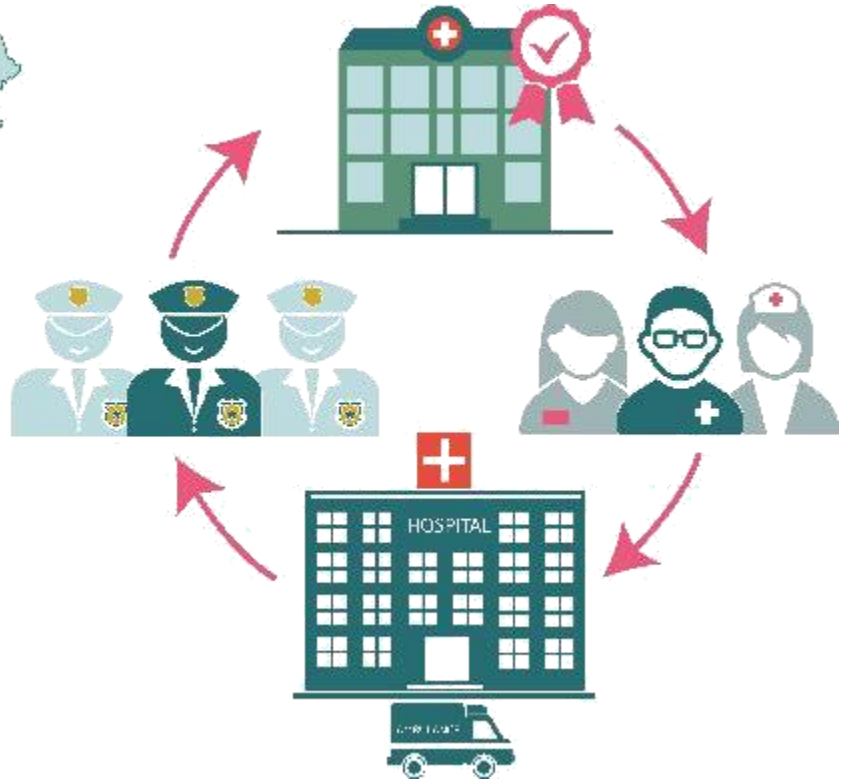
CCBHCs

Certified Community Behavioral Health Clinics

- Setting the standard of care for the behavioral health services industry -

Missouri ✧ New Jersey ✧ New York ✧ Oregon ✧ Minnesota ✧ Oklahoma ✧ Nevada ✧ Pennsylvania





CCBHCs will be required to coordinate with other sectors such as primary care, law enforcement, hospitals, and other health and social services.

Why is the Excellence Act important?

It sets standards for care for the behavioral health services industry.

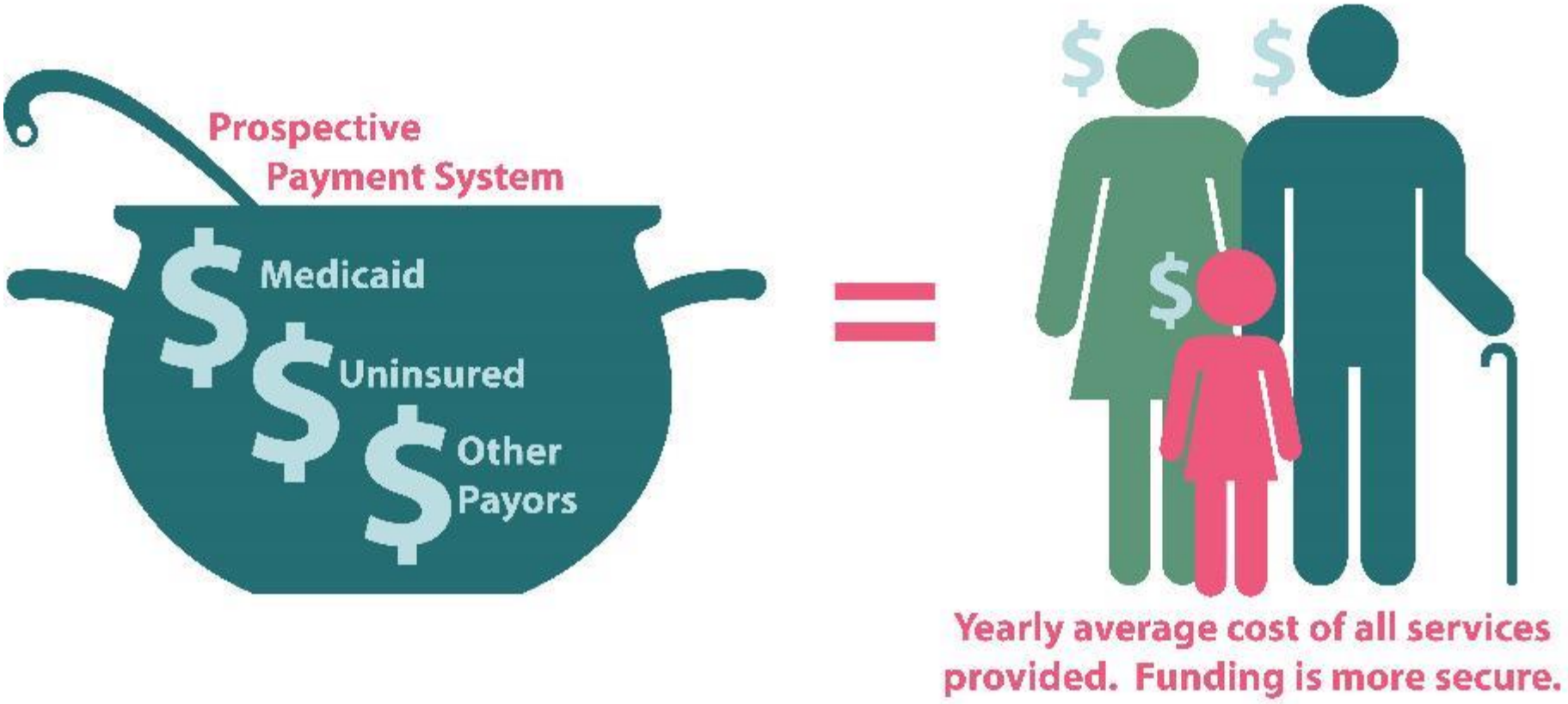
- It defines what they are

- It defines who they must serve

- It defines what outcomes they must achieve

How do CCBHCs expand capacity?

CCBHCs will adopt a Prospective Payment System to assure clinics have the financial resources to provide high quality, comprehensive care



What's the relevance for Indiana?

- Our goal = expand the Excellence Act nationwide
- Are you ready to be Cohort 2?

Moving toward value-based purchasing…

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States opening up billing codes

States changing billing codes to allow CMHCs to bill for primary care services:

- Indiana
- Tennessee
- Missouri
- Kentucky

New Collaborative Care G-Codes

- Medicare plans will begin coverage and reimbursement for “Psychiatric Collaborative Care Management Services” starting in 2017
- Based on Collaborative Care Model (CoCM)
- Includes 3 codes to describe services furnished as part of the psychiatric CoCM

New Codes for 2017

- GPPP1
- GPPP2
- GPPP3

These codes parallel the CPT codes that are being created to report these services.

New care management CPT code

- Medicare Transitional Care Management Services Codes[1,2]
  - Includes services provided to a patient whose medical and/or psychosocial problems require moderate- or high-complexity medical decision making during transitions in care
  - Communication and face-to-face visit within specified time frames post-discharge
  - CPT Codes 99495 and 99496

1. American Medical Association. CPT-Transitional Care Management Services (99495-99496). http://www.sccma-mcms.org/Portals/19/assets/docs/TCM-CPT.pdf. Accessed April 14, 2016. **2.** American Academy of Family Physicians, Frequently Asked Questions: Transitional Care Management: http://www.aafp.org/dam/AAFP/documents/practice_management/payment/TCMFAQ.pdf. Accessed April 14, 2016.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

INNOVATION MODELS

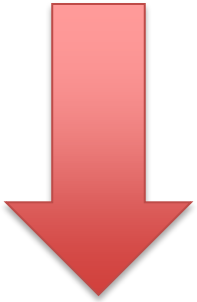
Moving from episodic "sick care" to population health management

In 2010, there were no ACOs…

Today, there are more than **700.**

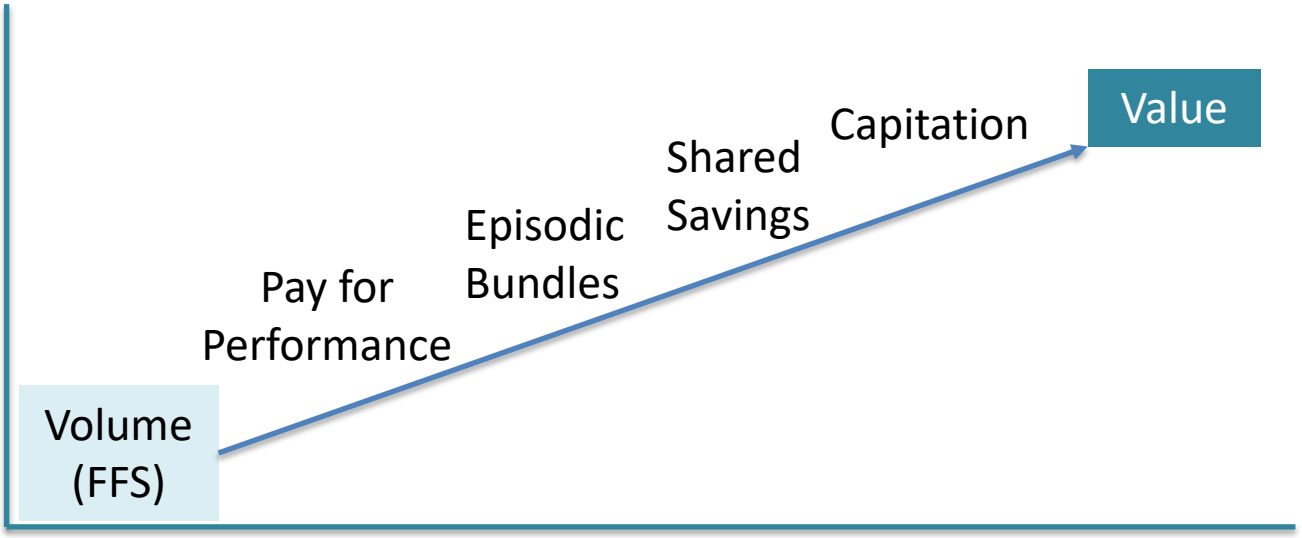
Not just another fad

"Medicare's ACOs reduced spending by **$466** million in 2015, according to fresh data from CMS."



On the downside: **nearly half** of participants didn't achieve any savings.

Shifting Focus from Volume to Value



Incentives for health system investment in behavioral health care

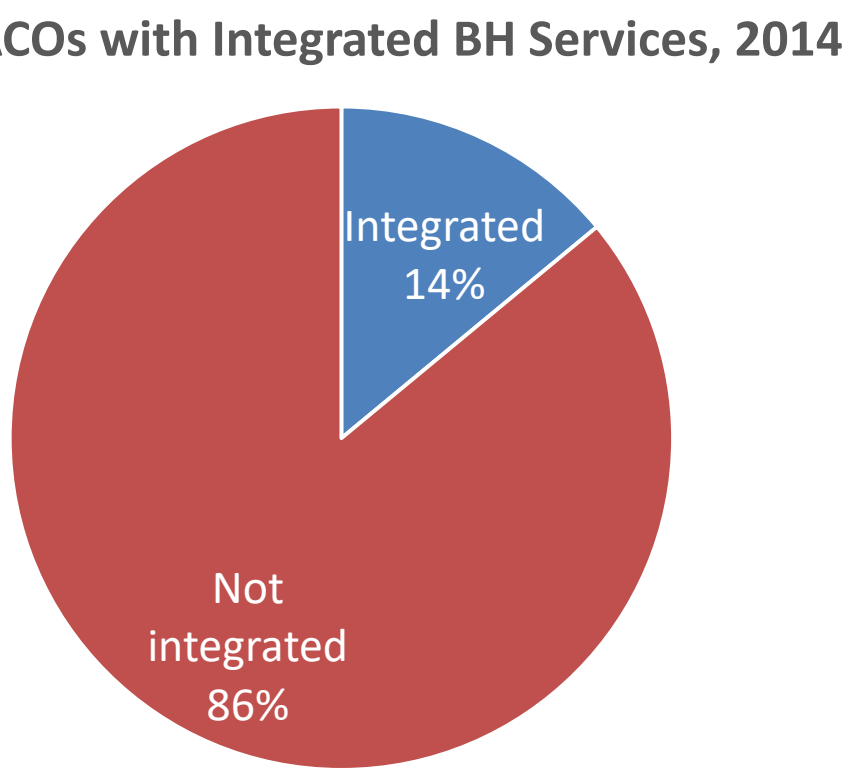
- Reduce ED overcrowding
- Improve bed availability
- Reduce inpatient length of stay

- Prevent unnecessary readmissions
- Improve clinical outcomes & reduce cost of care for complex, chronically ill populations

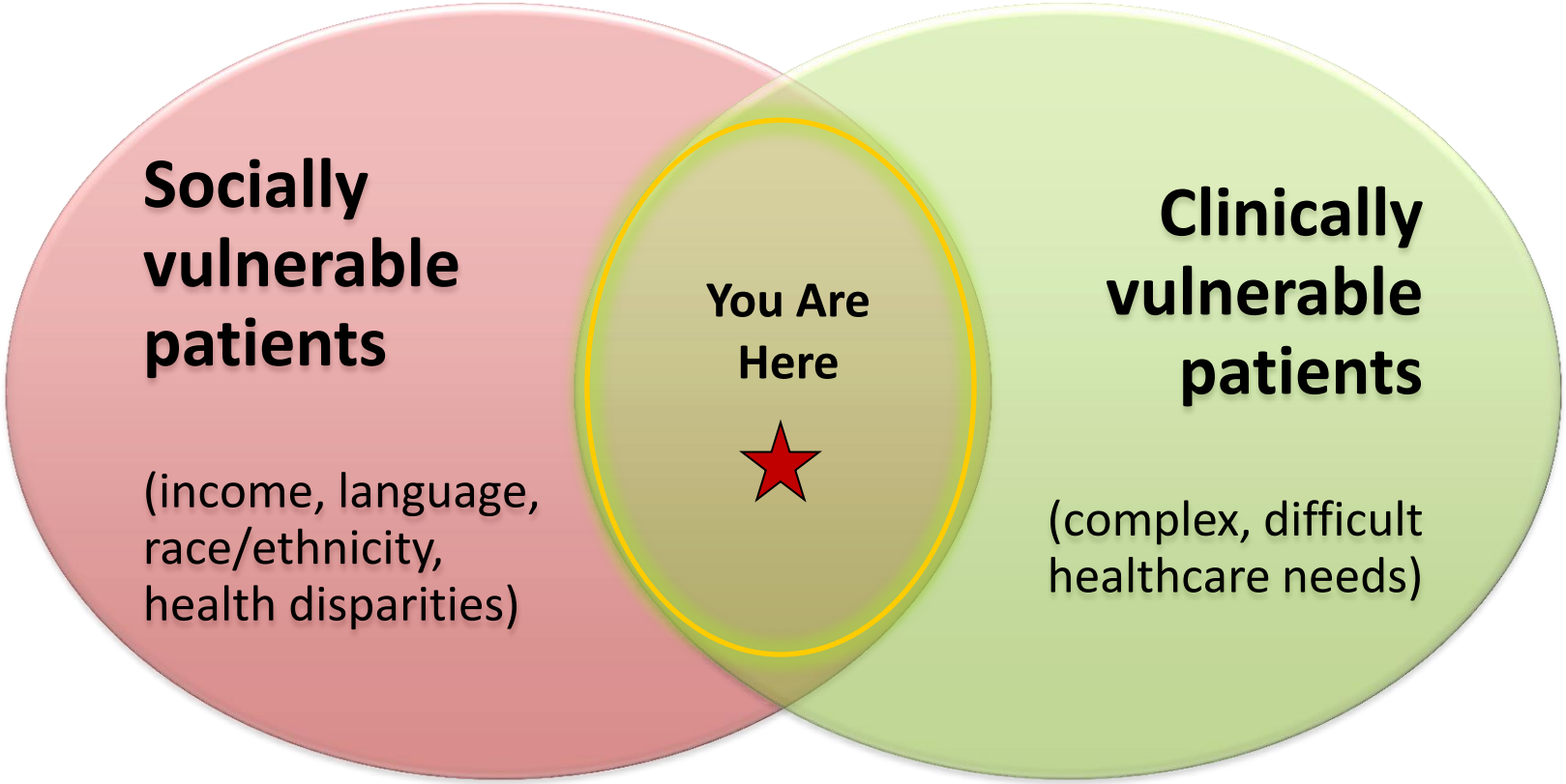
Despite accountability for behavioral health…

Few ACOs have engaged MH/SUD providers

"We recognize the need to engage with existing behavioral health providers, but we need to know what unique capabilities they bring to the table."



Our niche: caring for complex, costly patients



Source: *Health Affairs:* VA Lewis, et al. "The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles." 2012.

Demand for impact

- Transparent organization
- Reliability and reputation
- Using patient-specific data to examine progress or lack of progress
- Using registries and monitoring to benchmark staff variance in clinical practice standards

Infrastructure Needs

- Contracting expertise and willingness to experiment
- Value-driven decision-making (outcomes + costs)
- Sophisticated compliance program
- EHRs with registries, HIEs
- Committed and valued workforce
- Smart, fearless, team-based leadership


If a tree falls in the forest and no one collected the data, it didn’t make a sound.

Data Gathering: Lessons Learned

- Identify infrastructure, technology needs
  - For data **reporting** and data **analysis**
- Know what data to gather
- Staff up: hire or train staff on using data analytics for quality improvement
- Sometimes the results don't demonstrate what you want
  - Be flexible in adjusting workflows, practices
  - Or reconsider: does this data accurately capture what I need for decisionmaking?

Learn to talk a different language with unfamiliar colleagues

Care Coordination:

The "Linchpin" of CCBHC

- Partnerships/care coordination agreements required with:
  - FQHCs/rural health clinics
  - Inpatient psychiatry and detoxification
  - Post-detoxification step-down services
  - Residential programs
  - Other social services providers, including
    - Schools
    - Child welfare agencies
    - Juvenile and criminal justice agencies and facilities
    - Indian Health Service youth regional treatment centers
    - Child placing agencies for therapeutic foster care service
  - Department of Veterans Affairs facilities
  - Inpatient acute care hospitals and hospital outpatient clinics

The “4 C’s” of health homes

First Contact

Continuity

Comprehensiveness

Coordination

Most integration models prioritize this piece…

…But research shows all four C’s are crucial to producing improved outcomes and reduced costs.

How do we pay for all this?

Payment Reform and Sustainability

- Billable and nonbillable components
  - Know what you can bill for – and by whom
  - Working with your state to turn on relevant billing codes
- Licensure – necessary? Which ones?
- Understand your costs and cost savings
  - Where does investment yield most return?
  - What are your greatest sources of savings/costs?
- Transition along the payment risk continuum – are you ready?

What's ahead for the ACO model?

- Fate of **ACA**?
- Increase in **mergers/acquisitions** in the BH sector increases contracting leverage?
- Impact of **other quality/value models** like MACRA?
- Increased **financial risk** creates increased incentives for partnership?

What we should glean from ACOs and CCBHCs

- “Value” is where our payment system is headed.
- There is growing recognition of the importance of investing in BH services & prevention.
- Organizations must be able to demonstrate their impact through data.
  - MUST include data on cost savings
- Partnerships with other health system entities will be a required component of care delivery.

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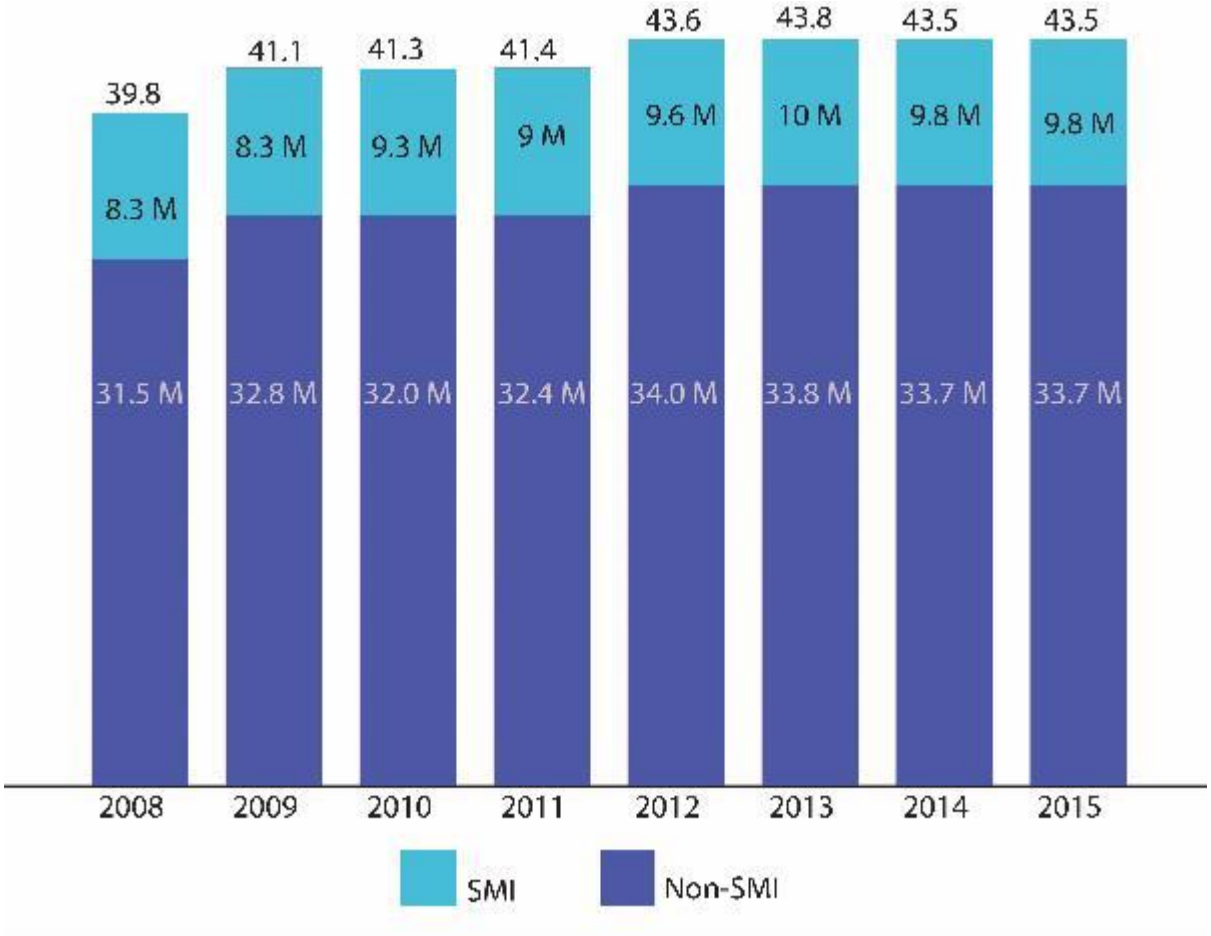
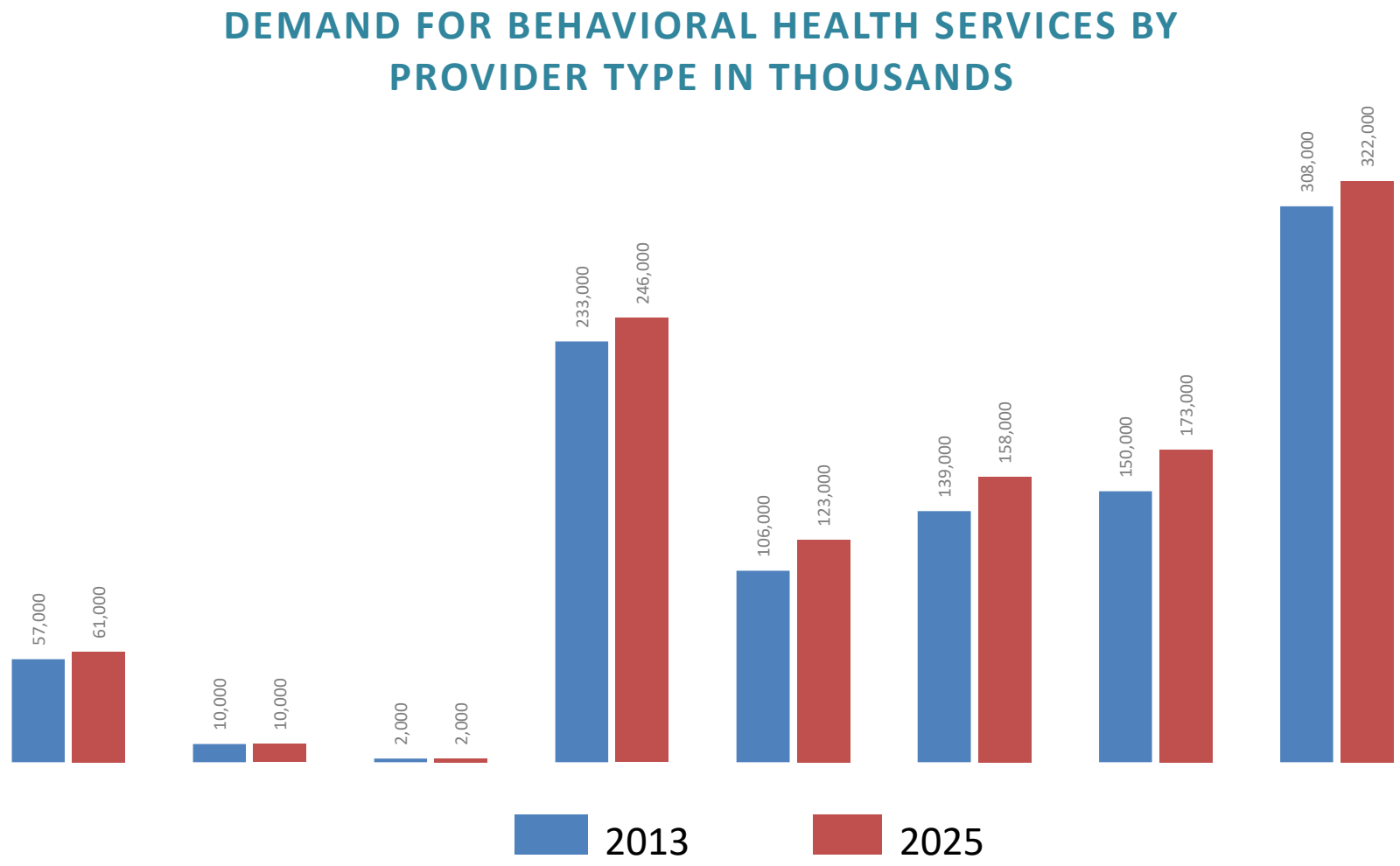
Demand for BH services is increasing

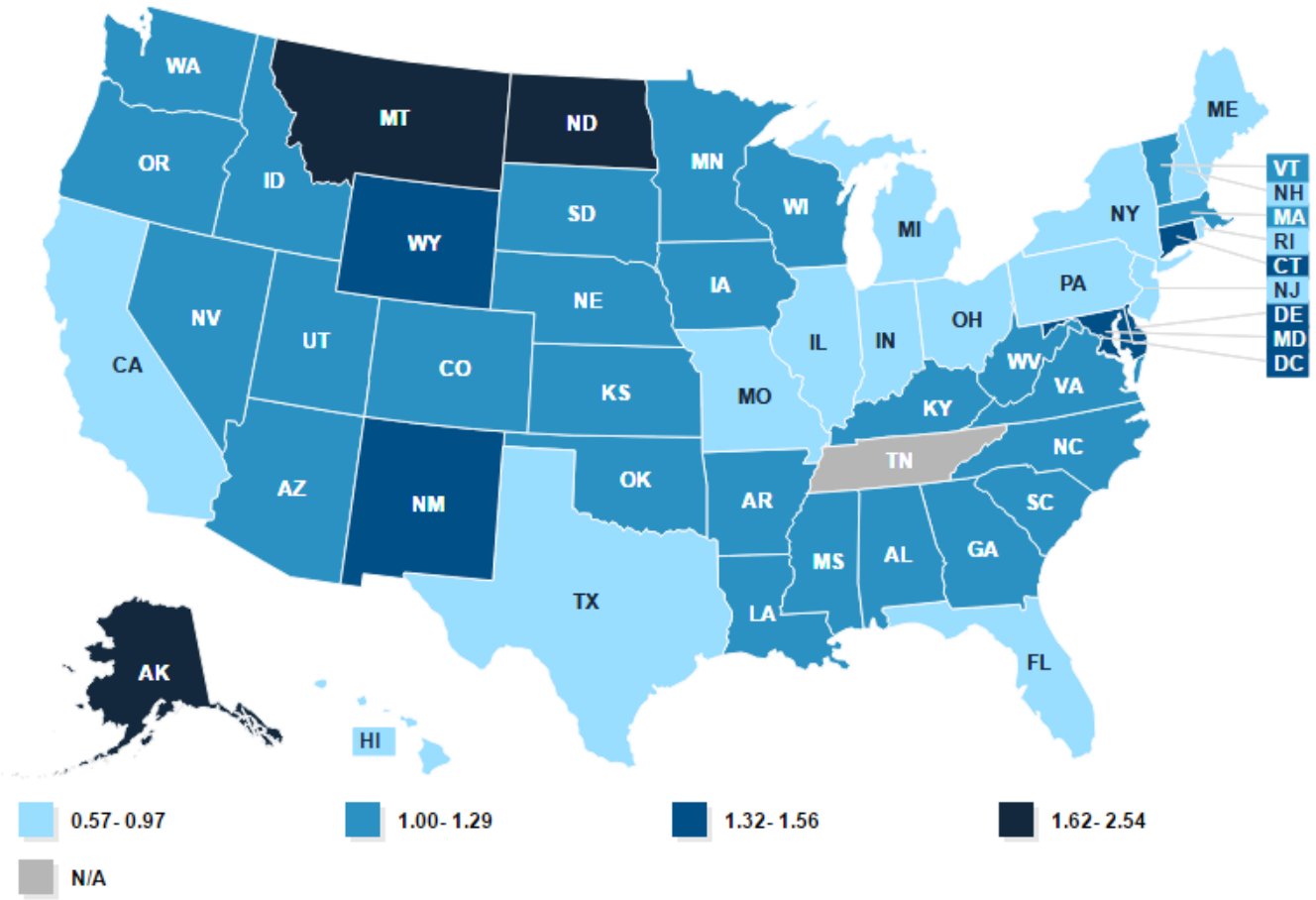


Growth in Demand for Behavioral Health Services will Exacerbate Chronic Workforce Shortages



Ability to recruit & retain staff limited by low rates

Map shows ratio of Medicaid to Medicare payment rates



HRSA projects ongoing shortages of professionals

By 2025…

- If levels of demand remain constant, shortages projected among 5 key behavioral health provider types
- If levels of demand increase, shortages projected among 9 key provider types
  - Including shortages of **more than 10,000 FTEs** among psychiatrists, psychologists, social workers, SUD counselors, mental health counselors, & school counselors

Multi-pronged solutions are needed

- Pipeline
- Loan forgiveness
- Higher education curricula
- Improving reimbursement to support increased salaries (CCBHCs)
- Telehealth / technology

"We're competing with grocery stores and fast food for our staff."

Questions

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