Health Care Reform Implications & Considerations for Mental Health

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Presentation Overview

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California's Public Mental Health System

- Under the provisions of our Medicaid Title 42, Section 1915(b) "freedom of choice" waiver covering the mandatory enrollment of eligible Medi-Cal beneficiaries in the Mental Health Plans (MHPs) for specialty mental health, emergency and hospital services, California's county MHPs are considered prepaid inpatient health plans.
- California's MHPs are responsible for assuring 24 hour, seven day/week access to emergency, hospital and post-stabilization care for the covered psychiatric conditions for Medi-Cal beneficiaries.
- In addition, California has two State Plan Amendments that increase the scope of outpatient, crisis and residential and inpatient mental health coverage provided to Medi-Cal beneficiaries when medically necessary, by the MHP.
- California's Approved SPAs:
  - Targeted case management for persons with mental illness.
  - Mental health services available under the Rehabilitation Option, broadening the range of personnel, services, and locations that were available to provide services to eligible beneficiaries.

California's Public Mental Health System

- MHPs are subject to CFR Title 42, Part 438 Managed Care requirements which specify additional access, beneficiary protection and quality management requirements that the MHP must conform to.
- Both federal and state code and regulation specify that there is to be a contract between the state and the MHP/PIHP specifying the conditions under which the managed care program will operate.
- The regulations and contract also specify requirements for the coordination of health and mental health treatment between the county and the state contracted health plans, including that an MOU be in place between the county and each health plan specifying the process for timely referral and treatment.

Major Mental Health Milestones

- 1969: Community Mental Health Services Act, Deinstitutionalization, Short/Doyle Act
- 1984: AB 3632 (Special Education Mandate)
- 1991: Realignment 1991
- 1993: Medi-Cal Rehabilitation Option
- 1995-97: Medi-Cal Specialty Mental Health Consolidation
- 2004: Prop. 63 – Mental Health Services Act
- 2008: Federal Mental Health Parity
- 2009-10 Federal Health Care Reform/CA 1115 Waiver
- 2011: AB 100/MHSA Changes
- 2011: Repeal of AB 3632
- 2011: Realignment 2011/Public Safety Realignment

Parity

- Prior to 1996, health insurance coverage for mental illnesses has historically been **less generous** than that for other physical health illnesses.
- This has generally been reflected either by a **complete lack of coverage** of a particular mental health condition or by a **differential structuring** of coverage terms for mental health benefits relative to benefits for medical/surgical services (e.g. lower annual/lifetime dollar limits, treatment limitations, increased cost-sharing)
- Mental health parity is a response to this **disparity in insurance coverage**, and generally refers to the concept that health insurance coverage for mental health services should be offered on par with covered medical and surgical benefits.

Brief History of Parity

- The **Mental Health Parity Act of 1996** was the first federal mental health parity law, primarily addressing annual/aggregate lifetime dollar limits.
- California has had **state parity laws** in place since 2000 (Mental Health Parity Act of 1999 – SB 88) requiring private insurers to cover treatment of specific severe mental illnesses, and to do so on the same terms and conditions applied to the treatment of other illnesses.
- The **Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008** expands the scope of MH parity requirements at the federal level and includes SUD within its scope.
- An Interim **Final Rule** was published in February 2010 outlining many of the relevant quantitative and non-quantitative limitations
- The **ACA** extended the reach some of the federal parity requirements to **all benchmark & benchmark equivalent plans**. Specifically, MH/SUD benefits must have parity with medical/surgical benefits with respect to financial requirements & treatment limitations.
- The ACA also creates a **coverage mandate** for MH/SUD services as one of the 10 required EHB categories.

Parity

- Specifically, **the ACA expands the reach of federal MH/SUD parity law to 3 main types of plans**: 1) QHPs, 2) Medicaid non-managed care benchmark and benchmark-equivalent plans, and 3) plans offered through the individual market.
- The ACA **requires Medicaid benchmark plans to provide MH & SUD services at parity** with other covered medical and surgical services, in accordance with MHPAEA (i.e. treatment limitations and financial requirements imposed on MH/SUD services cannot be more restrictive than those imposed on other covered medical and surgical benefits).
- **Medicaid managed care plans** (non-benchmark) **are also required to comply with MHPAEA.**
- MHPAEA, which preexists the ACA, contained an exemption for small employers. **The ACA extends the requirements of MHPAEA to small group plans.** Plans offered through the small group and individual market will need to not only cover mental health and substance use disorder services but also provide those services at parity with medical and surgical benefits.

Affordable Care Act Highlights

- ACA signed into law March 23, 2010
- Changes to Private Insurance (expanding dependent coverage, limiting exclusions for pre-existing conditions, imposing market rules, etc.)
- Emphasis on Quality Improvement & Health System Performance Initiatives
- Emphasis on Prevention & Wellness
- Creation of State Health Insurance Exchanges (imposing individual mandate and offering premium & cost-sharing subsidies to individuals)
- Expansion of Public Programs

The ACA & Mental Health

- The ACA explicitly includes MH & SUD services, including behavioral health treatment, as one of ten categories of service that must be covered as **essential health benefits**.
- Furthermore, the ACA also mandates that mental health and substance use disorder benchmark coverage must be provided at **parity**, compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008).
- Given the low rate of service utilization among uninsured adults with MH and SUD needs, the expansion of health insurance coverage through health care reform could ***increase access to and utilization of mental health and substance use disorder services*** for many uninsured adults in California.
- According to a recent UCLA study, half a million uninsured CA adults with MH needs will become ***eligible for health insurance*** coverage in 2014.
- The ACA offers an extraordinary opportunity to provide access to rehabilitative and recovery-oriented MH services to individuals ***before they become disabled***. Qualified adults without a disability will, for the first time, have access to MH/SUD services through the Medi-Cal program or subsidized insurance.

Medicaid Expansion

- Beginning January 1, 2014, the ACA establishes a **new Medicaid eligibility group** of non-pregnant adults between the ages of 19 and 64 with incomes at or below 138% of the federal poverty level based on modified adjusted gross income.
- This new eligibility group consists of non-Medicare eligible **childless adults and individuals receiving Aid to Families with Dependent Children.**
- Participating states will receive **100% federal medical assistance percentage** (FMAP) for the first three years of implementation (2014-2016), gradually declining to 90% in 2020 and thereafter.
- Participating states are required to provide **essential health benefits, including MH & SUD treatment**, to Medicaid beneficiaries in the new eligibility group.

Medicaid Expansion

- California's state legislature passed this year two key pieces of ***special session legislation*** to implement the ACA: SB X1 1 (Perez – 2013) and AB X1 1 (Hernandez – 2013).
- Together, these companion bills expand Medi-Cal coverage, effective January 1, 2014, to individuals with incomes up to 133% of the federal poverty level and provide full-scope Medi-Cal benefits, which are supplemented with ***new mental health and substance use disorder benefits***.
- These bills require LIHP enrollees to transition to the new Medi-Cal expansion program. The bills also convert Medi-Cal income eligibility to a Modified Adjusted Gross Income (MAGI)-based standard, effective January 1, 2014 (except for seniors and people who are blind or disabled) and prohibit the use of an asset or resources test. The bills simplify and streamline the Medi-Cal application, eligibility and redetermination processes.

Medicaid Expansion

- Beginning January 1, 2014, covered Medi-Cal benefits shall include ***mental health services included in the essential health benefits package*** adopted by the state for the individual and small group market (i.e., the selected Kaiser Small Group product).
- ***Medi-Cal managed care plans shall provide the mental health benefits covered in the state plan***, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver.
- Expanded mental health benefits include:
  - Individual and group mental health evaluation and treatment (psychotherapy).
  - Psychological testing when clinically indicated to evaluate a mental health condition
  - Outpatient services for the purposes of monitoring drug therapy
  - Outpatient laboratory, drugs, supplies and supplements
  - Psychiatric consultation

Covered California

- Qualified health plans (QHPs) serving the individual and small group market must provide ***essential health benefits***, as defined in California law (e.g. the Kaiser Small Group benchmark), which include mental health and substance use services.
- Coverage should include services and benefits for a ***broad range of mental health conditions***, utilizing the mental disorder definition as supplied by the DSM-IV-TR.
- Coverage should not be limited to specific diagnoses.

Covered California

- QHPs must also ***comply with the MHPAEA of 2008*** and all corresponding rules, regulations and guidance.
- Inclusion of this reference to federal parity law was particularly important in order to ensure plan/policy compliance with both ***quantitative and non-quantitative limitations*** – the latter of which may not be easily discernible in the benchmark evidence of coverage.
- Non-quantitative limitations include network adequacy, utilization review, provider rates, etc.
- CMHDA has weighed in to emphasize parity requirements in QHP contracting discussions – meaning that ***networks must be adequate, grievance processes appropriate, health assessments inclusive***, etc.

Low Income Health Program

- The Low Income Health Program (LIHP) is a new, **optional program** established under the waiver that is being implemented at the **county level** in California to expand coverage to eligible low-income adults.
- LIHP is available to adults between 19 and 64 years of age who are not eligible for Medi-Cal or the Children's Health Insurance Program, are not pregnant, are within the **county's income requirements**, meet county residency requirements, and meet federal citizenship and immigration verifications and restrictions.
- County LIHPs will be effective July 1, 2011 through December 31, 2013, at which time the **majority of enrollees will become Medi-Cal eligible** under the optional Medicaid expansion.

Low Income Health Program

- The LIHP offers two sets of core benefits – one for the MCE portion (under 133%) and one for the HCCI portion (up to 200%).
- **Among the MCE core benefits are minimum mental health services that must be offered to MCE-eligible enrollees.**
- According to the Special Terms and Conditions of the waiver, "the state must offer a minimum evidence-based benefits package for mental health services under the Demonstration to promote services in community-based settings with an emphasis on prevention and early intervention."
- **SUD services are NOT included as a required core MCE benefit**.
- However, each LIHP may choose to include additional benefits (as approved by CMS) as part of the core benefit offering, such as expanded mental health services and/or substance use disorder treatment. **Several counties have opted to include expanded MH or SUD services in the benefit package for LIHP enrollees**.

Coordinated Care Initiative

- The CCI will **expand the managed care benefits** for selected demonstration health plans as part of the blended (Medicare/Medi-Cal) capitated rate to the participating managed care organizations charged with coordinating care for dually eligible beneficiaries.
- While county-administered **Medi-Cal mental health and substance use disorder services are <u>not</u> to be initially included in the health plans' blended capitated rate**, demonstration plans will be charged with managing the entire Medicare benefit, including mental health services covered by the Medicare program.
- County ***mental health priority areas for further consideration*** include risk and cost shifting concerns, information exchange barriers and opportunities, payment policies, conflict resolution, network coordination, performance measures and shared savings opportunities, MOU elements, among others.
- The state has been developing a shared accountability framework to incentivize coordination between MHPs/SU administrators and demonstration health plans.

CMHDA-CADPAAC Health Care Reform Principles

1) Health equity must be integrated into all aspects of ACA implementation. This includes addressing systematic disparities in health status related to race, ethnicity, gender, sexual orientation, income and geography. People of color and people living in rural areas are more likely to be low-income, uninsured, and without access to employer-based health insurance , and therefore have the most to gain from the ACA.

2) Mental health and substance use disorder systems must be equity partners with physical health care systems. Parity between mental health and substance use disorder and other medical systems and services must be realized at every level.

3) Recovery and resiliency-driven services that are culturally and linguistically appropriate must be the standard for covered mental health and substance use benefits available to California's Medicaid Expansion population. This includes coverage of consumer/client- and family-directed case management and behavioral health rehabilitation services in the community that reflect the cultural, ethnic and racial diversity of mental health and substance use consumers/clients, and that address each consumer/client's individual needs.

CMHDA-CADPAAC Health Care Reform Principles

4) Access to mental health and substance use disorder services for both the Medicaid Expansion population and the Covered California population should be based upon established medical/clinical necessity criteria for specialty mental health services and substance use services – e.g. Medi-Cal criteria and evidence-based ASAM placement criteria.

5) Education, prevention and early intervention for mental health and substance use disorders must be fully integrated as part of the spectrum of reimbursable services in any benefit package provided to the Medicaid Expansion population, or individuals insured through Covered California.

6) Specialty mental health and substance use disorder services provided in field, home and community-based settings must be available and reimbursable under all coverage programs and opportunities. Effectively addressing the rehabilitative needs of children, youth, adults and older adults with SMI/SUD requires assertive, proactive, culturally and linguistically appropriate outreach in a variety of settings by specialty and community providers who have the expertise in engaging individuals at the earliest possible point in an episode of mental illness and/or substance use.

CMHDA Health Care Reform Principles

7) Mental health and substance use benefit packages must promote high quality, patient-centered and cost-effective care, and continue to support the existing safety net. This includes, but is not limited to, services not traditionally provided in the medical arena and/or covered by Medicaid, such as many homeless outreach services, mobile response programs, services to children and youth in specialized foster care, supports for housing stability, recovery maintenance homes, field-based services, etc.

8) Safety net funding for residually uninsured populations must be preserved. As healthcare reforms take hold and insurance coverage gradually expands, we must ensure that a shifting or reduction in safety net funding does not diminish access to mental health and substance use disorder services for residually uninsured populations.

CMHDA-CADPAAC Health Care Reform Principles

9) Support for policies that address the workforce composition, development and expansion to address the needs of the Medicaid expansion and Covered California populations is critical, including pathways to employment, competencies for peer support, etc. This includes the utilization of non-licensed providers and peer support to most effectively and efficiently meet the needs of consumers/clients with mental health and substance use disorders.

10) Coordination of mental health, substance use and primary care is essential to ensuring quality care and realizing cost savings. The aim of the ACA is to ultimately reduce the cost of healthcare delivery to the entire population. In order to more effectively care for the whole person, there must be more seamless coordination between system partners. This includes reducing barriers to the exchange of information necessary to appropriately coordinate care, improve quality, and address confidentiality.

Outstanding Questions & Considerations

1) What will managed care organizations assure access to expanded mental health benefits?
2) How will qualified health plans in the Exchange be held accountable for meeting MH/SUD parity standards?
3) How will individuals covered through the Exchange access specialty rehab mental health services if medically indicated?
4) How will the methadone exclusion in the benchmark coverage offered in the individual & small group market impact the county SUD system?
5) How will continuity of care be ensured for individuals with mental health needs churning between Medi-Cal and Covered California?
6) To what extent will Medicaid streamlining/outreach identify and enroll new currently eligible beneficiaries with MH/SUD needs?
7) How will county MHPs and health plans take advantage of the changing landscape and new opportunities to better coordinate and integrate care for individuals with specialty mental health/SUD needs?

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For additional resources on ACA implications for CA's public mental health system, go to:
http://www.cmhda.org/go/publicpolicy/healthcarereformresources.aspx