Healthcare Reform: Implications for Behavioral Health Providers

Webinar presented by:
John O’Brien, Senior Advisor, SAMHSA
Charles Ingoglia, Vice President, National Council
Dale Jarvis, Managing Consultant, MCPP
Healthcare Consulting

September 21, 2010
2:00-3:30pm ET
How to participate

- Your unique audio pin is located in the Audio Pane. See example.
- Submit your text question using the Questions pane
- **Note:** A copy of this presentation and the recording will be made available within 48 hours
Abstract

The passage of the Patient Protection and Affordable Care Act has ensured that the role of behavioral health in the overall healthcare system will change. Now, it is more important than ever to know how healthcare reform will affect your role and the role of States, behavioral healthcare providers, and consumers.

Today’s Webinar will provide information and guidance to plan and prepare for clinical and fiscal changes, including those related to Medicaid and discuss the implications of the Patient Protection and Affordable Care Act for the behavioral health system.
Webinar Agenda

2:00  Welcome/Introductory Comments

John O’Brien, MA  Senior Advisor for Healthcare Financing, SAMHSA

2:10  Presentation

Charles Ingoglia, MSW  Vice President, Public Policy, NCCBH

Dale Jarvis, CPA  Managing Consultant, MCPP Healthcare Consulting

3:10  Question & Answer Session

3:30  Conclude Teleconference
Charles Ingoglia has worked as a provider, advocate, and educator for government and public sector organizations for more than 15 years. In his current role, Mr. Ingoglia directs the federal affairs function of the National Council for Community Behavioral Healthcare as well as its policy and technical assistance outreach to more than 1,700 member organizations across the nation. Most recently, his efforts have centered on key issues such as parity, healthcare reform, and increasing access and retention in community behavioral healthcare.
Dale Jarvis, CPA

Dale Jarvis brings a diverse background as administrator, author and educator to healthcare organizations throughout the western United States. He has served as the financial director for healthcare organizations in Washington and Michigan. He also taught Health Care Financial Management at the University of Washington School of Public Health.
John O’Brien has extensive experience in the design and implementation of system reform initiatives. He has provided consultation to more than 35 States and local human services authorities. He has worked with Medicaid, child welfare, State behavioral health and mental retardation authorities. His primary focus is assisting States in developing State plan amendments for mental health services, federal Medicaid Waivers, managed care vendor procurements and financing mental health, substance abuse and child welfare services and research of children’s behavioral health systems.
The Affordable Care Act

Why is integration of primary care and behavioral health important?

- 12 M visits annually to ERs by people with MH/SUD
- 44% of all cigarette consumption by individuals with MH/SUD
- 70% of individuals with significant MH/SUD had at least 1 chronic health conditions, 45% have 2, and almost 30% have 3 or more
SAMHSA’s PCBHI Project

- Bi-directional approach to primary care and behavioral health integration
- 13 sites, more sites will be awarded
- Developing a technical assistance center to assist both mental health and substance abuse providers with primary care integration strategies
This Webinar Explores Two Questions

**Question 1:** Will healthcare reform really change the healthcare system?

**Question 2:** How will the answer to question #1 affect Americans with mental health and substance use disorders and the organizations that serve them?
Definition of Terms: Today’s Alphabet Soup

- **SMI**: Serious Mental Illness
- **SU**: “Substance Use” describes the broadest context of Alcohol and Other Drug Services and Disorders
- **BH**: “Behavioral Health” describes Mental Health and Substance Use
- **COD**: “An individual with a co-occurring disorder (COD) has been generally defined by the presence of both a mental disorder and substance-related disorder.” (COSIG Clinical Protocol Committee)
Question 1: Will healthcare reform really change the healthcare system?
Connecting Three Dots: Healthcare Quality

The U.S. Healthcare System is both the Best and the Worst Healthcare System in the Industrialized World.

![Preventable Deaths graph](image)

*Preventable Deaths* per 100,000 Population in 2002-2003 (19 Industrialized Nations, Commonwealth Fund)

(*by conditions such as diabetes, epilepsy, stroke, influenza, ulcers, pneumonia, infant mortality and appendicitis*)
Connecting Three Dots: Healthcare Cost

- The cost growth of the current American healthcare system is unsustainable.
- Growing at a rate much higher than the rest of the economy.
Connecting Three Dots: The Importance of Behavioral Health

Mental Health, Substance Use, and Co-Occurring Disorders: an Inseparable Part of the Equation

Co-occurring Diagnoses and the GA-U Population

- 52 percent had substance abuse or mental illness identified
- 31 percent had a chronic physical condition only

<table>
<thead>
<tr>
<th>PRIMARY CONDITIONS</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Physical</td>
<td>69%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>36%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>32%</td>
</tr>
</tbody>
</table>

Sources: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper.
The 53 year lifespan for Americans with SMI is comparable with Sub-Saharan Africa

Americans with COD are dying, on average, at age 45*

*Oregon Department of Human Services Addiction and Mental Health Division, June, 2008

NASMHPD 2006 Study: *Morbidity and Mortality in People with Serious Mental Illness*
Consequences for the Overall Healthcare System

Healthcare Expenditures of Americans with Serious Mental Illness are 2 to 3 times higher

<table>
<thead>
<tr>
<th></th>
<th>Medi-Cal FFS Total</th>
<th>Medi-Cal FFS SMI</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal FFS Enrollees</td>
<td>1,580,440</td>
<td>166,786</td>
<td>11% SMI % of Total</td>
</tr>
<tr>
<td>Medi-Cal FFS Costs</td>
<td>$6,186,331,620</td>
<td>$2,395,938,298</td>
<td>39% SMI % of Total</td>
</tr>
<tr>
<td>Medi-Cal FFS Cost/Enrollee</td>
<td>$3,914</td>
<td>$14,365</td>
<td>3.7 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4%</td>
<td>11%</td>
<td>2.8 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Ischemic Heart Disease</td>
<td>2%</td>
<td>6%</td>
<td>3.0 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Cerebrovascular Disease</td>
<td>1%</td>
<td>3%</td>
<td>3.0 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Chronic Respiratory Disease</td>
<td>5%</td>
<td>13%</td>
<td>2.6 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Arthritis</td>
<td>2%</td>
<td>7%</td>
<td>3.5 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Health Failure</td>
<td>1%</td>
<td>3%</td>
<td>3.0 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Inpatient Episodes/1,000</td>
<td>100</td>
<td>293</td>
<td>2.9 SMI/Total-Ratio</td>
</tr>
<tr>
<td>ER Visits/1,000</td>
<td>337</td>
<td>1,167</td>
<td>3.5 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Inpatient Acute Days/1,000</td>
<td>609</td>
<td>2,094</td>
<td>3.4 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Primary Care Visits/1,000</td>
<td>128</td>
<td>492</td>
<td>3.8 SMI/Total-Ratio</td>
</tr>
<tr>
<td>Specialist Visits/1,000</td>
<td>1,211</td>
<td>6,058</td>
<td>5.0 SMI/Total-Ratio</td>
</tr>
</tbody>
</table>

Data from JEN Associates, Cambridge, MA
Alignment of the Stars for Persons with MH/SU/COD Disorders

- A growing awareness of the prevalence of MH/SU disorders and the cost of not providing effective treatment and supports
- Combined with the awareness that
  - Behavioral Health is necessary for Health
  - Prevention is Effective
  - Treatment Works
  - People Recover
- Results in increasing recognition that we can’t bend the cost curve without addressing the healthcare needs of persons with SMI and the MH/SU needs of all Americans
- We come back to this in Question 2
The Goals of Healthcare Reform are Quite Straightforward…

We need to **Improve Quality** and **Manage Costs** by...

- Moving further upstream with **prevention** & **early intervention** services to prevent health conditions from becoming chronic health conditions

- Dramatically improving the **management of chronic health conditions** for Americans with one or more such conditions

- Reducing errors and waste in the system and reducing incentives for high cost, low value, procedure-based care
Four Strategies in the New Healthcare Reform Law...
Many new protections, including:

- Insurance companies can’t deny coverage
- Bans pre-existing condition exclusions
- Prohibits all annual and lifetime limits
- Provide dependent coverage for children up to age 26 in individual and group policies
Coverage Expansion: The Accountable Care Act

Expands coverage to most Americans

- Expands Medicaid for all under 133% of the federal poverty level
- Creates State Health Insurance Exchanges to help newly insured and those with individual and small group coverage to purchase affordable policies (large buying club)
- Provides credits & subsidies up to 400% of the federal poverty level to help individuals and families purchase insurance

Important: The majority of low income, uninsured Americans with behavioral health disorders will obtain coverage by 2014
Service Delivery Redesign and Payment Reform

The Commonwealth Funds The Path to a High Performance. U.S. health system identifies 10 Healthcare Reform Policies that can save $3 trillion over 10 years (Commonwealth Fund, 2009).
Everyone is Talking about Healthcare Homes

- What are they?
- Where did they get that name?
- Why are they important?
Healthcare Homes: What are They?

• Trying to navigate the healthcare system in the U.S. is like trying to find your way through a tangled maze

• Especially if you are one of the 45% of Americans with a chronic health condition such as diabetes or hypertension

• Most of whom have three or more doctors that don’t talk with each other or share information
Healthcare Homes: Primary Care Clinics that Look and Act Differently

Picture a world where everyone has...

• An ongoing relationship with a PCP;
• A Care Team who collectively takes responsibility for ongoing care;
• A Care Team that provides all healthcare or makes appropriate referrals; and
• A Care Team that helps ensure that care is coordinated and/or integrated.

And where...

• Quality and safety are hallmarks;
• Enhanced access to care is available (evenings & weekends); and
• Payment appropriately recognizes the Added Value

(Joint Principles of the Patient-Centered Medical Home: www.pcpcc.net)
ACCESS TO CARE
Be there when I need you.

ACCOUNTABILITY
Take responsibility for making sure I receive the best possible health care.

COMPREHENSIVE WHOLE PERSON CARE
Provide or help me get the health care and services I need.

CONTINUITY
Be my partner over time in caring for my health.

COORDINATION AND INTEGRATION
Help me navigate the health care system to get the care I need in a safe and timely way.

PERSON AND FAMILY CENTERED CARE
Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.
Healthcare Homes: Where Did They Get That Name?

Actually there are several names:

- Patient-Centered Medical Home (PCPCC)
- Person-Centered Healthcare Home (National Council)
- Patient-Centered Primary Care Home (Oregon)
- Medical Homes
- Health Homes

All are trying to convey the message that the primary care clinic of the future isn’t going to look like most primary care clinics today.
Healthcare Homes: Why Are They Important?

The Group Health Cooperative Story

- 2002-2006: Move towards medical home
  - Email your doctor
  - Online medical records
  - Same day/next day appointment

  Results: Increased patient access but also saw provider burn-out and decline in quality scores

- 2007: More robust healthcare home pilot
  - Added more staff (15% more doctors; 44% more mid-levels; 17% more RNs; 18% more MAs/LPNs; 72% more pharmacists)
  - Shifted to 30 minute PCP slots

  Results: Reduced burnout, increased quality scores, broke even in the first year
Healthcare Homes: Why are They Important?

Paul Grundy, MD*

Pilots include Geisinger’s, which Grundy says has been remarkably successful, yielding a 12% reduction in ER utilization, a 20% reduction in hospitalization, and a 48% reduction in rehospitalization.

"In Denmark, over the last few decades, the number of hospitals has dropped from 155 to 21 today" according to Grundy.

Excerpt from the Providence Business News 5/27/2010

*Director of Healthcare, Technology and Strategic Initiatives for IBM Global Wellbeing Services
Payment Reform for Medical Homes

- Fee for Service is headed towards extinction
- Healthcare Home models are beginning with a 3-layer funding design with the goal of the FFS layer shrinking over time
- Being replaced with case rate or capitation with pay for performance
All of which brings us to Accountable Care Organizations

Accountable Care Organizations Dual Purpose:

- Organization structure to support **coordination of care and payments** between Healthcare Homes, Specialists and Hospitals
- Way for small to mid-sized primary care practices to **obtain the infrastructure** of larger practices as they work to become Person-Centered Healthcare Homes

Harold Miller, How to Create Accountable Care Organizations, [www.chqpr.org](http://www.chqpr.org)
Accountable Care Organizations: The Homes for Medical Homes

Accountable Care Organization Model

- Medical Homes
- Specialty Clinics
- Hospitals
- Clinic
Service Delivery Redesign and Payment Reform

$700 Billion Question

Will the current healthcare reform law and accompanying payment reform & delivery system redesign tools be enough to improve quality and bend the cost curve before healthcare costs bankrupt us?

Our Prediction

Not unless the healthcare system addresses the needs of individuals with MH/SU and/or COD
Question 2: How will the answer to question #1 affect Americans with mental health and substance use disorders and the organizations that serve them?
A growing awareness of the prevalence of MH/SU disorders and the cost of not providing effective treatment and supports

Combined with the an awareness that
- Behavioral Health is necessary for Health
- Prevention is Effective
- Treatment Works
- People Recover

Results in increasing recognition that we can’t bend the cost curve without addressing the healthcare needs of persons with a SMI and the MH/SU needs of all Americans
Short answer: Yes

Longer answer:

- **Parity in Medicaid Expansion:** Expands Medicaid eligibility to all Americans up to 133% of federal poverty and requires coverage of mental health and substance use disorder services for all newly eligible parents and childless adults and existing persons in Medicaid managed care programs.

- **Parity in the Exchanges:** The ACA requires a basic benefit package that requires coverage of mental health and substance use disorder services for all health plans operating in the new Health Insurance Exchanges (for newly insured and those coming in from the individual and small-group markets).
Did the Authors of the Accountable Care Act Understand These Things?

Longer Answer (continued):

- **National Prevention Council:** The ACA creates a National Prevention Council with the director of the Office of National Drug Control Policy as a member and alcohol and other drug addictions listed as a national priority for that Council's report to Congress.

- **Workforce Expansion:** The ACA names behavioral-healthcare workers as a high priority in the bill's National Workforce Strategy section.

- **Community Health Team Grants:** The ACA lists addiction and mental-health providers as eligible for community health-team grants.
What Are the Implications for Organizations that Provide MH/SU/COD Services?
The Four Quadrant Clinical Integration Model

Each quadrant considers the behavioral health and physical health risk/complexity (low to high) of the population.

Generally…

Persons in Quadrants I and III should receive BH services in Primary Care.

Persons in Quadrants II and IV should receive PC services in Behavioral Health.

BUT WAIT, THIS PRINT IS TOO SMALL…
Person-Centered Healthcare
Home: Quadrants I and III

The larger print:

Quadrant I
• PCP
• PCP-based BHC/care manager
• Specialty prescribing consultation
• Wellness programming
• ED based MH/SU/COD interventions

Quadrant III
• PCP
• PCP-based BHC/care manager
• Specialty medical/surgical-based BHC/care manager
• Specialty prescribing consultation
• ED based MH/SU/COD interventions
• Medical/surgical inpatient
• Nursing home/home-based care
• Wellness programming
• Other community supports
Person-Centered Healthcare
Home: Quadrants II and IV

The larger print:

**Quadrant II**
- Outstationed medical NP/PCP
- BH clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient MH/SU/ COD treatment including medication-assisted therapy
- Residential SU/COD treatment
- Crisis/ED based MH/SU/COD interventions
- Detox/sobering
- Wellness programming
- Other community supports

**Quadrant IV**
- Outstationed medical NP/PCP
- Nurse care manager/BH site
- BH clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient MH/SU/COD treatment
- Residential SU/COD treatment
- Crisis/ED based MH/SU/COD interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports
Bi-Directional Care:

Behavioral Health in Primary Care and Primary Care in Behavioral Health

Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity

- Primary Care Clinic with Behavioral Health Clinicians embedded, providing assessment, PCP consultation, care management and direct service
- Partnership/Linkage with Specialty CBHO for persons who need their care stepped up to address increased risk and complexity with ability to step back to Primary Care

Clinical Design for Adults with Moderate to High BH Risk and Complexity

- Community Behavioral Healthcare Organization with an embedded Primary Care Medical Clinic with ability to address the full range of primary healthcare needs of persons with moderate to high behavioral health risk and complexity
California has done some of the most in-depth work…

to sort out the key questions of **who, how many, what and where** of Primary Care-Behavioral Health Integration

### The California California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative

<table>
<thead>
<tr>
<th>Four Levels of Mental Health/Substance Use Complexity and Need</th>
<th>Mild</th>
<th>Moderate</th>
<th>Serious</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the characteristics of each group?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many people are in each group?</td>
<td>Adults 2.8 million</td>
<td>Adults 2.6 million</td>
<td>Adults 847 thousand</td>
<td>Adults 706 thousand</td>
</tr>
<tr>
<td>What type of Healthcare Home Medical Services are needed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the MH/SU Services that should be available?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where should MH/SU services generally be provided?</td>
<td>Primary Care</td>
<td>Local Decision</td>
<td>Local Decision</td>
<td>Specialty Beh. Hlth.</td>
</tr>
</tbody>
</table>
And What About Accountable Care Organizations for Persons with COD

- Good medical care alone isn’t the answer
- We need to expand the available services in medical homes to include a focus on the behavioral health, housing, social and personal supports needed to achieve and maintain health
But Will All These Great Ideas Really Work?

Short Answer: We don’t know...

Longer Answer:

- We have a once in a generation opportunity
- We have the knowledge and technology to move from a sick care to a health care system for persons with mental health, substance use and co-occurring disorders, but...
- It’s going to take strong advocacy on the part of consumers and advocates
- And a lot of hard work by provider organizations to prepare for this brave new world
How to participate

• Your unique audio pin is located in the Audio Pane. See example.

• Submit your text question using the Questions pane

• **Note:** A copy of this presentation and the recording will be made available within 48 hours
Thank you for participating in today’s webinar!

To listen to archived Webinar presentations and download a copy of the PDF version, go to:


Your feedback is important. Please complete the evaluation form that will be sent to you later today.

For additional information contact: [contact@codimail.org](mailto:contact@codimail.org)