



HEALTH CARE REFORM – IMPLICATIONS AND CONSIDERATIONS FOR MENTAL HEALTH AND SUBSTANCE USE

**PRESENTATION TO JOINT CMHDA-CADPAAC MEETING
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PRESENTATION OVERVIEW

- ❖ The ACA & Mental Health and Substance Use Disorders
- ❖ Parity – History and Status of Current Guidance
- ❖ Managed Care in California
- ❖ California's Bridge to Reform and the Low Income Health Program
- ❖ Medicaid Expansion
- ❖ Covered California & Essential Health Benefits in the Individual and Small Group Market
- ❖ Other Initiatives – Duals Demonstration
- ❖ The Remaining Uninsured
- ❖ CMHDA-CADPAAC Health Care Reform Principles
- ❖ Outstanding Questions and Considerations



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 AND SUBSTANCE USE DISORDERS

- ❖ The ACA explicitly includes mental health and substance use disorder 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).
- ❖ The Low Income Health Program, established under California's 1115(a) "Bridge to Reform" waiver, requires a **minimum mental health benefit** for the MCE population in implementing counties. SUD benefits are not required. However, several counties have opted to include expanded MH or SUD services in the benefit package for LIHP enrollees.
- ❖ As part of California's 1115 Waiver requirements, California must develop and submit to CMS a **behavioral health needs assessment and service plan** to prepare for the 2014 Medicaid expansion.

OPPORTUNITIES

- ❖ In 2011, **California had the largest number of people under age 65 without health insurance** – 7.1 million – of any US state. The percentage of Californians who have employer-based coverage continues to fall, dropping from 65% in 1987 to 52% in 2011. While public insurance has partially covered this gap, **almost 22% of Californians remain uninsured.**
- ❖ Given the low rate of service utilization among uninsured adults with mental health and substance use disorder 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 California adults with mental health needs will become eligible for health insurance coverage** in 2014.
- ❖ The ACA offers an extraordinary opportunity to provide access to rehabilitative and recovery-oriented mental health services to individuals **before they become disabled.** Qualified adults without a disability will, for the first time, have access to mental health/substance use services through the Medi-Cal program or subsidized insurance.



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.

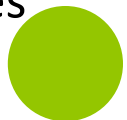


BRIEF HISTORY OF PARITY

- ❖ 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.



PARITY

- ❖ It is anticipated that HHS will promulgate **additional rule-making** on mental health and addiction parity shortly.
- ❖ Some speculate that the forthcoming guidance may simply finalize the interim final rules released in February 2010. However, many hope that the final parity guidance will be more substantive than the interim final rule (i.e. **address service exclusions**).
- ❖ CMS released a State Health Official letter on January 16, 2013 on the **application of MHPAEA to Medicaid MCOs, CHIP, and benchmark plans**. The letter additionally includes some limited discussion of “Prepaid Inpatient Hospital Plans” (PIHPs) and “Prepaid Ambulatory Health Plans” (PAHPs) and their role in providing a more limited set of state plan services, including in some instances through a “carve-out arrangement.” CMS urges states with these arrangements to **apply the principles of parity across the whole Medicaid managed care delivery system** when mental health and substance use disorders services are offered through a carve-out arrangement.
- ❖ According to CMS, **additional guidance is forthcoming regarding carve-out arrangements.**



MANAGED CARE IN CALIFORNIA

- ❖ As of October 2012, approximately 4.8 million Medi-Cal beneficiaries in 30 California counties receive their health care through **three models of managed care**: Two-Plan, County Organized Health Systems and Geographic Managed Care.
- ❖ As part of the 1115 waiver, California recently completed a yearlong transition to mandatorily enroll most **Seniors and Persons with Disabilities** in managed care (some exemptions).
- ❖ Beginning in June 2013, California plans to **expand managed care into rural areas** (28 counties) that are now Fee-For-Service only.
- ❖ Subject to legislative approval, California intends to **expand the Coordinated Care Initiative** (Duals Demonstration) to all counties in the state



CALIFORNIA'S BRIDGE TO REFORM

SECTION 1115(A) MEDICAID DEMONSTRATION

- ❖ The California Department of Health Care Services (DHCS) received approval in November 2010 for the Section 1115(a) Medicaid Demonstration, entitled “**California’s Bridge to Reform.**”
- ❖ The demonstration is effective November 1, 2010, through October 31, 2015.
- ❖ Through the Section 1115 waiver, California intends to advance Medi-Cal program changes that will **help the state transition to the federal reforms** that will take effect in January 2014.
- ❖ Changes under the waiver involve **expanding coverage** today for those who will become “newly eligible” in 2014 under health care reform, implementing models for more comprehensive and **coordinated care** for some of California’s most vulnerable residents, and testing various strategies to **strengthen and transform the state’s public hospital health care delivery system.**



LOW INCOME HEALTH PROGRAM

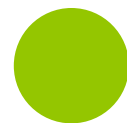
- ❖ The Low Income Health Program (LIHP) is a new, **optional program** established under the waiver that is being implemented at the **county level** in California to expand coverage to eligible low-income adults.
- ❖ LIHP is available to adults between 19 and 64 years of age who are not eligible for 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.
- ❖ The LIHP builds on California's existing ten-county Coverage Initiative program by offering participation to all counties in the state.
- ❖ 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

ELIGIBILITY

- ❖ The **Medicaid Coverage Expansion (MCE)** portion of LIHP is for those individuals who have family incomes at or below 133% of the federal poverty level (depending on participating county income standards).
- ❖ The **Health Coverage Initiative (HCCI)** portion of LIHP is for those individuals who are not insured and have family incomes above 133% through 200% of the federal poverty level (depending on participating county income standards).
- ❖ It is possible for a county to offer the MCE portion but not the HCCI portion.
- ❖ The **upper income limit** in either the MCE or HCCI **may vary by county** and those counties who do not offer HCCI may lower the upper income limit in MCE below 133%.



LOW INCOME HEALTH PROGRAM

CORE BENEFITS

- ❖ The LIHP offers two sets of core benefits – one for the MCE portion and one for the HCCI portion.
- ❖ **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.**



LOW INCOME HEALTH PROGRAM

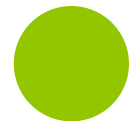
MENTAL HEALTH BENEFITS

- ❖ Each participating county must, at minimum, provide:
 - Up to 10 days/year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility;
 - Psychiatric pharmaceuticals;
 - Up to 12 outpatient encounters per year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment. If a medically necessary need to extend treatment exists, the LIHP may optionally expand services.
- ❖ County may opt to provide mental health services through a delivery system that is separate from the LIHP – i.e. “carve out mental health services”.



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** (benchmark or benchmark equivalent coverage), **including MH & SUD treatment**, to Medicaid beneficiaries in the new eligibility group.



MEDICAID EXPANSION

- ❖ Following the June 2012 Supreme Court decision, **states face a decision** about whether to adopt the optional Medicaid expansion.
- ❖ Recent CMS guidance and proposed regulations provide an overview of the **intended approach for state implementation** (for participating states).
- ❖ The recent CMS FAQ further clarifies a number of issues related to the expansion opportunity, including making clear that states choosing to expand **must expand coverage to 133% of FPL** in order to receive the enhanced federal matching funds (100% support for newly eligible adults in 2014, 2015, and 2016).
- ❖ Accordingly, CMS has asserted that **the law does not provide for a phased-in or partial expansion** and, as such, CMS will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016.



MEDICAID EXPANSION & ESSENTIAL HEALTH BENEFITS

- ❖ **Alternative benchmark plans (ABPs)** were first defined in federal law per the 2005 DRA which provided states with significant flexibility to design Medicaid benefit packages under the state plan.
- ❖ The guidance and proposed regulations closely align with the current ABP option, as established in 2005, and **continues to provide states with significant flexibility in designing benefit packages.**
- ❖ The benchmarking process outlined is **very similar to the process outlined in the proposed rule for the commercial sector**, however states are required to choose from slightly different plans.
- ❖ Also, an important additional option offered to states is “**Secretary Approved Coverage**” – which includes the Medicaid state plan adult benefit package offered in the state and may be supplemented to ensure coverage of the ten statutorily-specified essential health benefits.
- ❖ The guidance and proposed rule are clear that the **MHPAEA applies to ABPs.**



MEDICAID EXPANSION

- ❖ Governor Brown's proposed budget makes it clear that **California intends to continue toward implementation** of federal health reform, and distinguishes between the "mandatory" expansions of Medicaid (i.e. eligibility determination and enrollment streamlining) and the "optional" expansions of Medicaid.
- ❖ The Governor's budget proposes **two "options"** for implementation of the optional Medicaid expansion – county vs. state.
- ❖ Significant discussion is intended to occur between the state and counties in order to determine California's course on the optional areas.
- ❖ With the adoption of the optional Medi-Cal Expansion, more than **1.4 million Californians will be newly eligible** for Medi-Cal, of which between 750,000 and 910,000 are expected to be enrolled at any point in time by 2019.



IMPACT OF MEDICAID STREAMLINING

- ❖ Medi-Cal currently has about 7.5M subscribers. According to the recently released UC Berkeley/UCLA report, it is estimated that of the additional 2.5M Californians who are **currently eligible** for Medi-Cal but not enrolled, **between 240,000 and 510,000 are expected to be enrolled at any point in time by 2019.**
- ❖ Increased enrollment is due to a variety of factors, including: simplified Medicaid eligibility determinations (and redeterminations) and enrollment processes, individual mandate, statewide outreach and education efforts, etc.
- ❖ While the ACA promises to cover 100% of the service costs for individuals eligible under the optional Medicaid expansion, **matching ratios for currently eligible individuals remain the same** (50% FMAP).
- ❖ The Governor's proposed budget for Fiscal Year 13-14 included a "placeholder" **cost to the state** of \$350 million in 13-14 (impact beginning January 2014) to plan for this anticipated increase in enrollment for currently eligible individuals.
- ❖ Given California's realigned structure, it is imperative that any provisions made to ensure the availability of funding to meet the needs of this anticipated increase in currently eligible individuals include **sufficient resources for counties** to meet the mental health needs of those meeting medical necessity criteria for specialty services.

BEHAVIORAL HEALTH SERVICE PLAN

- ❖ As part of California's 1115 Waiver requirements, California must develop and **submit to CMS** a behavioral health needs assessment and service plan to prepare for the 2014 Medicaid expansion.
- ❖ The plan is to include the **steps and infrastructure necessary to meet requirements of a benchmark plan** and ensure strong availability of behavioral health services statewide no later than 2014. The plan will address:
 - Which benchmark benefit package California will choose
 - The delivery system(s) for those benefits
 - Concurrent implementation strategies for financing, enrollment, quality oversight and monitoring, access, and work force development
 - Recommendations for serving the expansion population
 - State readiness to meet the MH & SUD needs of this population



BEHAVIORAL HEALTH SERVICE PLAN

- ❖ Per agreement between DHCS and CMS, DHCS submitted a plan outline to CMS on October 1, 2012, to satisfy the due date listed in the STCs.
- ❖ DHCS will plan to submit a revised Services Plan by **April 1, 2013.**
- ❖ The finalized Services Plan will describe California's recommendations for serving the Medi-Cal expansion population and **demonstrate the State's readiness** to meet the mental health and substance use disorder needs of this population.
- ❖ According to DHCS, adjustments to the plan may be necessary depending on **forthcoming federal guidance and/or state legislative action** to implement components of the ACA.
- ❖ DHCS has indicated that they plan to **convene stakeholders** to inform the development of the final plan.



COVERED CALIFORNIA

- ❖ Covered California (California's Health Benefit Exchange) is making steady progress towards its **October 1, 2013 open enrollment** launch.
- ❖ On January 3, 2013, HHS Secretary Kathleen Sebelius announced that California has been conditionally approved to operate a **State-based Exchange**. The approval is conditional on Covered California continuing to meet its regulatory and start-up benchmarks.
- ❖ Covered California has been actively working with interested **private health care plans** to offer health benefit products online for individuals and small businesses.
- ❖ Consumers should be able to begin using the **web portal** on October 1, 2013 to select the health plan that best meets their needs and determine if they qualify for **federal subsidies** to offset the cost of their premiums, or if they are eligible for other **public insurance programs**.



COVERED CALIFORNIA

- ❖ Recent focus has been **qualified health plan contracting and benefit design**, including making adjustments to co-pays and deductibles for each metal tier to meet federal actuarial value requirements.
- ❖ According to the board, the top priority in benefit design is ensuring that the **plan designs sell well** and that consumers can make **informed choices** about options.
- ❖ CMHDA, alongside our partners with CCWH, has weighed in to **emphasize parity requirements** in QHP contracting discussions – meaning that networks must be adequate, grievance processes appropriate, health assessments inclusive, etc.



ESSENTIAL HEALTH BENEFITS FOR THE INDIVIDUAL AND SMALL GROUP MARKET

- ❖ California's Governor Brown recently signed complementary Senate (SB 951 – Hernandez) and Assembly (AB 1453 – Monning) bills requiring an individual or small group health care service plan contract or health insurance policy that is issued, amended or renewed in California on or after January 1, 2014 to **at minimum include coverage for essential health benefits.**
- ❖ This coverage requirement applies to individual and small group plans/policies offered to consumers and small businesses **both inside and outside of the California Health Benefit Exchange.**
- ❖ The legislation selects a **Kaiser small group product** as California's reference ("benchmark") plan.



MENTAL HEALTH BENEFITS IN THE BENCHMARK PLAN

- ❖ According to the Evidence of Coverage (EOC) for the identified benchmark plan, 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.
- ❖ According to the EOC, mental health services are covered “...only when the services are for the diagnosis or treatment of mental disorders. A mental disorder is a mental health condition identified as a mental disorder in the DSM-IV-TR that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.”
- ❖ **Coverage is not limited to a specific list of conditions or diagnoses.**



MENTAL HEALTH BENEFITS IN THE BENCHMARK PLAN

- ❖ Outpatient Mental Health Services:
 - Individual and group mental health evaluation and treatment
 - Psychological testing when necessary to evaluate a mental disorder
 - Outpatient services for the purpose of monitoring drug therapy
- ❖ Inpatient & Intensive Psychiatric Treatment:
 - Inpatient psychiatric hospitalization
 - Short-term hospital-based intensive outpatient care (partial hospitalization)
 - Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
 - Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24 hour/day monitoring by clinical staff for stabilization of an acute psychiatric crisis
 - Psychiatric observation for an acute psychiatric crisis



SUD BENEFITS IN THE BENCHMARK PLAN

- ❖ Inpatient Detoxification : Hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recover services, education and counseling
- ❖ Outpatient Chemical Dependency Care:
 - Day treatment programs
 - Intensive outpatient treatment programs
 - Individual and group chemical dependency counseling
 - Medical treatment for withdrawal symptoms
 - Methadone maintenance treatment for pregnant members during pregnancy and for 2 months after delivery at a licensed treatment center approved by the Medical Group. ***Methadone maintenance treatment is NOT covered in any other circumstances**
- ❖ Transitional Residential Recovery Services: Chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group that provides counseling and support services in a structured environment.



PARITY AND THE BENCHMARK BENEFITS

- ❖ CMHDA and CADPAAC successfully advocated that language be added to the legislation to clarify that any individual or small group plan or policy issued, amended, or renewed on or after January 1, 2014 **must 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 EOC.
- ❖ Some questions still remain regarding coverage of certain substance use disorder treatments, such as **methadone maintenance treatment** , which is excluded from coverage in the benchmark EOC.



COORDINATED CARE INITIATIVE – CALIFORNIA'S DUALS DEMONSTRATION

- ❖ The Duals Demonstration will involve models through which **one entity** is coordinating care for the **total needs of a person** – medical and social.
- ❖ The demonstration will **expand the managed care benefits** for selected demonstration health plans to include the In-Home Supportive Services (IHSS) program, as well as Multipurpose Senior Services Programs (MSSP), Community-Based Adult Services, and skilled nursing facility services as part of the blended capitated rate to the participating managed care organizations.
- ❖ While county-administered **Medi-Cal mental health and substance use disorder services are not 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.



COORDINATED CARE INITIATIVE – CALIFORNIA'S DUALS DEMONSTRATION

- ❖ Contingent on CMS approval, the demonstration is slated to begin **September 2013**.
- ❖ The **8 selected demonstration counties** are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara.
- ❖ County mental health & SUD 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 is currently developing a shared accountability framework to incentivize coordination between MHPs/SU administrators and demonstration health plans



THE REMAINING UNINSURED

According to a recent report by the UC-Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research – After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured? – September 2012:

- ❖ **3.1 to 4M Californians are predicted to remain uninsured in 2019.**
- ❖ Almost 3/4 of the remaining uninsured in California will be **U.S. citizens or lawfully present immigrants.**
- ❖ 2/3 of California's remaining uninsured will be **Latino**
- ❖ Nearly 3 out of 5 California adults who remain uninsured will be **LEP**
- ❖ 62% of California's remaining uninsured will be residents of **Los Angeles** and other **Southern California** counties.
- ❖ 57% of Californians who remain uninsured will have household incomes at or **below 200% FPL.**
- ❖ **Half of all remaining uninsured will be eligible for Medi-Cal or Exchange subsidies but remain unenrolled.**
- ❖ 72% of remaining uninsured Californians will be exempt from paying tax penalties under the minimum coverage requirements of the ACA due to income, lack of an affordable offer of coverage or immigration status.

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 the mental health and SUD benefits be for newly eligible individuals qualifying under the optional expansion and what will the delivery system(s) be?
- 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>

