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IADDA Conference

Models of Behavioral Health and Primary Care Integration in FQHCs

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9/7/2011

Agenda

- Overarching/Framework
  - Wagner Chronic Care Model
  - Four Quadrant Model
  - Self Assessment on the Continuum of Integration
- Review of Clinical Models
- Core Components of Integrated Care
- Overview of Behavioral Health Services in FQHCs
- Review of Integration Models in FQHCs and Legal Considerations

The Chronic Care Model

Community

Resources and Policies

Self-Management Support

Health Systems

Organization of Health Care

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
® ACP-ASIM Journals and Books

The National Council's Four Quadrant Clinical Integration Model (MH/SU)

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MH/SU Risk/Complexity (Low → High)

Physical Health Risk/Complexity (Low → High)

Quadrant II MH/SU ↑ PH ↓	Quadrant IV MH/SU ↑ PH ↑
• Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP • MH/SU clinician/case manager w/ responsibility for coordination w/ PCP • Specialty outpatient MH/SU treatment including medication-assisted therapy • Residential MH/SU treatment • Crisis/ED based MH/SU interventions • Detox/sobering • Wellness programming • Other community supports	• Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP • Nurse care manager at MH/SU site • MH/SU clinician/case manager • External care manager • Specialty medical/surgical • Specialty outpatient MH/SU treatment including medication-assisted therapy • Residential MH/SU treatment • Crisis/ED based MH/SU interventions • Detox/sobering • Medical/surgical inpatient • Nursing home/home based care • Wellness programming • Other community supports
Quadrant I MH/SU ↓ PH ↓	**Quadrant III** MH/SU ↓ PH ↑
• PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy) • PCP-based BHC/care manager (competent in MH/SU) • Specialty prescribing consultation • Wellness programming • Crisis or ED based MH/SU interventions • Other community supports	• PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy) • PCP-based BHC/care manager (competent in MH/SU) • Specialty medical/surgical-based BHC/care manager • Specialty prescribing consultation • Crisis or ED based MH/SU interventions • Medical/surgical inpatient • Nursing home/home based care • Wellness programming • Other community supports

Persons with serious MH/SU conditions could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Clinical Models/Strategies – Bi-Directional Integration

Behavioral Health –Disease Specific

- IMPACT
- RWJ
- MacArthur Foundation
- Diamond Project
- Hogg Foundation for Mental Health
- Primary Behavioral Healthcare Integration Grantees

Behavioral Health - Systemic Approaches

- Cherokee Health System
- Washtenaw Community Health Organization
- American Association of Pediatrics - Toolkit
- Collaborative Health Care Association
- Health Navigator Training

Physical Health

- TEAMcare
- Diabetes (American Diabetes Assoc)
- Heart Disease
- Integrated Behavioral Health Project – California – FQHCs Integration
- Maine Health Access Foundation – FQHC/CMHC Partnerships
- Virginia Healthcare Foundation – Pharmacy Management
- PCARE – Care Management

Consumer Involvement

- HARP – Stanford
- Health and Wellness Screening – New Jersey (Peggy Swarbrick)
- Peer Support (Larry Fricks)

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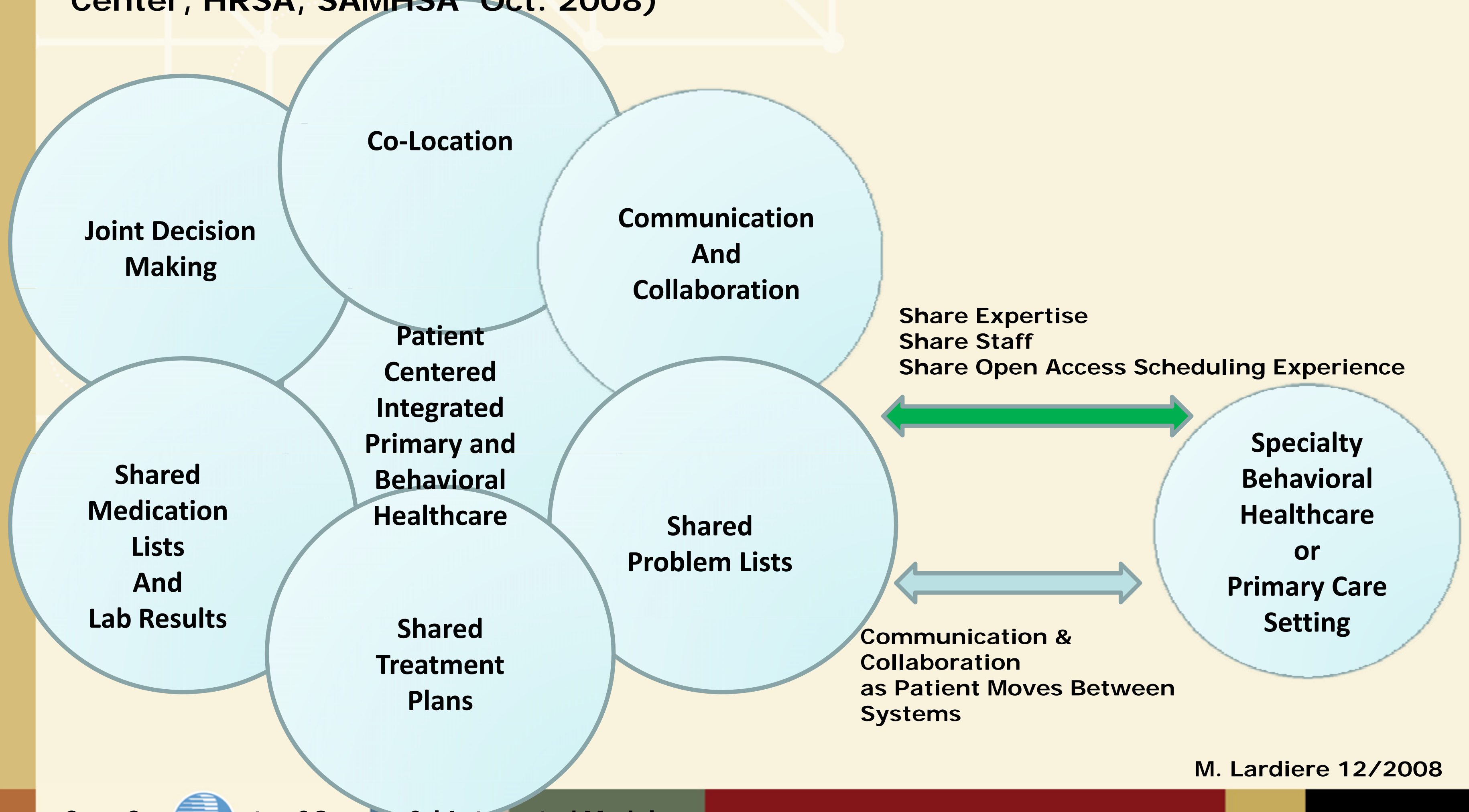
Behavioral Health Integration in Primary Care: Making it Real (Morehouse University, Carter Center, HRSA, SAMHSA Oct. 2008)



Core Components of Successful Integrated Models

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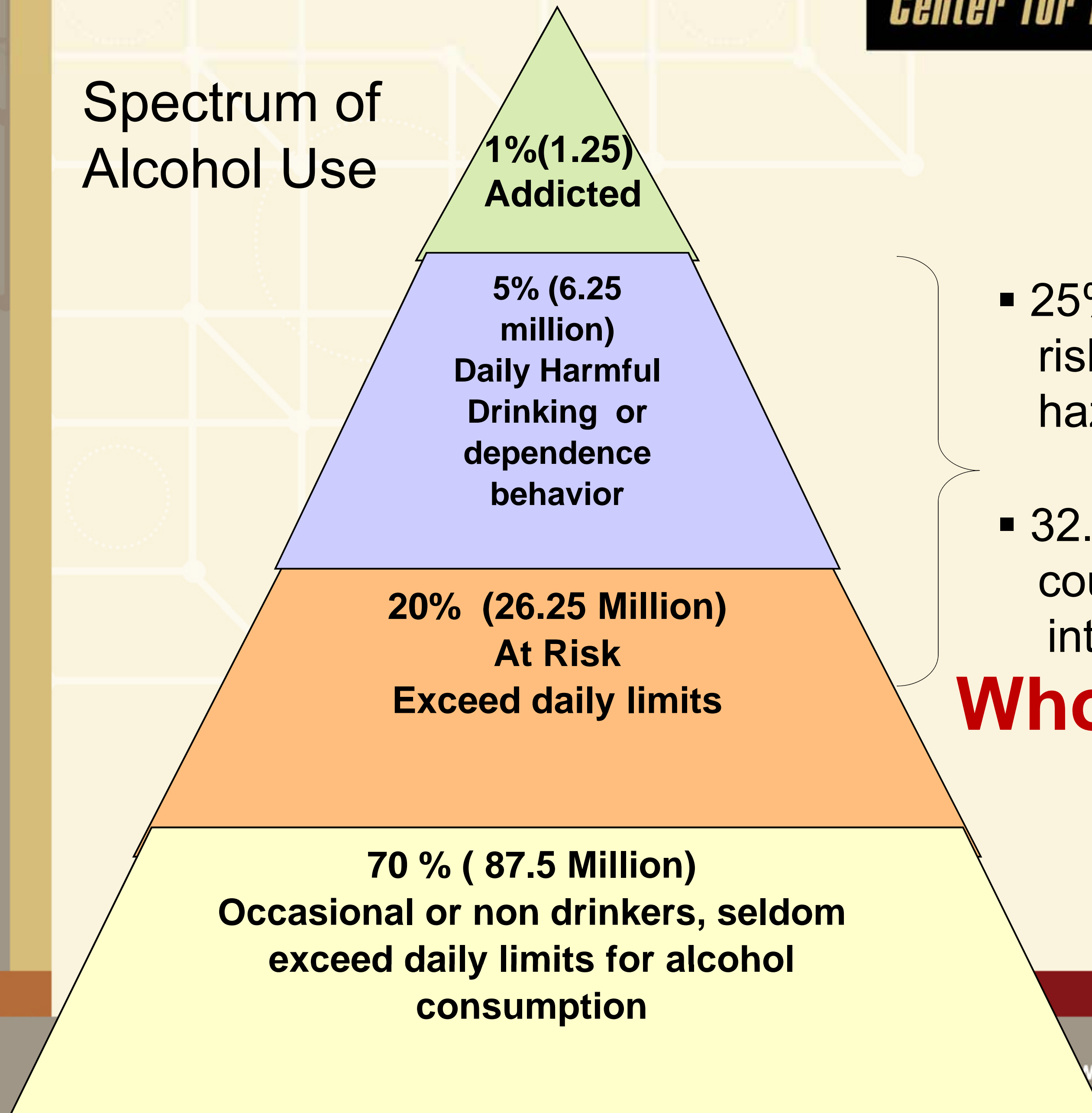

- 25% engaged in risky, harmful or hazardous drinking
- 32.5 million people could benefit from brief intervention

Who Are We Trying to Reach?

NACHC 2010 Assessment of Behavioral Health Services in Federally Qualified Health Centers: Measures of Integration with Medical Care

- Survey tool developed
- 56 items on behavioral health staffing, provision, screening practices and other elements of integration with medical care, and training needs
- February 2010 through July 2010
- 1080 grantees (38.9 percent response rate)

Survey Response (1080 Grantees)

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- 70% of Health Centers Currently Provide Behavioral Health Services

- All Health Centers are required to have a behavioral health intervention identified in their annual plan

Total BH Patients by Type, 2009

	Patients
Mental Health	758131
Substance Abuse	114565

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Number of Sites with Onsite MH Services

# of CHCs	One site only	Two sites	Three or more sites	All sites
Percent	17.3%	16.4%	26.0%	40.4%

Note: Among health centers that specified the number of sites and provide MH services

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% of Total FTEs by Provider Type

Social Workers 31.0%
Other BH, 21.5%
Prof. Counselors, 10.1%
Other Masters Level, 9.2%
Psychologists, 8.6%
Psychiatrists, 6.9%
Addiction Counselors, 6.2%
Nurses, 3.8%
Marriage/Family, 2.6%

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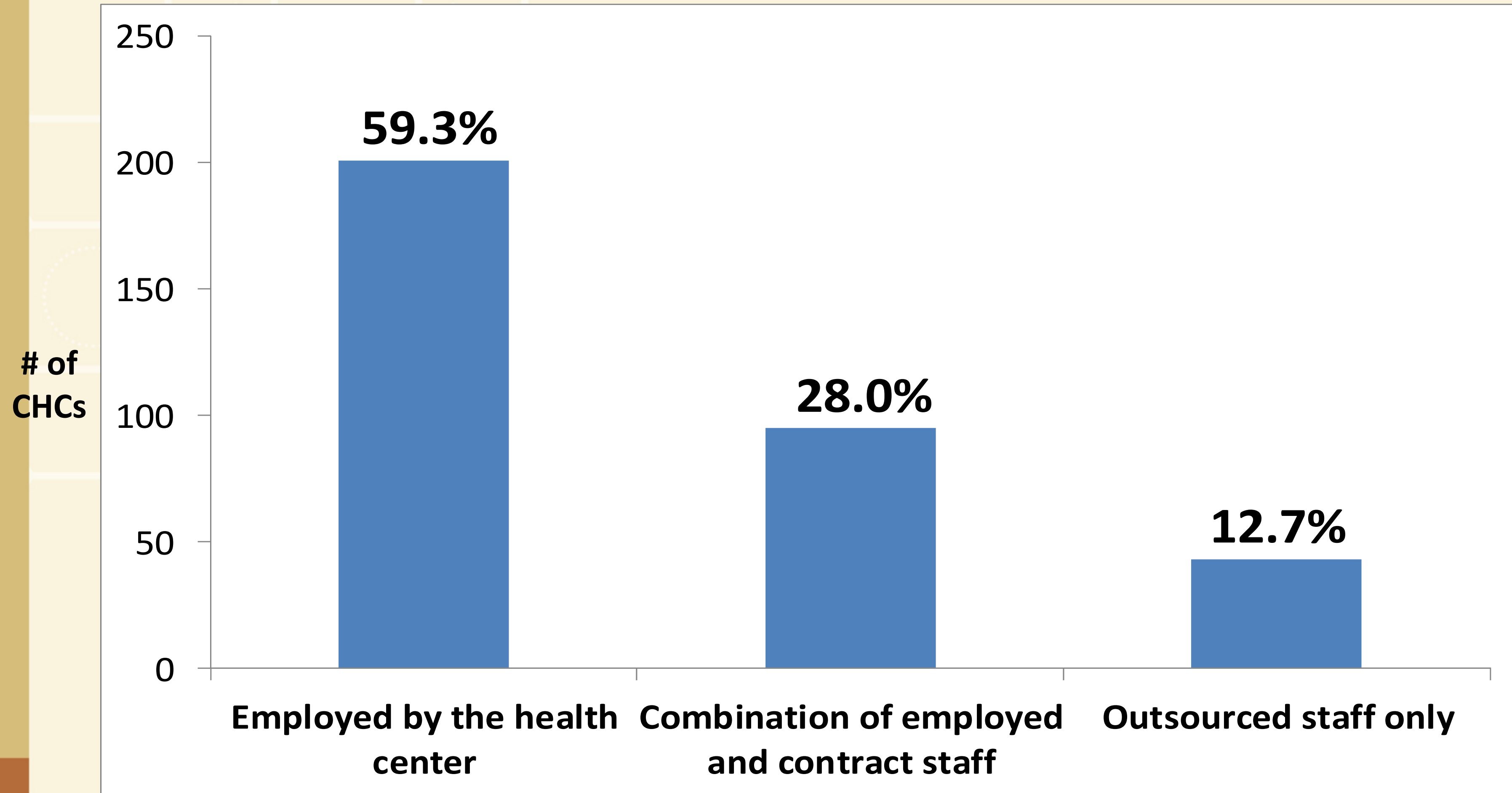
Mental Health Staff Types



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Staff Status – SA Services

Outsourced Staff Only 10%

Combination of Employed & Contracted Staff 16%

Employed by Health Center 74%

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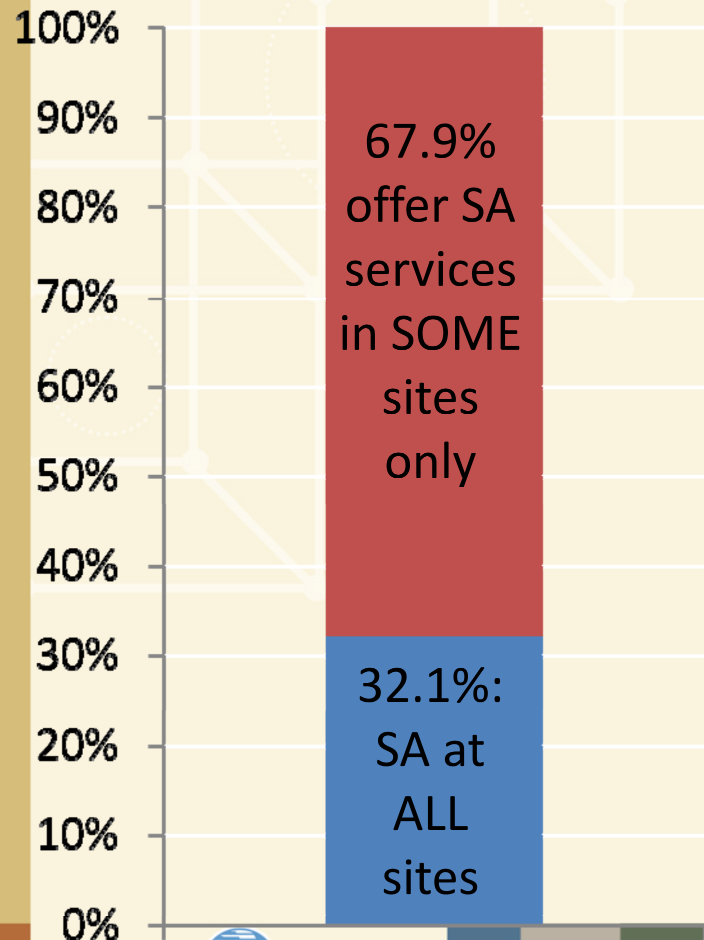
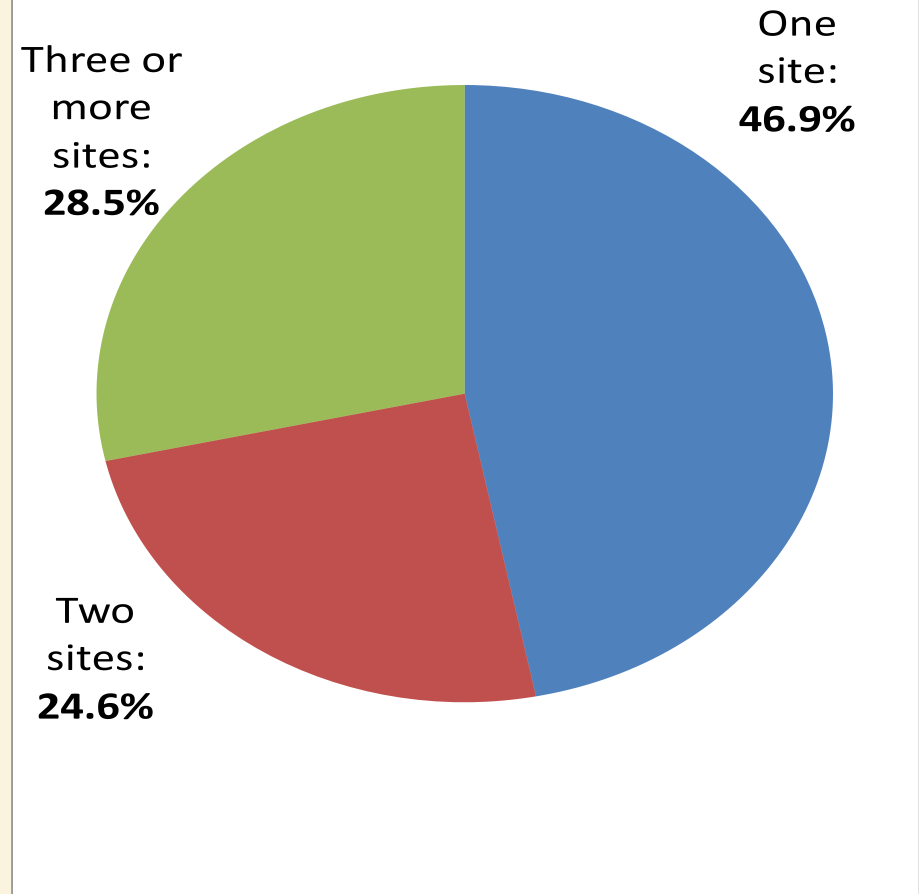
Substance Abuse Service Provision





Note: The bar graph is based on the 193 health centers that provide SA services; the pie chart is based on the 130 grantees that specified the number of sites offering SA services.

Onsite Structured Substance Abuse Program

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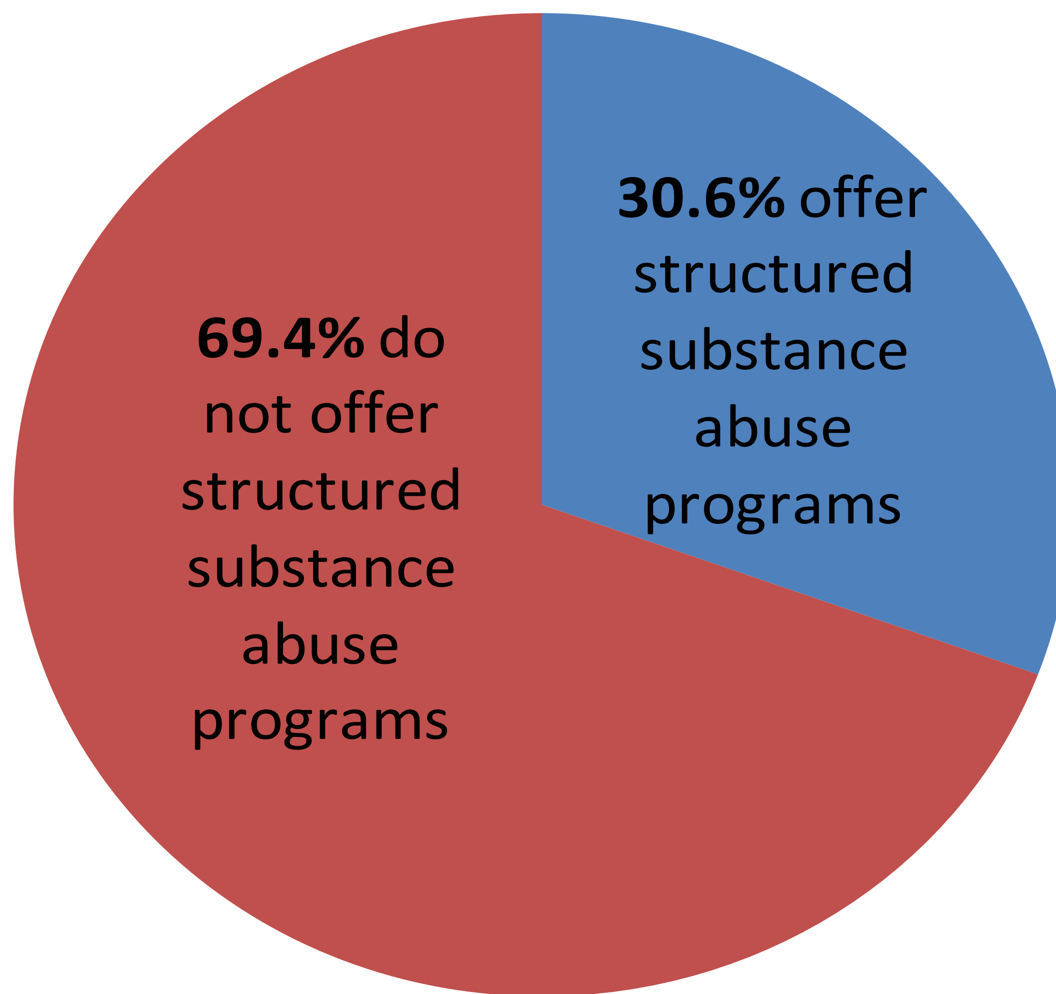
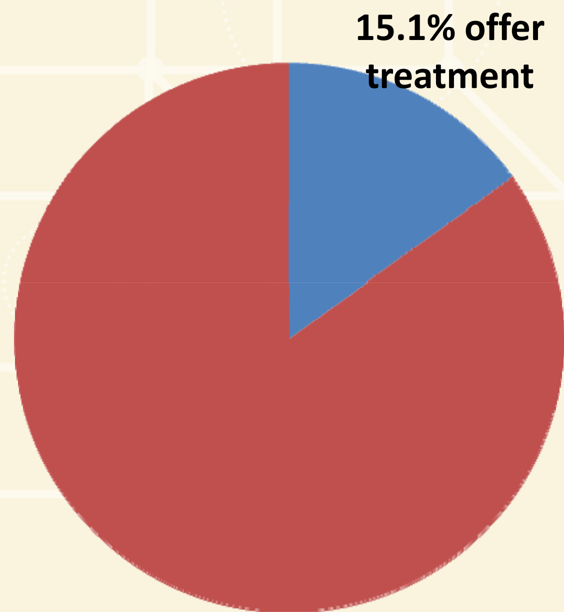
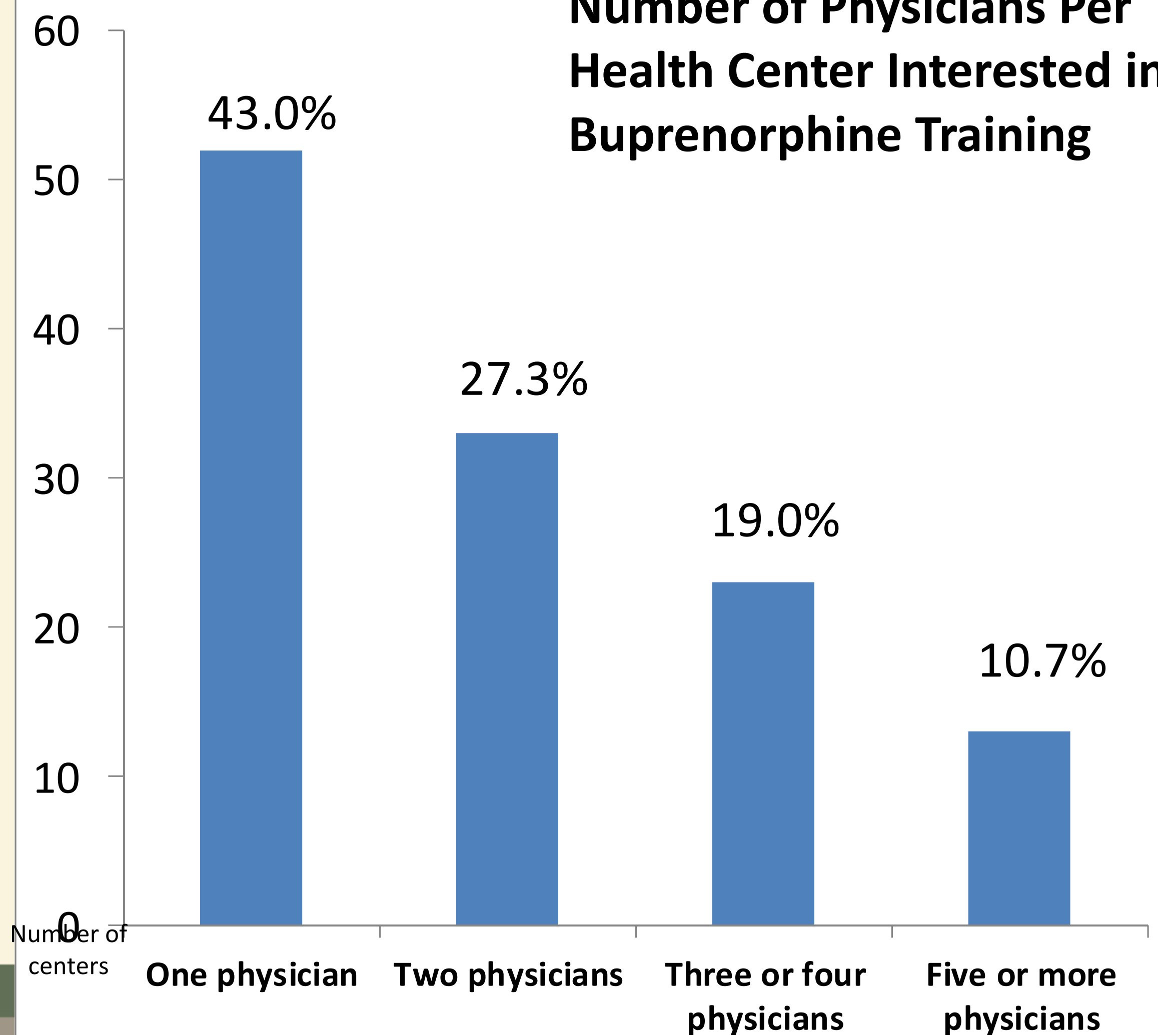


A ***structured program*** is: patients seen in individual and/or group sessions on a regularly scheduled basis to address their substance abuse issues. In contrast, unstructured programs would allow patients to show up as needed or in conjunction with their medical visits and not provide interventions at regularly scheduled times.

Buprenorphine Treatment





Note: Pie chart based on the respondents to that question, the bar chart is based on the 121 respondents that reported interest among providers for the training.

Routine Depression Screening

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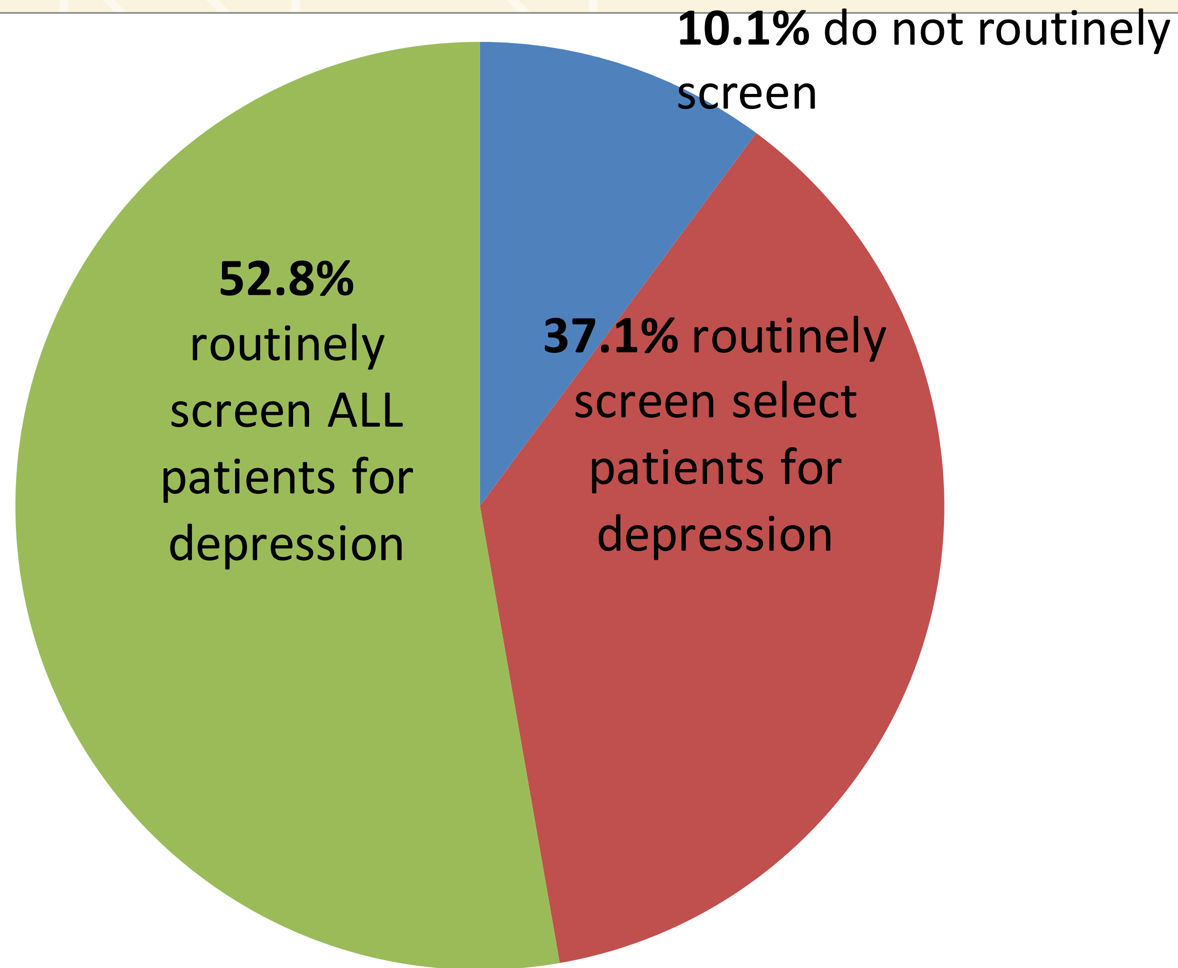
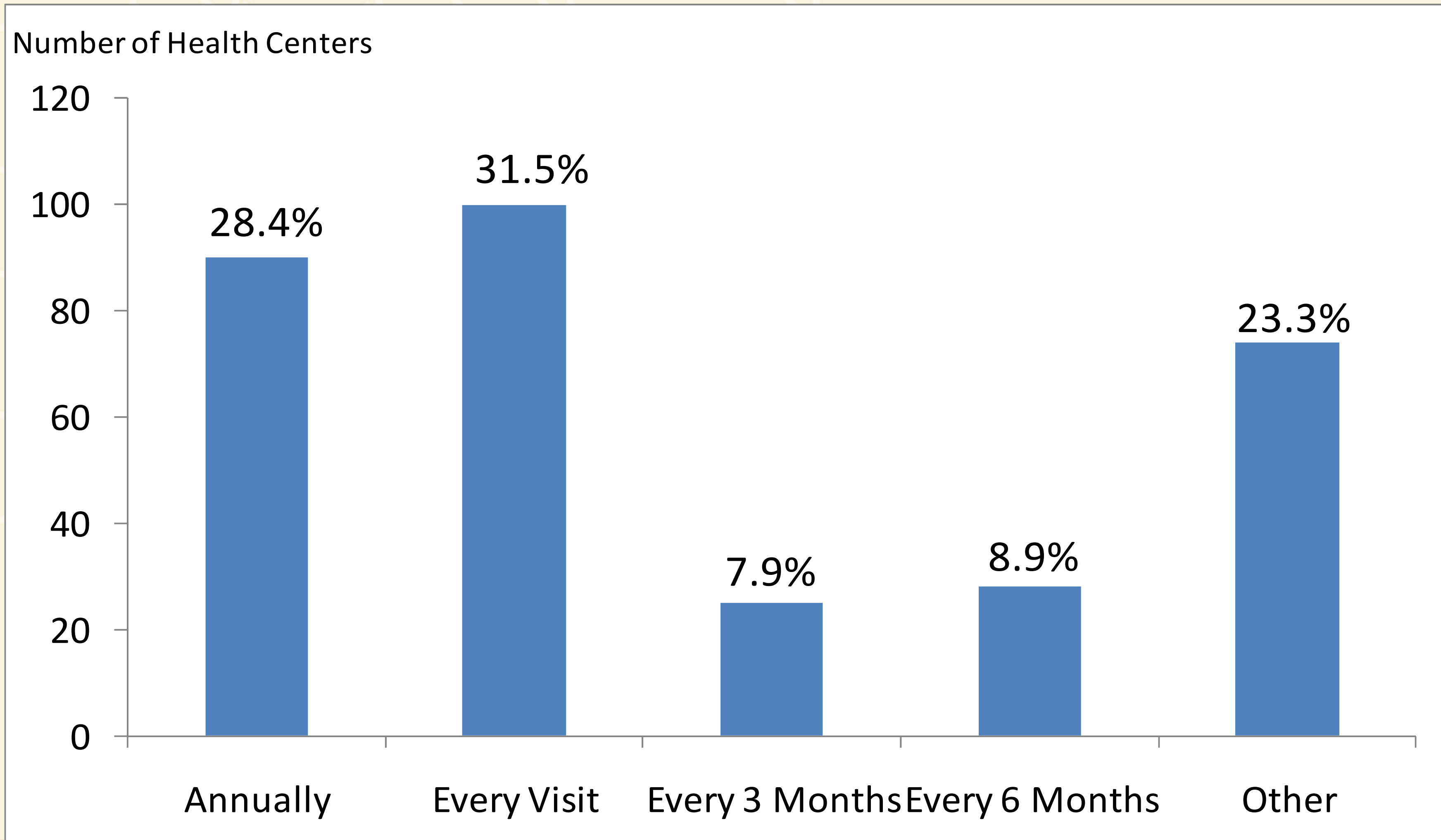


Frequency of Routine Depression Screening



Frequency of Depression Screening

Substance Abuse Screening

39.9% routinely screen ALL patients for substance abuse

24.6% screen a SELECT group of patients

35.5% DO NOT routinely screen for substance abuse

Frequency of Routine Substance use Screening

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Number of Health Centers

	Number of Health Centers	Percent
Annually		31.9%
Every Visit		28.3%
Every 3 Mos		5.6%
Every 6 Mos		4.8%
Other		29.5%

Y-axis: 0, 10, 20, 30, 40, 50, 60, 70, 80, 90

Frequency of Substance Abuse Screening

Self-Rated Communication: Medical and BH Providers

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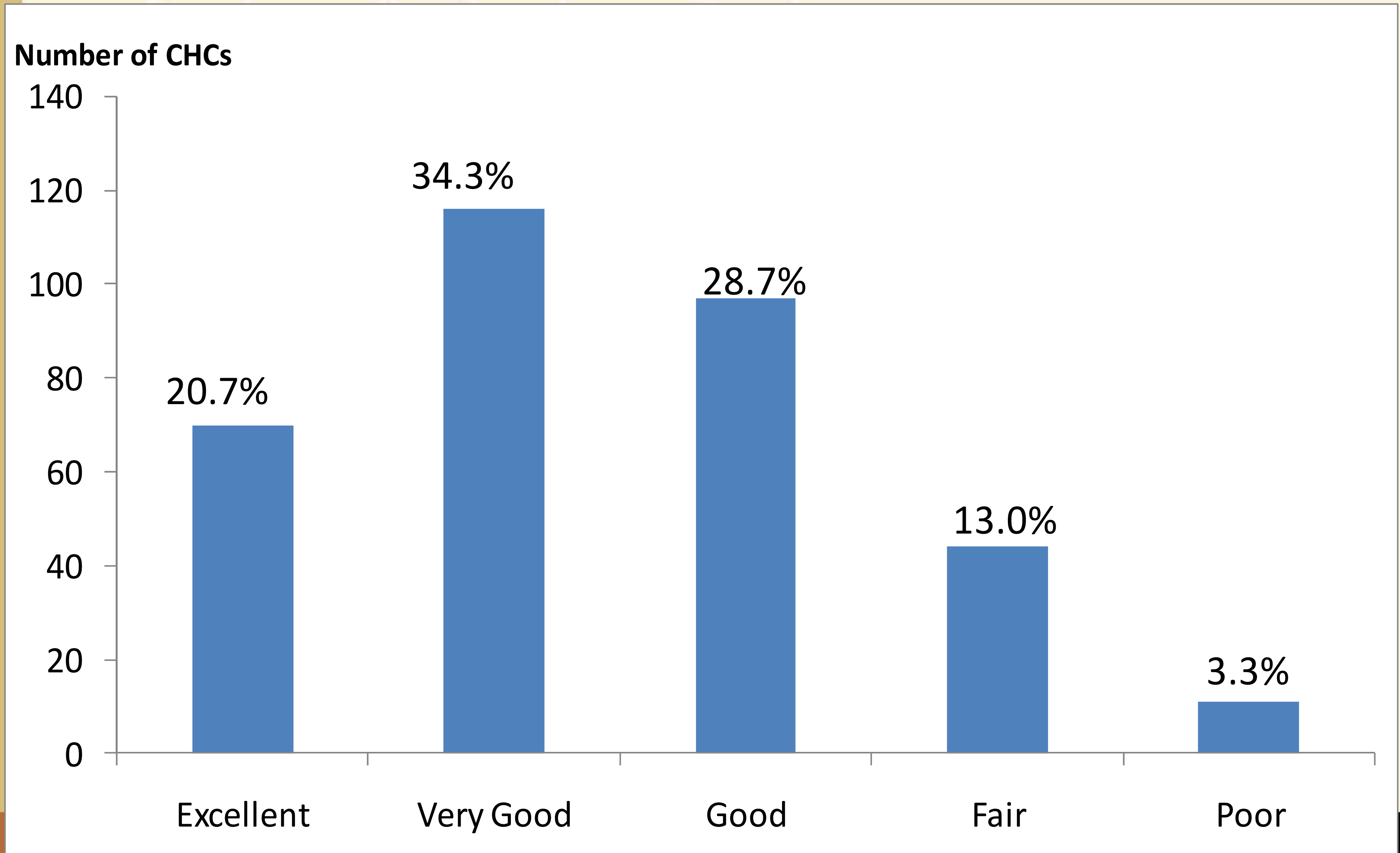

Formal Medical/BH Staff Meetings About MH Cases

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Number of Health Centers

Frequency	Percent
Daily	13.2%
Weekly	34.1%
Monthly	35.7%
Other	17.1%

Y-axis: 0, 5, 10, 15, 20, 25, 30, 35, 40, 45, 50

Frequency of Formal Meetings Between Medical and Behavioral Health Staff for MH Cases

Formal Medical/BH Staff Meetings About SA Cases

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Number of Health Centers

	Daily	Weekly	Monthly	Other
Percentage	18.2%	35.1%	35.1%	16.9%

Y-axis: 0, 5, 10, 15, 20, 25, 30

Frequency of Formal Meetings Between Medical and Behavioral Health Staff for SA Cases

Joint Decision Making on Patient Care Plans

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No joint decision making: 20.7%

Joint decisions by both medical and BH staff: 79.3%

Access to BH Treatment Plans in Patient Charts

No BH treatment plans exist in patient charts: 9.0%

Limited staff access to BH treatment plans in patient charts: 11.3%

BH and medical staff have access to BH treatment plans in patient charts: 79.7%

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Access to Problem Lists and Labs/Medication Lists

# of CHCs	Problem Lists	Labs and med lists
Yes	90.1%	91.7%
No	9.9%	8.3%

Yes= Both medical and behavioral health staff have

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Conclusions

- Health centers commonly provide mental health services onsite and with health center-employed staff, but substance abuse services are not as widely provided

- Screening for depression and substance abuse is used routinely in health centers

- Behavioral health services might not be available at all health center sites, especially services like structured substance abuse programs

Conclusions

- Self-rated provider-to-provider communication is high-quality and care teams meet frequently
- Information is shared between different types of providers
- Providers make joint decisions on patient care plans in 4 of 5 health centers
- Widespread interest in training on varied topics such as motivational interviewing, short-term interventions, and documentation

Assessment
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National Webinar Series Focusing on Primary Care & BH

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Four part series focused on basic activities important for effective BH integration

- Motivational Interviewing, 02/22/11 - Arturo Gonzales et al from Sangre de Cresto (BH agency), & Saverio Sava MD, Medical Director for First Choice Community (FQHC)
- SBIRT, 04/25/11- Eric Goplerud PhD from NORC & Bill McFeature PhD from SVCHC
- Primary Care & Behavioral Health Treatment, 06/01/11, Alexander Blount PhD, U Mass & CHC partner TBD
- Short Term & Brief BH Interventions in Primary Care, 09/14/11- Parinda Khatri PhD & Ken Mays MD from Cherokee Health Systems

SBIRT ,Medication Assisted Treatment & Expanding Substance Use Treatment resources for FQHCs

Establishing Relationships and identifying resources

NIATX,

- **Getting Started with Medication-assisted Treatment**
  - http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=256l

NIDA

- Latest "Buprenorphine Suite of Blending Products"

http://www.nattc.org/explore/priorityareas/science/blendinginitiative/buptx/

http://www.nattc.org/explore/priorityareas/science/blendinginitiative/bupdetox/

http://www.nattc.org/explore/priorityareas/science/blendinginitiative/bupyoungadults/

DVDs on NIDA Blending Products
http://www.nattc.org/explore/priorityareas/science/blendinginitiative/science_of_tx.asp

IRETA SBIRT Toolkit http://www.ireta.org/sbirt/clinical_tools.html

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Models of Integration in FQHCs

- Statutory requirement
  - Under Section 330 of the Public Health Service Act (42 USC §254b), all FQHCs must provide –
    - "Required primary health services," which are defined to include "referrals to providers of … other health-related services (including substance abuse and mental health services) – 42 USC §§254b(a)(1) & (b)(1)(A)(ii)
  - NOTE: Programs receiving targeted Health Care for the Homeless funds must provide additional substance abuse services (detoxification, risk reduction, outpatient treatment, residential treatment, rehabilitation in non-hospital settings) - 42 USC §254b(h)

- HRSA priority (as evidenced by service expansion funding opportunities)
- Important components
  - Enhances ability to provide comprehensive primary care
  - Increases access to essential services which assist in ensuring the overall health and well-being of community and patients served

- Includes Mental Health Services
  - Such as pharmacological management, assessment, psychiatric diagnostic interview, individual and group counseling, crisis intervention
- Includes Alcohol and Drug Services
  - Such as ambulatory detoxification, assessment, case management, crisis intervention, individual and group counseling, lab urinalysis, medical/somatic, methadone administration, Buprenorphine administration, SBIRT

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HRSA Guidance

- BH program should include the following components (cont.)
  - Application of exemplary practices and lessons learned
  - Effective risk management practices
  - Incorporation of program activities into the FQHC's quality plan

- Services can be provided on-site or off-site through an established contractual arrangement

- HRSA strongly encourages using an integrated primary MH/SA care model in developing the service delivery plan
  - Delivery of brief patient-centered MH/SA consultations
  - Co-management of patients by MH/SA providers (who are "members" of primary care team) and medical providers

Traditional Key Differences Between FQHCs and BH Providers

FQHC	CMHC
National System	State-Defined
Safety Net Provider	Medicaid Provider
Need-Based Services	Eligibility-Based Services
Prevention-Oriented	Rehab-Oriented
Lifespan Care	Episodic Care

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3 Methods of Integration in FQHCs

- FQHC takes sole responsibility for providing BH Services
- FQHC Purchases Services from BH Specialty Provider
- Referral Relationship
  - BH Specialty Provider locates their services in same location as FQHC
  - BH Provider located off site at another location

Purchases Services/Capacity

- FQHC takes sole responsibility for providing BH Services
  - Easiest to Implement
  - No Special Legal considerations
    - Requires Clinical Expertise
      - Supervision
      - Linkages with BH specialty Providers are still required for patients that require services beyond FQHC clinical capacity/expertise

Purchases Services/Capacity

- FQHC purchases BH services and/or personnel from BH Provider - services are provided on behalf of the FQHC
- FQHC maintains control over and is legally and financially responsible for contracted services
  - Patients are considered FQHC patients
  - BH Provider provides assurances to meet FQHC's
    - Professional standards
    - Clinical and other pertinent policies, procedures and protocols
    - Quality assurance standards
    - Data collection standards
    - Medical records preparation
    - Financial and programmatic reporting
    - Standards of care
    - Productivity standards (as applicable)

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Purchases Services/Capacity

- Other BH Provider required assurances
  - Act consistent with Section 330 rules
  - Eligible to participate in Federal health care programs (not suspended or excluded)
- FQHC can evaluate BH Provider and, if necessary
  - Suspend services or assigned personnel
  - Terminate assigned personnel or contract in its entirety
- FQHC provides payment to BH provider based on arm's length negotiated, fair market value rate (reasonable, in accordance with federal cost principles of OMB Circ A-122)
  - Note: If the health center is paying less than fair market value, the agreement should meet the requirements of the health center safe harbor (42 C.F.R. §1001.952(w))
- FQHC bills and collects from patients and third party payors

Purchases Services/Capacity

- FQHC assumes operational and financial authority over the BH program that is integrated into the FQHC's delivery system

- BH provider's clinicians may be integrated into the FQHC workforce or their time/services may be purchased by the FQHC through a purchase of services/clinical capacity agreement

Referral Relationships

- BH Provider agrees to furnish services to FQHC patients referred by the FQHC, regardless of ability to pay (subject to capacity limitations)
- BH Provider retains control and liability
  - Patients are considered BH Provider's patients
  - FQHC disclaims liability for services provided by BH Provider – BH Provider is solely liable for damages related to the services it provides
- BH Provider policies/procedures/standards govern
- BH Provider furnishes services consistent with prevailing standards of care (at a minimum)

Referral Relationships

- BH Provider keeps separate financial system and bills and collects from patients and third party payors for services rendered

- BH Provider agrees to refer patients back to the FQHC for clinically appropriate primary and preventive care

Referral Relationships

- PIN #2008-01: Requirements for in "in-scope" referral arrangements
  - If referral provider provides and bills for service, the service itself is not in scope
  - However, the formal referral arrangement and the follow-up care provided by health center will be in-scope if health center:
    - Executes a formal, written agreement that describes
      - How referral will be made and managed
      - Process for referring patient back to health center for follow-up care
    - Maintains responsibility for treatment plan
    - Provides, pays for and/or bills for appropriate follow-up care
  - Informal referral arrangements CANNOT be used to provide required services or any other "in-scope" services

Referral Relationships
On-site

- Similar to referral relationship, but BH Provider is physically located in and provides services to FQHC patient at FQHC facility
- Need to ensure that the patient can distinguish between the FQHC and BH Provider (i.e., separate signage, entrances, registration etc.)
- Control/liability: same as referral relationship
  - Circuit riding (contracts on as-needed basis)
  - Co-location
- Standards of care: same but FQHC may want right to review and approve them
- Financing: same as referral relationship

Additional Considerations: Extra Privacy Protections for Substance/Alcohol Diagnosis, Treatment, Referral Information

- 42 CFR Part 2 prohibits the transfer of individually identifiable information about a patient that is receiving substance use or alcohol treatment services without valid written specific authorizations, called consents
  - Also applies to past patients
- More prohibitive than HIPAA, which generally allows individually identifiable "protected health information" to pass for the purposes of treatment, payment, health care operations

Additional Considerations: 42 CFR Part 2

- Applies to programs, which are:
- Individuals or entities (other than general medical facilities), or identified units within general medical facilities,
  - that hold themselves out as providing, and actually provide alcohol or drug abuse diagnosis, treatment, or referral for treatment; or
- Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers

Additional Considerations: 42 CFR Part 2

Part 2 allows certain information to pass without specific patient consent:

- Communications within a program or between a program and an entity having direct administrative control over that program;
- Communications between a program and a qualified service organization ("QSO");
- Medical emergencies, research activities and audit or evaluation activities.
- Health Information Exchange

Caveat: Re-disclosures — secondary disclosures stemming from an initial one — are prohibited unless made back to the program from which the information was obtained

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Why Provide Integrated Substance Abuse Treatment?

Washington State
Studies of SU and Healthcare Costs

Medicaid medical expenses prior to specialty SU treatment and over a five-year follow up were compared to Medicaid expenses for the untreated population.

For the Supplemental Security Income (SSI) population, Washington studied the Medicaid cost differences for those who received treatment and those who did not.

- Average monthly medical costs were $414 per month higher for those not receiving treatment, and with the cost of the treatment added in, there was still a net cost offset of $252 per month or $3,024 per year.
- The net cost offset rose to $363 per month for those who completed treatment.

- Providing treatment for stimulant (methamphetamine) addiction resulted in higher net cost savings ($296 per month) than treatment for other substances. For SSI recipients with opiate-addiction, cost offsets rose to $899 per month for those who remain in methadone treatment for at least one year.

In the SSI population, average monthly Emergency Department (ED) costs were lower for those treated—the number of visits per year was 19% lower and the average cost per visit was 29% lower, almost offsetting the average monthly cost of treatment.

  - For frequent ED users (12 or more visits/year) there was a 17% reduction in average visits for those who entered, but didn't complete SU treatment and a 48% reduction for those who did complete treatment.

Mental Health Parity and Addiction Equity Act

Overview

Federal and State parity standards, application and outstanding issues

Expansion of addiction and mental health coverage under the Affordable Care Act and application of parity standards

Guidance on enforcement and appeal rights

Mental Health Parity and Addiction Equity Act Purpose and General Principles

- Ensure that health insurance coverage for mental health and substance use disorders (MH/SUD) is on par with coverage for physical illnesses
- End discrimination in the design and operation of insurance plans for MH/SUD benefits in large group plans (fully insured) and large self-insured plans
- Does not require the coverage of MH or SUD benefits and provision of coverage for one or more MH condition or SUD does not require plan to provide coverage for any other condition
- If plan provides MH/SUD benefit, it must be on par with medical/surgical benefits
  - State laws may mandate certain coverage → application of MHPAEA rules
- Does not supersede state parity standards that require more protective standards for MH/SUD disorder coverage

Parity Laws

Two parity laws may apply to group health plans in the state

1. **Federal Mental Health Parity and Addiction Equity Act of 2008**

   Financial requirements, treatment limitations and medical management standards for MH/SUD benefits must be comparable to these standards for M/S benefits

   Effective Date: October 2009 and Interim Final Regulations effective as of July 1, 2010.

   Final Rule – still awaiting agency action (as well as regulations for Medicaid managed care plans)

2. **State Specific Parity Laws**

   May Mandate certain benefits for mental health and addiction care

Which Law Applies?

Plan Type	State Parity Law	Federal Parity Law
Large Group Health Plans – more than 50 employees fully insured	√	√
Large Group Health Plans – more than 50 employees self insured		√
Small Group Health Plan – 2-50 employees self-insured or fully insured	Neither Law Applies No Change Under Affordable Care Act	
Individual Health Plans	√	2014 – Affordable Care Act

Is there a state specific law? E.g. Maryland Parity Law below

All large group employers (51+ employees), fully insured, must offer the following MH/SUD benefits

- Inpatient benefits – duration of care equal to or greater than duration for inpatient physical illnesses
- Partial hospitalization – a minimum of 60 days
- Outpatient benefits – must be offered on same terms and conditions as outpatient physical illnesses
- No separate lifetime maximums, deductibles, coinsurance amounts or annual out-of-pocket limits for MH/SUD

E.g. Maryland Parity Law

Individual Plans are covered under State parity law and must offer the following MH/SUD benefits:

- Inpatient benefits: duration of care equal to or greater than duration for inpatient physical illnesses
- Partial hospitalization: minimum of 60 days
- Outpatient benefits: no limit on number of visits but tiered co-payment
  - 80% first 5 visits
  - 65% 6th through 30th visit
  - 50% 31st visit and beyond
- No separate lifetime maximums, deductibles, coinsurance amounts or annual out-of-pocket limits for MH/SUD

MHPAEA – Standards

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If a plan offers MH/SUD benefits, it cannot impose separate or more restrictive (1) treatment limitations or (2) financial requirements than those for M/S benefits.

A plan may not apply any financial requirement or treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all M/S benefits in the same classification.

MPHAEA Implementation

6 Benefit Classifications Established

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
4. Outpatient, Out-of-Network
5. Emergency Care
6. Prescription Drugs

Plans must place all benefits in one of the six classes and cannot create other classes

If the plan provides a MH/SUD benefit in one class, it must provide a MH/SUD benefit in all classes in which it provides a M/S benefit

MHPAEA
Comparative Standard

A plan may not apply any financial requirement or treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all M/S benefits in the same classification

Three criteria:

- **Substantially all**: the financial requirement or treatment limitation applies to at least **2/3 of all M/S** benefits in the classification.
- **Predominant**: the most common or frequent level -- applies to **more than ½** of the M/S benefits in the classification.
- **More Restrictive**: comparing the standards that apply to the MH/SUD and M/S benefits, the MH/SUD standard cannot be more restrictive – higher cost sharing or more limited care.

MHPAEA
Financial Requirements and Treatment Limitations

Financial requirements include deductibles, copayments, coinsurance, facility charge and out-of-pocket maximums.

- Single combined deductible is required for MH/SUD and M/S benefits
- Annual and lifetime limits are not defined as a financial requirement and separate rules apply

Treatment Limitations – Quantitative

- Quantitative Treatment Limitation (QTL): numerical or quantifiable limitation, such as number of visits, frequency of treatment, days of coverage, length of stay/episode

Compliance Test

- Does requirement/limitation apply to 2/3 of M/S benefits?
- What level applies to more than ½ of M/S benefits?
- Is the level applied to MH/SUD more or less restrictive?

Examples of Financial Requirements and Quantitative Treatment Limitations

- Fully insured plan imposes a $10 copayment for outpatient primary care visit to treat illness or injury; a $20 copayment for outpatient MH/SUD and a $30 copayment for outpatient specialty care
- Fully insured plan applies a facility fee for outpatient MH/SUD treatment and some outpatient diagnostic services for M/S, but doesn't apply that fee to outpatient care for illness or injury or preventative services
- Commercial plan applies a 60 day limit for partial hospitalization for MH/SUD, no day limits for outpatient care for an illness or injury and a 60 day limit for occupational rehabilitation

Non-Quantifiable Treatment Limitation Rules

Second type of treatment limitation – non-quantifiable standards that limit duration or scope of treatment

- medical management standards, including preauthorization requirements
- exclusion for certain conditions or services; i.e. residential treatment, court-ordered care
- prescription drug formulary standards
- standards for provider admission to networks, including reimbursement rates
- plan method for determining usual, customary and reasonable charges
- “fail first” policies and “step therapy” protocols

Standard for review:

- NQTLs for MH/SUD benefit must be **comparable to** and applied **no more stringently** than the standard for M/S benefit
- Exception – if a clinically appropriate standard justifies a different standard

Non-Quantifiable Treatment Limitations Examples

Preauthorization standards – requiring preauthorization for every outpatient MH/SUD visit after patient uses 25 visits; preauthorization for inpatient in-network MH/SUD care but not inpatient hospital; preauthorization for buprenorphine but not other prescription drugs

Fail-first policies – must be unsuccessful in outpatient care before receiving authorization for residential care

Miscellaneous separate rules – refusal to pay for court-ordered treatment of MH/SUD; attendance at 3 AA meetings/week prior to authorization of intensive outpatient treatment

MHPAEA
Additional Standards

Aggregate Lifetime and Annual Dollar Limits

- Cannot impose on MH/SUD if such limit applies to < ⅓ M/S benefits
- If imposed on at least ⅔ M/S, then can apply that limit to both MH/SUD and M/S or apply a limit on MH/SUD that is no less than M/S

Deductibles and out-of-pocket limits

- Expenses for both MH/SUD and M/S must accumulate to satisfy a single, **combined** deductible (out-of-pocket limit or any other accumulating limit)

Prescription drug benefits

- May apply different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed for M/S or MH/SUD. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

Access to Information Enforcement/Compliance

Medical Necessity Criteria

- MH/SUD criteria must be made available to both current or potential participant, beneficiary or contracting provider upon request
- Criteria for M/S benefits are “plan” documents that must be furnished within 30 days of request for ERISA-governed plans. (DOL/HHS Guidance)

Denials of Reimbursement and Payment

- Reason for denial of reimbursement or payment for MH/SUD benefits shall be made available upon request to participant or beneficiary
- Internal review and external appeal regulations set out information required and timeframes

Outstanding Issues
Final Regulation

- Scope of Services – IFR states issue not addressed and seeks comments (2 perspectives)
  - Should not address -- exceeds legislative authority because no mandate to provide any MH/ SUD treatment; Congress intended plans to have full discretion to define which MH/SUD benefits would be covered
  - Must explicitly address -- law prohibits treatment limitations that are more restrictive; failure to cover full scope of services needed to treat MH/SUD violates law if full scope of services is covered to treat M/S condition
- Standard for reviewing NQTL – should "substantially all" standard apply?
  - Standards that are applied to relatively few M/S benefits but uniformly to MH/SUD can evade rule unless require threshold

Coverage of "medical management" as NQTL

- Did regulators exceed authority in creating NQTL and does inclusion invalidate cost evaluation?

Affordable Care Act
Addiction + Mental Health Coverage

Mental health and substance use disorder benefits must be included in the "essential health benefits package" – one of 10 different health services that will be offered in all qualified health plans.

- Federal government will specify MH/SUD services
- States can require additional MH/SUD services but will have to cover cost above the federal standard

Essential benefit package must be offered by **any** insurer who sells individual or small group employer insurance.

Essential benefit package must be included in all qualified plans offered in the Health Benefit Exchange (and also can be offered outside the Exchange)

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Affordable Care Act
Addiction + Mental Health Care

Parity standards in 2014

- Will apply to individual plans
- Will not apply to small employer group plans even though MH/SUD benefits must be included (unless Congress amends law to extend parity to small group market)

Small employer – will more employers be exempt from MHPAEA under ACA?

- ACA amends definition of “small employer” to 100 or fewer employees as of Jan. 1, 2014 for certain purposes (i.e. employers that may participate in Health Benefit Exchange and qualify for subsidies)
- DOL/HHS Guidance: “Small employer” definition in ERISA and Internal Revenue Code not amended → **only employers with 2-50 employees exempt**
- DOL/HHS Guidance: Non-federal government plans: “small employer” definition amended -- employer with 100 or fewer employees. Can seek exemption from MHPAEA.

Affordable Care Act
Medicaid

Medicaid managed care plans – Parity applies to SUD

- Does not apply to MH Carve-out

Medicaid expansion to cover adults up to 133% of poverty (no later than 2014)

- Benchmark plan or benchmark equivalent must provide essential health benefits
- MH/SUD benefits provided under a Medicaid managed care provided at full parity
- MH/SUD benefits provided in a non-managed care system provided on par for financial requirements and treatment limitations

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Enforcing Right to Parity

1. Determine which law applies based on plan type – individual, small, large (fully or self-insured)
2. Determine the plan benefits
3. Obtain disclosures of medical necessity criteria (MH/SUD and comparable M/S) and reason(s) for adverse decision
4. File an appeal with insurer – must exhaust internal appeal process (both fully and self-insured); Maryland Attorney General's Health Advocacy Unit can assist with appeal to fully insured plan
5. File complaint with government agency – MIA (if fully insured) will refer to Independent Review Organization; DOL if fully insured
6. Appeal agency review decision – Administrative hearing or state court (if fully insured); court action (self-insured)

State and Federal Agency Assistance

If State law or both Federal and State laws apply:	**Contact the State Insurance Commissioner - Complaint Unit** **Or** **State attorney General's Office** **Each state will have a specific process**
If only federal law applies:	Only the U.S. Department of Labor can address these appeals: Contact ERISA benefit advisor at 202-693-8700 http://www.dol.gov/ebsa/publications/how_to_file_claim.html

Resources

Drug Policy Clinic, Univ. of Maryland Law School

- Ellen Weber – 410-706-0590, eweber@law.umaryland.edu
- Provider Parity Resource Guide; advice and assistance

Maryland Parity Project, Mental Health Association of Maryland

- Adrienne Ellis – aellis@mhamd.org
- www.marylandparity.org
- Materials available; advice and assistance

National Parity Coalition

- www.mentalhealthparitywatch.org
- Parity Toolkit for Addiction & Mental Health Consumers, Providers and Advocates (Sept. 2010)

New Medicaid State Option for Healthcare Homes – Section 2703 Affordable Care Act

State plan option allowing Medicaid beneficiaries with or at risk of two or more chronic conditions **(including mental illness or substance abuse)** to designate a "health home"

Community mental health organizations are included as eligible providers

Effective Jan. 2011

Additional guidance forthcoming from HHS

Medicaid Healthcare Homes

90% Federal match rate for the following services during the first 8 fiscal year quarters when the program is in effect:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Patient and family support
- Referral to community and social support services
- Use of health IT to link services (as feasible/appropriate)

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Other Considerations for SPA

Policy-level decisions needed to pursue a Health Home Option, including identifying target populations, provider qualifications,, team composition, etc.

Selection of quality measures and specifications and the use of HIT in conducting health home services, quality measurement and state reporting

Consideration for rate setting (PMPM, case rate), as well as gain sharing options.

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On Your Mark, Get Set, ACO…

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

Core Principles of an ACO

- Directed by a **coordinated set of providers**
- Provides a **full continuum of care** to patients and populations
  - Healthcare homes, specialty care, hospital, case management, care coordination, transitions between levels of care…and more
- **Financial incentives** aligned with clinical goals
- **Cost containment**
- Enhancement of **care quality** and the patient experience
- **Improvement of overall health status**

ACOs and the Safety Net

Coverage expansions: The massive expansion of coverage in 2014 will require new models to assure access and control costs – particularly for serving Medicaid patients, who will make up 14 million of the newly insured

Care management: Individuals served by the safety net experience higher rates of serious mental illness, substance use disorders, and poorly controlled multiple chronic conditions

Community behavioral health organizations have **expertise and experience** in caring for these populations, making them valuable partners in an ACO

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Partnering with Health Homes and Accountable Care Organizations

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

Health IT at the Heart of the ACO Framework & Health Homes

- Builds patient-centric systems of care
- Improves quality and cost
- Coordinates care across participating providers
- Uses IT, data, and reimbursement to optimize results
- Builds payer partnerships and accepts accountability for the total cost of care
- Assesses and manages population health risk
- Reimbursed based on savings and quality → value

Health IT Requires More than an EHR

Requirements	Data Sources to be Mined
• Predictive modeling • Registries • EHR interfaces • Reminder Systems • Claims and clinical data warehouses • Episode of care analysis systems • Specifications for integrated claims & clinical databases • Patient portal options • Health enabling information exchange alternatives	• Medical records • Clinical outcomes data • Patient billing systems • Payer data • Quality measures abstracts • Charge master • Physician, payer, service line utilization data • Infection surveillance data • Labor, productivity and throughput records • Adverse drug events

From Meaningful Use to Accountable Care

Integrated care

Outcomes Management

Care coordination

- Outcomes mgmt.
- Patient education
- Care coordination
- Referral management

- Health risk assessmt.
- Acuity classification
- Predictive modeling

- Population mgmt.
- Chronic disease mgmt.
- Risk management

Basic service

Delivery Model

Advanced health management

Integration and HIT

Stage 1 Meaningful Use Objectives include:

Recording patient information into EHRs, such as gender, race, preferred language, height, **weight, smoking status,** and **blood pressure**

PBHCI – SAMHSA/HRSA Center for Integrated Health Solutions Grant

Awarded to the National Council for Community Behavioral HealthCare

Four years; $5.3 Million/year

Target Audience

- SAMHSA Grantees
- HRSA Grantees
- General Public

Services

- Training and Technical Assistance
- Knowledge Development
- Prevention and Wellness
- Workforce Development
- Health Reform Monitoring and Updates

www.CenterforIntegratedHealthSolutions.org

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