



Addiction Messenger

SERIES 41 - January 2011 Volume 14, Issue 1

Ideas for Treatment Improvement

Healthcare Reform and Behavioral Health Part 1 - A Sea Change

Healthcare reform is a flexible recipe for a major transformation, a sea change, in how healthcare services will be delivered. Across the nation – from community to federal levels – organizations are rallying to respond and prepare for its mandates. “Reform of the health care system will be complex, challenging, and laden with competing priorities,” states John O’Brien, SAMHSA’s senior advisor for behavioral health financing. “The next three years will provide the foundation for the newly reconfigured health care system for many years.” (SAMHSA, 2010).

“What we see as we look into the future to 2014,” says Barbara Mauer, a national consultant on the impact of reform on the behavioral health industry, “is there are two forces coming together – healthcare reform and the passage of parity – that change almost everything about the assumptions we’ve had for organizing and delivering services.” Mauer (2010) was addressing Washington State’s *Behavioral Health and Primary Care Integration Collaborative*.

Integration – long a core theme in behavioral health – has now been swept to a broader arena as part of a multi-faceted national strategy for change. Integration, in the context of reform, is considered a means to more efficiently and effectively deliver care; therefore, for reform to achieve optimum success, all providers must be equally involved in planning and partnering for change.

With an eye to implications for behavioral health, this three part series will examine key strategies and components of healthcare reform, including driving forces, emerging concepts and models, and examples and suggestions to help providers prepare.

The Affordable Care Act

In March of 2010 President Obama signed into law the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act of 2010*, together referred to as the Affordable Care Act (ACA). ACA builds on the Wellstone and Domenici Mental Health Parity and Addiction Equity Act of 2008, and together the groundbreaking acts combine to create a playing field where behavioral health is equal to physical health, and more Americans than ever in history will be able to access mental health and addictions services.

In fact, it bears such good news for consumers that planners and providers are being challenged – and quickly – to expand, transform, and rethink how behavioral health services will be delivered. This means new opportunities for stakeholders, especially those that embrace the idea of change and are willing to work within the emerging new paradigm for healthcare integration.

4 Key Goals + 4 Key Strategies

The overarching goals of reform are to make healthcare more accessible, affordable, efficient, and effective. Toward these goals, key strategies address four major areas: 1) coverage expansion, 2) insurance reform, 3) service delivery system redesign, and 4) payment reform. Also, in a major shift for healthcare, reform recognizes prevention as integral to improving and maintaining health, with provisions for prevention cutting across strategies.

“To improve the golden moment of opportunity, and catch the good that is within our reach, is the great art of life.”

~ Samuel Johnson
(1709 - 1784) ~

Northwest Frontier
Addiction Technology
Transfer Center
3181 Sam Jackson Park
Rd. CB669
Portland, OR 97239
Phone: (503) 494-9611
FAX: (503) 494-0183

A project of OHSU
Department of Public
Health
& Preventive Medicine

Steve Gallon, Ph.D.
Principal Investigator

Mary Anne Bryan, MS, LPC
Program Manager, Editor
bryanm@ohsu.edu

Next Issue:

*Service Delivery
System Redesign and
Payment Reform*

Coverage Expansion and Insurance Reform

Reform provisions are being enacted from 2010 through 2018, with most to occur by 2014.

When fully implemented HCR is expected to expand coverage to an estimated 32 million currently uninsured Americans, meaning about 95% of the legal population would be covered (U.S. Government, 2010). Also, those currently covered will experience expanded and improved benefits. The following summarizes some key components of expansion and insurance reform that are particularly relevant for behavioral health:

- **Provisions prohibit insurers from denying coverage to people with pre-existing conditions, charging higher premiums based on health status, placing caps (annual or lifetime) on coverage, and dropping patients from plans (the practice of “rescission” often done due to high medical expenses).** Consumer protection reforms are critical for individuals seeking or in recovery, many of whom are currently denied benefits due to pre-existing conditions.
- **The Wellstone/Domenici Parity Act combined with specific components of HCR legislation essentially creates a situation where parity laws will cut across all payers.** The idea behind parity legislation is to remove treatment limits or financial requirements on mental health or substance abuse treatment benefits that are not imposed for physical ailments. Parity laws now not only apply to large employers (Parity Act), but to Medicaid benefits (Parity Act and reform legislation), and individual and small group policies in new state “Health Insurance Exchanges” (reform legislation). Also, parity in Medicare coverage is being phased in by the Medicare Improvements Act (MIPPA) and Medicare Modernization Act of 2003.
- **In 2014 reform will expand Medicaid eligibility to include all individuals under the age of 65 (including childless adults) who have an income up to 133% of the Federal Poverty Level (FPL); newly eligible parents and childless adults are eligible for essential health or “benchmark” benefits that include MH/SUD services at parity.** The National Council for Community Behavioral Healthcare (Mauer, 2010) estimates that with HCR about 16 million people will gain coverage through Medicaid by 2019 (an increase of about 46 percent, though this will vary by state). Medicaid expansion also means that many people who currently lose and regain Medicaid due to changing circumstances (e.g., related to disability and/or incarceration) will now have continuous coverage.
- **Beginning in 2014, individuals will be required to obtain basic health insurance coverage (be it through individual or employer policy, Medicaid, Medicare, military, or the Veterans Administration).** By 2019, with HCR, about 16 million currently uninsured Americans

will have gained coverage through private or other insurance, an increase of about 8% (Mauer, 2010). Those without coverage will pay a fee to help offset the costs of caring for uninsured Americans; some, who can show they really can’t afford insurance, may be deemed exempt. (This law is facing legal challenges; some challenges have been overturned and others are pending.)

- **By 2014 states will be required to have “Insurance Exchanges” in place. Exchanges will include state-subsidized plans (up to 400% of FPL on a sliding fee); and all plans in Exchanges must cover essential health or “benchmark” benefits that include MH/SU services at parity.** The goal of Exchanges is to give small businesses and individuals not covered by employers a central place to shop for plans, set rules related to coverage and exclusions, help inform choice by grouping plans into standard categories based on generosity of coverage, and streamline the application process. Also, it is hoped that increased transparency related to coverage differences may spur competition and help drive down costs. (Note: States will have latitude in establishing the scope of “benchmark” benefits, so it will be important to keep an eye on how MH/SA benefits are included.)
- **MH/SUD prevention strategies and efforts are included in the bill’s chronic disease initiatives.** For example, co-payments and other forms of cost-sharing are being removed for services such as screening for depression, drug and alcohol misuse, and smoking cessation efforts. Also, a new Prevention and Public Health Fund will support proven programs that foster health, such as those for smoking cessation and to combat obesity.
- **Increasing the behavioral health workforce is a high-priority in the bill’s National Workforce Strategy section.** HCR has broad implications for the behavioral health workforce, not just in terms of capacity, but related to need for training and education to fulfill shifting or new roles (as we’ll discuss more in Part 3 of the series).

“Key Facts” - Implications for Behavioral Healthcare

According to the 2009 National Survey on Drug Use and Health, of an estimated 22.5 million Americans 12 or older classified with substance abuse or dependence in the past year, only about 4.3 million received treatment in 2009 (a much smaller percentage than those treated for other chronic diseases, such as diabetes, hypertension, or asthma). A huge treatment gap also exists for mental health. Considered in light of HCR provisions, the following “key facts” (SAMHSA 2010; SAMHSA News 2010) help illustrate how reform addresses these gaps, and the huge implications it bears for service demand:

- Of the 32 million more uninsured Americans expected to be covered by 2014, between 20 to 30% (6 to 10 million)

will have a mental or substance use disorder.

- Among the currently uninsured aged 22–64 with family income below 150 percent of FPL, 32.4 % have illicit drug or alcohol dependence/abuse or mental illness.
- People with serious behavioral health problems may not be employed and thus lack the insurance coverage that often goes along with employment. For example, individuals with a mental health disorder are twice as likely to be uninsured than those without a mental disorder.
- An increase in screening for MH/SU misuse and disorders will raise demand for brief and specialty treatment.

Service Delivery System Redesign and Payment Reform

It is a painful paradox that reform is occurring at a time of budgetary crisis at state and national levels. Reform, however, does include provisions and funding to help states and communities experiment with promising delivery-system models that aim to bend a rising “cost curve” while improving quality and outcomes through a more integrated approach. At the heart of reform is a shift away from fragmented, episodic approaches toward integrated chronic-care models. The following are a few key examples (which we’ll discuss at more length in Part 2 of the series):

- *Beginning in January, 2011, states can apply to add a “health home” option to their Medicaid coverage (including, as encouragement, a “sweetener” of a 90 percent federal match for the first two years).* The general idea is patients (particularly those with chronic conditions) would have a “home base” for care where integrated teams (such as a doctor, nurse, pharmacist, and/or behavioral health providers) would collaborate to handle basic care and coordinate care with specialists and hospitals. Some states have already been piloting “health home” models.
- *Expanding on the team concept, HCR incentivizes Medicare/Medicaid programs to establish Accountable Care Organizations (ACOs), large partnerships integrating provider groups – e.g. PCPs, MH/SUD and other specialists (some gathered in health homes), and hospitals – who would share responsibility for a patient’s care from beginning to end. Being in a large group would help lower costs and risks related to service delivery.*
- *Health Homes and ACOs will experiment with payment reforms aimed at bringing down the cost curve, while improving care.* An emerging model is a three-layered design mixing 1) case or capitated payments (based on membership) to cover ongoing prevention, intervention, and interdisciplinary care coordination; 2) fee for service; and 3) bonuses related to cost and quality performance.

Timeline

Given the magnitude of HCR provisions the timeline of

2010 through 2018 is short, with major provisions being enacted by 2014. Some are already occurring. For example, young adults can now be covered on their parents’ plans until age 26; co-payments and/or deductibles have been removed for some preventative services; and in some cases restrictions related to pre-existing conditions, and annual and lifetime limits, have been lifted. SAMHSA News (2010) includes a descriptive, but brief, timeline; the National Council for Community Behavioral Healthcare (2010) has crafted a comprehensive table of events; and the U.S. Government (2010) offers an interactive timeline and a great deal of other information on HCR.

Conclusion/Next Issue

Now is the time for planners and providers to become involved in reform so that behavioral health emerges as a strong partner in a more integrated system. Part 2 of this series will focus on emerging concepts and models (e.g., Patient-Centered Health Homes), and how the national discussion is shifting toward “bi-directional integration”, including the integration of primary care into behavioral health.

Author

Lynn McIntosh is a Technology Transfer Specialist for the Northwest Frontier ATTC and the Alcohol and Drug Abuse Institute at the University of Washington in Seattle. She is preparing this series of articles on Healthcare Reform for the *Addiction Messenger*.

Sources

- Mauer B (MCPH Healthcare Consulting, Inc.), May 25, 2010. Behavioral Health/Primary Care Integration: Pt. 1; video presentation for WA State Dept. of Social and Health Services. <http://www.dshs.wa.gov/dbhr/video.shtml>
- National Council for Community Behavioral Healthcare (2010). Timeline for Implementation of the Major Provisions in the Patient Protection and Affordable Care Act. http://www.thenationalcouncil.org/cs/healthcare_reform
- SAMHSA, 2010 (DRAFT 10/01/10). Leading Change: A Plan for SAMHSA’s Roles and Actions 2011-2014; Strategic Initiative #4: Health Care Reform (pg. 51). <http://www.samhsa.gov/healthReform/>
- SAMHSA News, Sept/Oct 2010. <http://www.samhsa.gov/samhsaNewsletter/archives.aspx>
- U.S. Government (2010). <http://www.healthcare.gov/law/about/order/byyear.html>
- U.S. Whitehouse Blog (March 19, 2010). Healthcare Reform By the Numbers: Why We Can’t Wait. <http://www.whitehouse.gov/health-care-meeting/by-the-numbers>

NFATTC WORKSHOPS for February and April

Cognitive Behavioral Therapy

March 10-11, 2011 - Spokane, WA

April 14-15, 2011 - Honolulu, HI

1.5-day Course (10 CE Hours) – Focuses on building skills in the use of cognitive behavioral therapy for counseling interventions.

Motivational Interviewing

February 7-8, 2011 - Kapolei, HI

2-day Course (14 CE Hours) - Focuses on foundational elements and spirit of MI to enhance skills in establishing rapport, eliciting change talk, and establishing commitment language from the client.

Cultural Considerations in Serving Latino/Hispanic Clients

March 1-2, 2011 – Seattle, WA

1.75-day Course (12 CE Hours) – Focuses on increasing awareness and building of culturally sensitive skills for working with Latinos.

Clinical Supervision I: Building Chemical Dependency Counselor Skills

February 10-11, 2011 - Olympia, WA

March 24-25, 2011 - Ontario, WA

April 11-12, 2011 - Honolulu, HI

2-day Course (14 CE Hours) - designed to increase understanding and skill in assessing the clinical skills of counselors in addiction treatment settings and building learning plans for their continued professional growth and development.

Promoting Awareness of Motivational Incentives (PAMI)

February 4, 2011 - Grants Pass, OR

March 11, 2011 - Spokane, WA

April 15, 2011 - Honolulu, HI

3-hour Course (3 CE Hours) - designed to build awareness of the use of Motivational Incentives as an evidence-based therapeutic strategy to enhance client retention in addiction treatment. Principles, history, research, and suggestions for overcoming implementation barriers are discussed.

Group Counseling & Facilitation Skills

March 14-16, 2011 – Honolulu, HI

March 17-18, 2011 – Honolulu, HI - Focused on Adolescents

3-day Course (21 CE Hours) - interactive training in how to establish and facilitate productive process-oriented and psycho-educational groups. Content includes stages of group development, resolving conflict in groups, and practicing interventions that facilitate group growth.

Advanced Motivational Interviewing

April 19-20, 2011 – Honolulu, HI

2-day Course (14 CE Hours) - designed for those who have had introductory MI training and want to further develop and refine their MI skills in the areas of identifying and eliciting change talk and using strategies to decrease resistance.

Treatment Planning MATRS

March 3, 2011 - Grants Pass, OR

1-day Course (7 CE Hours) - designed to help counselors develop treatment plans that are individualized, strength-based, and oriented toward specific client needs. Course is focused on using assessment information effectively in treatment planning and ongoing case management.

Our NFATTC office has relocated to Oregon Health & Science University (Building 28).
Please update your records.

NFATTC/OHSU
Department of Public Health & Preventive Medicine
3181 SW Sam Jackson Park Rd. CB669
Portland, OR 97239
(P) 503-494-9611
(F) 503-494-0183