Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Health Care Reform
Potential Impact

Presentation to NAADAC

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SAMHSA
“You’ve got to be very careful if you don’t know where you are going, because you might not get there”
Affordable Care Act

• Major Drivers
  – More people will have insurance coverage
  – Medicaid will play a bigger role in MH/SUD than ever before
  – Focus on primary care and coordination with specialty care
  – Major emphasis on home and community based services and less reliance on institutional care
  – Rethink what is offered as a benefit
  – Outcomes: improving the experience of care, improving the health of the population and reducing costs
Other Important Drivers

- If Health Reform is going to be successful, the following will be needed:
  - Covered lives
  - Covered Services
  - Participating providers
  - Clear Measures of Success

Source: Congressional Budget Office
What Are the Major Drivers?

• Change in Coverage for non-elderly individuals (2019)
  – 158 M will have coverage through employers
  – 50 M will have coverage through Medicaid/CHIP
  – 25 M will have coverage through exchanges
  – 26 M will have coverage through non-group plans
  – 26 M will remain uninsured

Source: Congressional Budget Office
What Are The Major Drivers

- Expanded Populations
  - Newly Medicaid Eligible--133% of the Federal Poverty Level (FPL)
  - Health Insurance Exchange Participants--Individuals and Families at or below 400% of the FPL
What Do We Know About the Newly Covered?

– Individuals Near the Federal Poverty Level
  • More diverse group than we think
  • Some our current clients seen in our specialty care system
  • Ages
    – 40% under the age of 29
    – 12% between 30-39
    – 29% between 40 and 54
    – 15% are over 55
  • 56% are employed or living with their families

Source: Center on Budget and Policy Priorities
What Do We Know About the Newly Covered?

- **Annual Insurance Coverage**
  - 47% of poor adults have insurance at some point in the year
  - 35% are uninsured all year
  - 18% are insured all year

- **60% forgo medical care due to coverage**
  - Conditions are more acute when they present
  - Care is more costly

Source: Center on Budget and Policy Priorities
What Do We Know About the Newly Covered?

<table>
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<tr>
<th>Traits</th>
<th>&gt;100%</th>
<th>100-200%</th>
<th>200% + FPL</th>
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<tr>
<td>Poor or fair <em>physical</em> health</td>
<td>25%</td>
<td>18%</td>
<td>11%</td>
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<tr>
<td>Poor or fair <em>mental</em> health</td>
<td>16%</td>
<td>11%</td>
<td>6%</td>
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Source: Center on Budget and Policy Priorities
Other Major Drivers

• Medicaid Will Play A Bigger Role
  – Almost 1/3 of the SA providers and 20% of MH providers do not have experience with 3rd party billing—including Medicaid.
  – Less than 10% of all BH providers have a EHR that is nationally certified.
  – Many staff don’t have credentials required through practice acts MCOs
Primary Care and Specialty Coordination—Why All the Fuss?

- 20% of Medicare and Medicaid patients are readmitted within 30 days after a hospital discharge
- Lack of coordination in “handoffs” from hospital is a particular problem
- More than half of these readmitted patients have not seen their physician between discharge and readmission
- Most FQHCs and BH Providers don’t have a relationship
Other Major Drivers

– Health homes (several new services):
  • Comprehensive Care Management
  • Care Coordination and Health Promotion
  • Patient and Family Support
  • Comprehensive Transitional Care
  • Referral to Community and Social Support Services

– Models
  • Still emerging—chronic disease and depression
  • Fewer models on chronic disease and alcohol or substance use
Home and Community Services

• State long term care systems still unbalanced
  – Some states still have more than 75% of LTC spending in “institutions”
  – Access to HCB services is limited—historical issues (limited Waiver slots)
  – Continued concerns about the quality of these services
Rethinking What We Offer

• Coverage
  – Benchmark plans for Medicaid
  – Essential benefits for exchanges
  – Scope of services for parity
  – What we buy under the SAMHSA Block Grants

• Decisions may be guided by:
  – What do we know works?
  – What do we know works for whom?
  – The “how” these are delivered is critical
Outcomes

- Working on identifying critical outcomes
- Aligning these with HHS outcomes
- Obtain consensus on outcomes
- Develop a plan for operationalizing these outcomes
Implications

• There will be more and new payment strategies
  – More documentation of individualized treatment planning and each service episode to “claim” reimbursement
  – Exchanges may have multiple plans
  – These plans may use managed fee for service
    • Unit rates
    • Authorizations
    • Compliance
    • Billing rules (same day of service billing)
  – Payment on “successful” episode of care
    • Will have to define successful and episode
    • Price it out based on what will be needed to be successful
Compliance and Payment

• Providers and managed care organizations must report/repay any overpayment from Medicare or Medicaid within 60 days.

• More rigorous screening procedures for providers seeking Medicare’s approval to bill

• Require providers as a condition of participation in Medicare, to adopt compliance programs that meet federal

• Soon all claims submitted online

• Bundling should not be mechanism to “hide” the services rendered
Implications

- For newly eligible:
  - What services do they need?
  - Will the traditional delivery mode work?
    - Dial phone vs. Tweeting
    - Continuing care strategies
    - Individuals versus Engaging families
    - 9-5ish
**Implications**

- **Changes in Mission of Block Grant**
  - The “who” changes—more people are covered by insurance. Who is left uninsured:
    - Individuals that done enroll or lapse coverage
    - Individuals not eligible for exchanges—too much income but can’t afford private pay
  - The “what” what changes
    - We need to buy what is “good and modern” - ACA requires “essential” MH/SUD
    - Need to make sure we don’t duplicate payment for same services
Implications

• Being consistent and clear about what services work for the individuals served by your grantees
• Mapping where these services are covered—where are the gaps
• Understanding the current vehicles that your state could use to address the gap (1915i/MFP/Rebalancing Initiatives)
• Helping states with tough choices about what they need buy
Implications

• Insurance Eligibility
  – Don’t wait until 2014
  – Perseverance regarding current eligibility avenues—many people are eligible but not enrolled
  – Outreach strategies for enrollment that will work for this population
  – Discussing with states the possibility of suspended eligibility
Implications

• Primary Care Opportunities—Help folks get to:
  – Community health centers—more focus on identifying and treating BH conditions
  – Health homes—SMI and SUD a critical focus for individuals with chronic conditions
  – Will require the ability to describe what these initiatives are—what is a PCP, how do I get an appointment etc.
How Can I Stay Informed?

- Watch a Movie:  
- Participate:  
- Write:  www.regulations.gov.