

# Strategic Opportunities For Community Behavioral Health Organizations in Healthcare Reform

For

Mental Health Corporations of America

By

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**Criterion Health, Inc**

# Today's Agenda

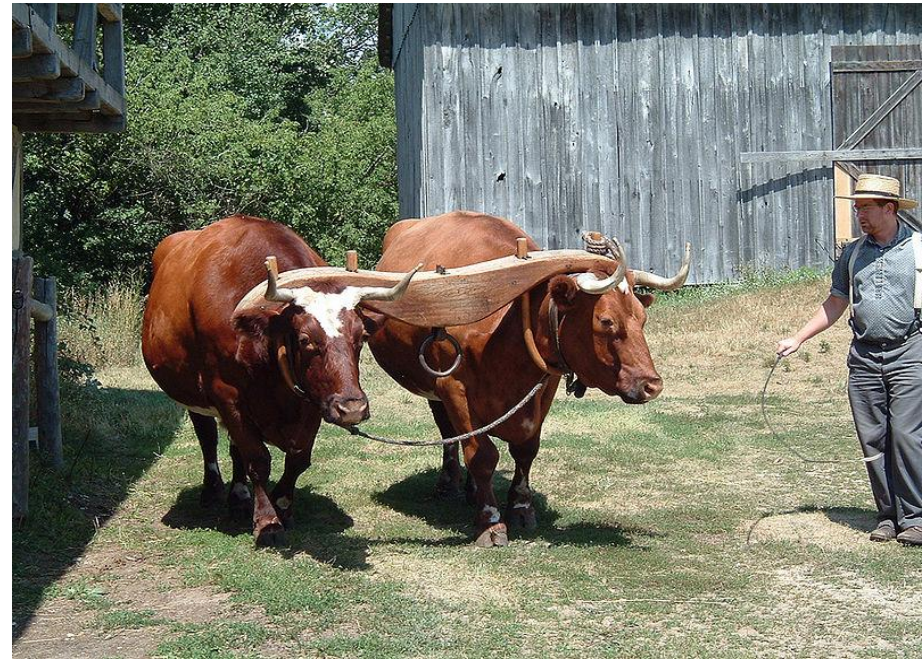
- Context of Health Care Reform for Community Behavioral Health
- Focus: Organizing for Reform
- Business Steps for Navigating Opportunities
- Planning for Portland Session

## Resources Handout for Future Reference

- Abstract of Public Law Elements
- Resources for ACA Component Pieces

# Plodding Along Today No Longer Seems a Good Strategy?

- Massive declines in state budgets?
- Demands for wholesale change to the core of Medicaid?
- Radically revised options for administration and delivery in the public market?
- Significantly greater demand for care coming
- We made noise, but we were mostly spectators, the ball went to the other players- Did our ox get gored?



# AN OBSERVER ROLE- NOT THE BEST POSITION



## Public Law 111-148

- At a high level, the main thrust is expansion of coverage and reform of the insurance system
- Big impacts for consumers
- Increased coverage
- Impact on uninsured; more folks coming our way...
- **New managers of public benefits- new public providers!!!**

# Patient Protection and Affordable Care Act: Now it's Law – Stand By For Change



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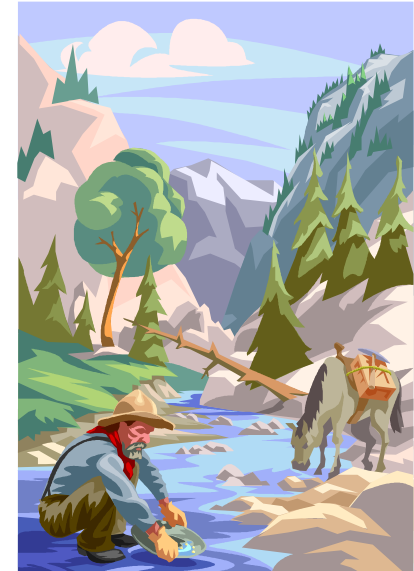
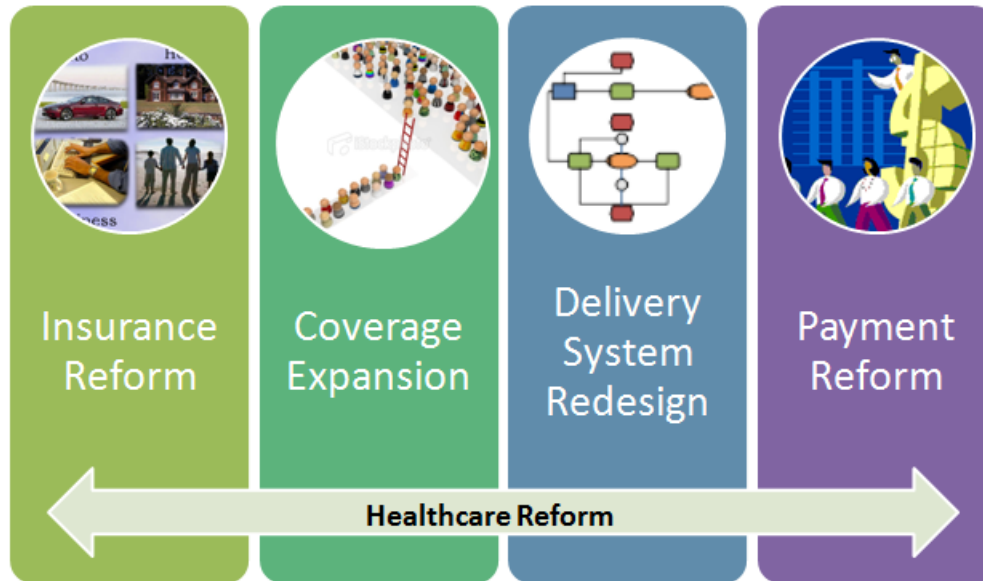




Bennett Chattanooga Times Free Press



# Is There “Gold” for Community Providers in Healthcare Reform?



# The Coming Attractions: New Managers of Public Benefits

Along with the current system, Medicaid services are open to be administered by specific entities identified in the bill:

- A. Health Insurance Exchanges
- B. Nonprofit Health Cooperatives
- C. Provider run Accountable Care Organizations
- D. Patient Centered Medical Homes
- E. Expanding Community Health Centers



# Welcome Our New Overlords

"And I, for one, welcome our new insect overlords. I'd like to remind them that as a trusted TV personality, I can be helpful in rounding up others to toil in their underground sugar caves."

"Kent Brockmann", *The Simpsons*

From the Simpsons, an episode where Homer has become an astronaut. In the course of the shuttle mission, he breaks the glass on the Ant Farm Experiment, and when TV cameras turn on in the shuttle, earth folks see what appears to be giant ants in control of the shuttle.



# Health Care Reform Elements Impacting Public Behavioral Health: They Are Coming Our Way

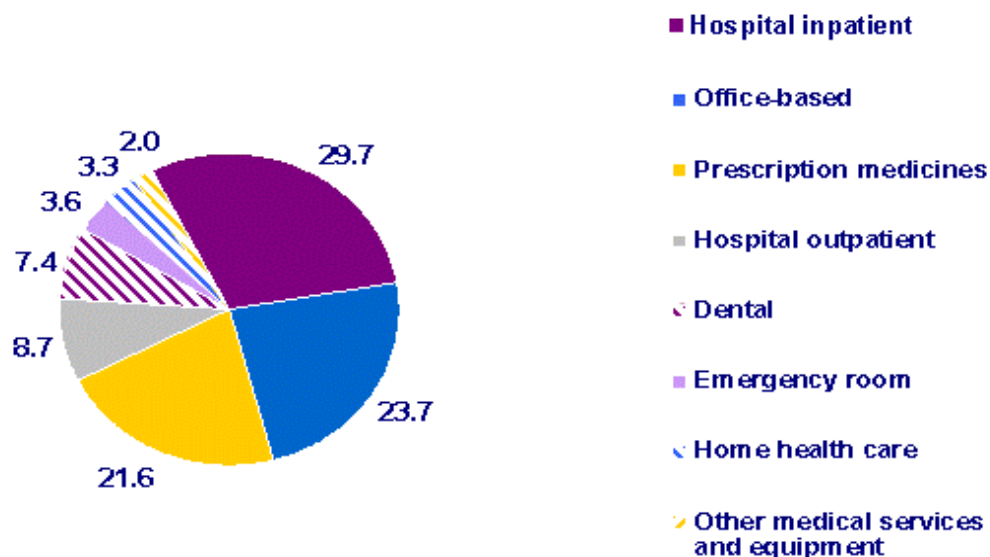


# Health Care Marketplace



Figure 1. Percentage distribution of health care spending, by type of service, U.S. civilian noninstitutionalized population, 2006

Total expenses = \$1.03 trillion



Note: Percentages may not add to exactly 100.0 due to rounding.

Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2006

# We Are Part Of The “Other” In Healthcare

- The 8.7% expenditure for healthcare called “other” includes behavioral health professionals, as well as all other specialty providers, i.e. PTs, OTs, chiropractors, podiatrists, respiratory therapists, med lab techs, etc.
- Estimates are BH care is about 5% of total healthcare, BUT... BH professionals, including CMHCs account for about 2% of health care costs.



# Mental Health in Healthcare Marketplace

(data from Healthcare Costs and Utilization Project, AHRQ)

In 2008 healthcare costs exceeded \$2.3 trillion: \$7,439 per person

- 85% of population saw physician
  - 72% only had office visits, no other care
  - 63% received prescription for medication
- \$56 billion spent commercially for mental health care (in 2006); fastest growing cost in healthcare
  - 25% of costs for mental health care are paid by patient- highest out of pocket rate in health care
- 36 million people sought care for depression
  - 6<sup>th</sup> most common reason for hospital admission
  - NOTE: The CMHC system nationwide served under 6 million people total
- 20 million saw primary care physician for other behavioral health issues
- 30 million were prescribed psychoactive medications by PCPs
  - In 2002 national survey 8.5% of population were taking an antidepressant
- \$1591 was average cost of outpatient mental disorder care

# Health Care Reform: Impact on CMHCs

- Increased demand from most all consumers and all payers
  - Especially for acute care issues, i.e. depression, anxiety disorders
  - Parity requirements mean BH services will no longer be automatically suppressed
- Complexity in public market
  - Health Exchanges, Coops, ACOs open to Medicaid eligibles; Special Needs Plans changing
  - Medicaid is expanding with greater consumer choices of delivery systems
- Increased competition
  - Funding and policies promoting primary medicine based care coordination, i.e. Medical Homes, Pediatric ACOs, hospital based care coordination
  - Community Health Centers receiving significantly increased funding
  - Specific initiatives funded for chronic care, specifically including SPMI
- Increased service coverage, i.e. expanded home based coverage, no annual limits

# Health Care Reform: Impact on CMHCs

- Funding for co-located primary care
  - Patient Protection and Affordable Care Act: PL 111-148
- Anticipate 12 million additional Medicaid eligibles nationwide
  - Currently 53 million on Medicaid
  - 133% of poverty will be covered nationwide by 2014
- Anticipate adding up to \$70 billion for BH coverage by 2019
  - Current total BH expenditure (2006) was \$135 billion
- Addition of Health Insurance Exchanges, Coops, Accountable Care organizations and Patient centered Medical Homes. Current public covered lives will have options other than us for care administration
  - Anticipate shift to have Medicaid covered by HIE, Coops, ACOs and dedicated medical home providers

ARE WE ADMINISTRATIVELY AND CLINICALLY PREPARED?

# Strategic Bad Ideas



Lawn Dart Tag

# Strategic Good Ideas

- Given the new Law (the new Overlords) and likely release of pent up demand, how do we:
  - Keep from being gored or worse yet ignored?
  - Move from peering over the fence to being at the table?

Some ideas for your consideration



# “4 P” Plan for Strategic Action (with apologies to Philip Kotler)

- **P**roduct
  - Acute and chronic: significant market share possible
  - Benefits management role
- **P**ositioning
  - Presence in primary care
  - All ancillary care covered
  - Take a Leadership Role
- **P**romotion
  - Awareness when need present
  - Proof of value to customers
- **P**rice
  - Ability to price in multiple ways rapidly



# Organizing Around The Four “Ps”

- Product
  - Service for high incidence issues e.g. depression and anxiety seeking substantial market share
  - Note our hospital brothers needs with ER diversion
  - Services for high risk patients e.g. case management and disease management (chronic care model) and medical home core elements
  - Seek to be over 10% of either volume or costs in total healthcare marketplace- be significant! (At least be 30% of BH marketplace; patients served- not costs)
  - Manage other “ancillary” services, i.e. OT/PT/ speech & hearing services, etc. to grow “significance”.
  - Serve as a Benefits Manager

Goal is to establish yourself as a needed and vital part of what the physical medicine world needs.

- **Positioning** -Getting a place at the table
  - Be both provider and benefits manager if you can
  - Take a leadership role in setting the table
    - Be an owner or partner in Coops or ACOs
    - Offer benefits management in HIE or ACOs
    - Create CHC
  - Join associations focusing on primary health care and health care reform (See Resource List)

Goal is to acquire 10% or more of total healthcare market share and at least 30% or more of behavioral health market share

# Gathering Intel

## On Health Insurance Exchange

- State Insurance Department

## On Accountable Care Organization

- State Hospital Association

## On Patient Centered Medical Homes

- State Medicaid agency
- State Medicaid health plan association

## On Community Health Centers

- State community health center association
- HRSA <http://bphc.hrsa.gov/>
- NACHC <http://www.nachc.org/>

## On Primary Care

- Medical Group Management Association <http://www.mgma.com/>
- American Medical Group Association <http://www.amga.org/>

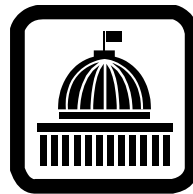
- **Promotion**- Proof of Performance
  - Visibility as provider of choice for high incidence needs: “When you have the need- you need speed!”
  - Prove your worth to public stakeholders through tax conservation
  - Prove your worth to commercial stakeholders through reduced episode costs and absenteeism

Goal is to present yourself as a partner that can deliver what the stakeholders value

# Public Model Proof of Performance

## Tax Conservation

- Total state taxes consumed
  - Healthcare, BH, residential, income, transportation, corrections costs



## Tax Contribution

- % reaching tax contribution (employment) status

# Commercial Proof of Performance

Third Party Administrators: for Employers

- Ease of contracting
- Performance reports
  - Accessibility
  - Acceptability
  - Impact
    - Decreased absenteeism days
  - Value

Trustee Groups: for Employees

- Access
- Care coordination



- **Price**

- Have flexible accounting and episode pricing
  - Learn Value pricing (see ACO materials)
- An adequate IT system
- Administrative efficiency
- Use outsourcing model for clinical care

Goal is to have primary care industry standard IT and accounting system, reduce traditional CBHO overhead cost, and outsource variable clinical services

# Do We Have Focus On The Big Stuff?



# Next Steps

## Your Take Away Ideas to Explore/Develop

1.

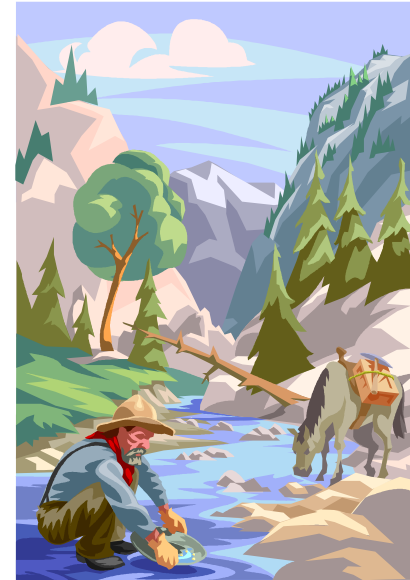
2.

3.

4.

5.

6.



## Next MHCA Meeting

What would you like from the next session?

1.

2.

3.

# Road To Portland

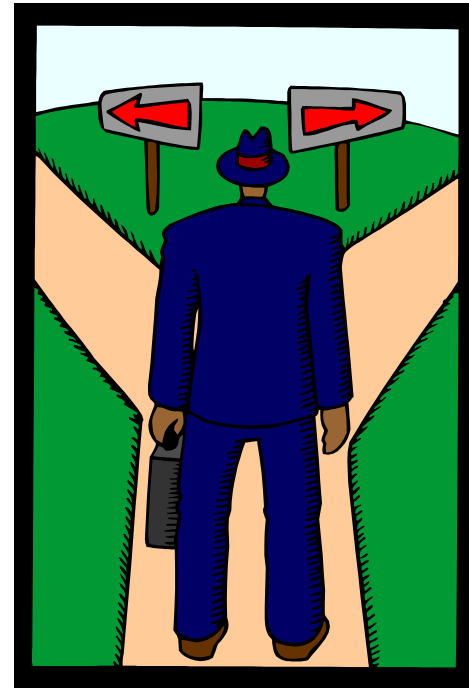
## Two Paths

1. Positioning for ACA implementation

Becoming a significant partner

2. Assisting in State Agency transformation

Assisting state changes



# Do What MHCA Does Best !

Take advantage of our two part session, today and Portland, and use our collective experience to formulate next steps.

- **Share with us:** How are you positioning with the new Overlords, how you are going from observer to participant, how you are repositioning your CBHO, and how are you influencing state transformation?
- In Portland, Session 2: Agenda will be Peer feedback and more elaboration of strategy.

# Path # 1: Sharing Ideas on Healthcare Integration and ACA Related Initiatives

- GOAL: Learn from and support each other.
- Questions for those who are willing to be interviewed:
  - What is the strategic goal for your initiative?
  - Who is your primary care partner that you trying to vend to, partner with, or help create?
  - What changes are you making to your organization or services?
  - What is working and what is not working?
  - What resources have you committed or need to commit?
  - What help do you need to enhance your success?

# Path # 1: Continued

If you are willing to share your experience, we can abstract your effort for the Portland meeting.

You can call or email:

Mel Smith

253-225-1384

[mels@criterionhealth.net](mailto:mels@criterionhealth.net)

Bob Dyer

425-830-1247

[bobd@criterionhealth.net](mailto:bobd@criterionhealth.net)

Or fill out the last page of today's presentation handout and leave it with us.

# Path # 2: Solicitation for Input on Ideas for State Agency Transformation

Criterion Health is organizing a resource for Public Policy Makers on State Public BH Agency Transformation

- The document will present a brief history of BH public policy, research on organization models (carve in and carve out) as public policy tools
- AND we want a section on feedback from the field- **what industry experts have to say** to guide public policy makers to support recommendations for policy makers.

If you are interested in directing comments or resources our way:

- MHCA will sponsor a list serve or an electronic forum for communication.
- You can call or email:

Wed Davidson  
207-227-3605  
[wesd@criterionhealth.net](mailto:wesd@criterionhealth.net)

Bob Dyer  
425-830-1247  
[bobd@criterionhealth.net](mailto:bobd@criterionhealth.net)

# Sign Up for Participation

Yes, I am willing and interested in sharing my experience and efforts to address the challenges resulting from health care reform. Please contact me to set up an interview on:

\_\_\_\_\_ Health Care Integration and ACA Related Activities

\_\_\_\_\_ State Agency Transformation

Name: \_\_\_\_\_

Best Time and Way to Contact Me \_\_\_\_\_

Phone:

Email:

Resources for  
Strategic  
Opportunities For  
Community  
Behavioral Health  
Organizations in  
Healthcare Reform

# Resources

- Abstract of PL 111-148
- New Game overview
  - Health Insurance exchange
  - Health Cooperative
  - Accountable Care Organization
  - Patient Centered Medical Home
  - Community Health Centers
  - Mental Health Parity
  - Meaningful Use
  - State Demonstrations for Dual Eligibles

# The Quick Course: The Patient Protection and Affordable Care Act

P. L. 111-148	Passed into law March 30, 2010
Insurance for Young Adults Sec 2714	Requires coverage for dependent children until age 26 (effective 10/1/ 2010).
Insurance for Young Adults Sec 2004	Allows former foster care adults qualification in Medicaid until age 25 (1/1/2019).
Pre-Existing Medical Conditions Sec 2704	Prohibits not enrolling because of pre-existing conditions (1/1/2014).
High Risk Insurance Pool Program Sec 1101	Establishes high risk pool for people who have lost coverage for six months (7/1/2010) Expires 1/1/2014. \$5 billion for care.
Lifetime & Annual Limits on Benefits Sec 2711	Prohibits lifetime and annual limits on care received (10/1/2010 & 1/1/2014).

# The Quick Course: The Patient Protection and Affordable Care Act P. 2

Medicaid Expansion Sec 2001	Medicaid programs cover all individuals 65 or younger with incomes up to 133% of poverty. Limited benefit packages (including BH benefits). Fed. Govt. finances at least 90%. 1/1/2014
Medicaid Medical Home Pilot Sec 2703	Provides (limited) funding for states to establish medical homes for chronic condition (including SPMI) Medicaid eligibles. 1/1/2011
Medicaid Accountable Care Organizations Pilot Sec 2706	Allows qualified Pediatric providers revenues for meeting performance standards. 1/1/2012
Medicaid Emergency Psychiatric Pilot Sec 2707	Funds psychiatric hospitals in support of medical assistance needed to treat psychiatric conditions. 10/1/2011

# The Quick Course: The Patient Protection and Affordable Care Act P. 3

<b>Medicaid Community Based Services Sec 2401, 2402, 10202</b>	<b>Establishes program for expanded attendant care services . 10/1/2011</b>
Medicare Medical Home Pilot Sec 3502	Establishes program to fund community health teams for coordinated community based care. 1/1/2012
Co-Location of Primary Care in Community Based BH Sec 5604	\$50 million for co-locating primary care in community based BH settings.
Training for BH Professionals Sec 5306	Grant monies for Social Work, graduate Psychology as well as child MH professionals and paraprofessionals.
Incentives for Pediatric BH Specialists Sec 5203	Establishes loan repayment program for serving rural and BH needs in pediatric medicine

# The Quick Course: The Patient Protection and Affordable Care Act P. 4

<b>Mental Health &amp; Addiction Care Parity Sec 1311 &amp; 1562</b>	<b>Applies mental health and addiction care parity to all health plans.</b>
Health Insurance Options Sec 1322, 1323, 1324	Establishes Consumer Operated and oriented Health Plans.
Individual Responsibility Sec 1501	Requires individuals to maintain minimum essential health insurance. 1/1/2014
Employer Responsibility Sec 1501	Requires employers with more than 50 full time employees to offer or pay into insurance funds. 1/1/2014
Community Living & Assistance Services Sec 8002	Establishes long term care insurance for community living assistance services for disables ( at least \$50/ day). 1/1/2011

# The Quick Course: The Patient Protection and Affordable Care Act P. 5

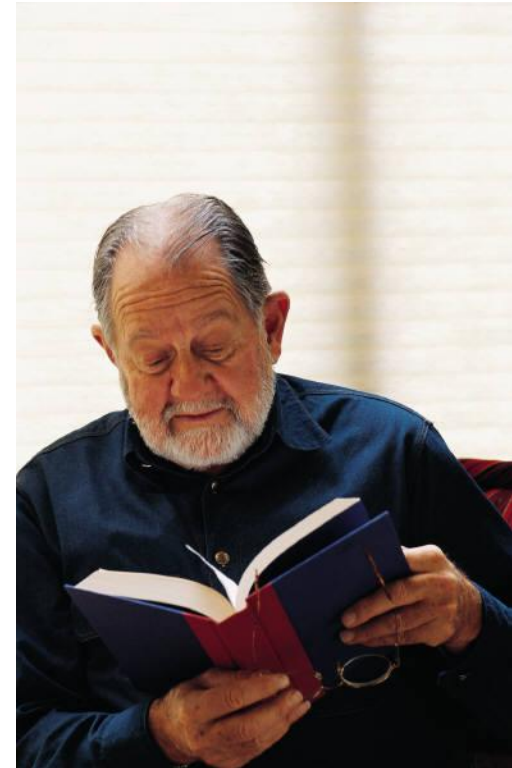
<b>Health Plan Exchanges Sec 1311, 1321</b>	<b>Funds states to create Health Benefits Exchanges open for individuals and small groups. 1/1/2015</b>
Individuals in Medicaid Sec 2201	Allows individuals to enroll in Medicaid (or Exchanges).
Behavioral Health Coverage Mandate Sec 1302, 1311	Requires Exchanges and Health Plans to offer essential BH services.
Individual Hardship Limits Sec 1401, 1402	Premium assistance for less than 400% of poverty level. Payment of any overage beyond 2% of income for those below 133% of poverty level. 1/1/2014
Medicare Accountable Care Organizations Sec 3022	Allows organizations meeting care standards to receive special payments from Medicare. 11/1/2012

# The Quick Course: The Patient Protection and Affordable Care Act P.6

<b>BH Education to Primary Care Providers Sec 5405</b>	<b>Funds for Primary Care Extension program to train about chronic disease mgt., BH services and evidence based care.</b>
Community Transformation Grants Sec 4201	Competitive funds for programs that promote health and decrease incidence of chronic disease.
Community Health Grants Sec 5313	Funds to promote positive health behaviors in underserved communities

# Resources for PL 111-148

- Kaiser Family Foundation: [www.kff.org](http://www.kff.org)
- [National Council:](http://www.thenationalcouncil.org/cs/healthcare_reform)  
[www.thenationalcouncil.org/cs/healthcare\\_reform](http://www.thenationalcouncil.org/cs/healthcare_reform)
- Perednia, D.A. Overhauling America's Healthcare Machine. FT Press: Upper Saddle River, NJ, 2011.
- U.S. Government- Dedicated website:  
[www.healthcare.gov](http://www.healthcare.gov)
- U.S. Government- The Bill:  
[www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html](http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html)



# Strategic Action Plan



## Organization

- Assure primary care relationship (or build CHC or become part of a health care system)
- Use outlier management utilization management capabilities; insure organization can work with case rates
- Install Mental Health Medical Home components
- Move fixed costs to contract relationship (outsource more variable volume services)
- Secure/ use electronic health record
- Get on insurer provider panels
  - Look for HIE, Coops and ACOs as they emerge and participate (as equity partner if you can)

# Strategic Action Plan

## Services

- Primary care disease management services (i.e. chronic disease management program) utilizing chronic care model [www.improvingchroniccare.org](http://www.improvingchroniccare.org)
- Primary care integration services
  - Primary care services in CMHCs
  - BH services specifically organized for primary care settings e.g. Prime Health solutions
- Acute care services (depression, anxiety, phobias, relationship counseling)
  - Be the **best** at treating depression
- Become/ participate as BH benefits manager

# A. Health Insurance Exchange



## HIE Services

1. Offering consumers a choice of health plans by clearly showing covered services and cost sharing (i.e., deductibles, coinsurance or copayments, and out-of-pocket limits), premium costs, plan performance, consumer satisfaction in a standardized manner.
2. Creating an administrative mechanism for enrollment. For people who obtain private insurance coverage, including people buying insurance on their own or who work for small businesses. The exchange could also be used to determine eligibility for and administer income-related subsidies.
3. Moving towards portability of coverage. Coverage through an exchange can be disconnected from employment, helping to make health insurance more portable for people moving from job to job.
4. Exchanges also coordinate enrollment shifts between Medicaid and subsidized private coverage for people with very low and potentially changing incomes.

# Health Insurance Exchange

- A government-administered marketplace or portal (via a website) where private or public insurance policies are sold. Reform proposals would create national or state-based exchanges open to individuals and small businesses. Policies offered there would be vetted by the government to make sure they meet minimum standards and would be less expensive than those now sold on the open market.

Read more:

<http://www.time.com/time/healthcaredebate#ixzz1JM4JyAYf>

[www.kff.org/healthreform/upload/7908.pdf](http://www.kff.org/healthreform/upload/7908.pdf)

[www.healthcarelawreform.com/.../health-insurance-exchange/](http://www.healthcarelawreform.com/.../health-insurance-exchange/)

- Goal: Make it easy for individuals and small businesses to purchase insurance.
- Each state to start a Health Insurance Exchange by 1/1/2015.
- Functions as a clearinghouse for plans.
- Anticipate 9 million enrollees on HIEs by 2019.

# HIE Characteristics

## Benefits to Consumers

- Portability
- Easy plan comparison
- Allows pre-tax purchases similar to employer based plans

## Benefits to Employers

- Decreased administrative burden
- Standard payroll withholding system
- Easy employer contribution

# B. Health Insurance Cooperative

Pools of people band together to collect premiums and pay health-care expenses without the help of the government or private insurance industry. These coops are nonprofit and owned and operated by members. The Senate Finance Committee has proposed the creation of 50 state-based coops as an alternative to a nationwide government-run health-insurance plan. Many policy experts think coops would not be able to pressure the private insurance industry to lower rates as effectively as a federally-run insurance plan, but some moderate Democrats and Republicans in the Senate believe creating these, instead of a federal plan, is the only way for state's buy in.

Read more: <http://www.time.com/time/healthcaredebate#ixzz1JM4bZ2Q1>

# Health Cooperatives

- Cooperatives are member-owned and controlled enterprises that provide mutual benefits. By forming a cooperative, members aim to gain benefits that they could not attain individually. In respect to health care, the benefit would be increased purchasing power from a pooling of health care consumers. It's important to note that membership is voluntary and that cooperative boards are elected by the membership.
- There are three categories of health care cooperatives in the United States: consumer owned, worker owned, and group-purchasing owned by businesses or hospitals. Consumer-owned integrated health cooperatives are the primary vehicle for providing health services to patients, and often are modeled after coordinated-care HMOs. The most successful have been the hospital or business owned, e.g. Kaiser-Permanente, Group Health NW and Harvard-Pilgrim.

# Health Cooperatives Status

- Some 300 health-care cooperatives already exist in parts of the country, including Arizona, California, Minnesota, Tennessee, and Washington state. (Paul Hazen, CEO, National Cooperative Business Assn)
- Coops are able to negotiate directly with health-care providers—doctors, hospitals, and drug companies—thus cutting out the insurance company middleman.
- Cooperatives are regulated at the state level. Health care cooperative HMOs may be regulated by the state department of insurance and/or the state department of health and human services, and/or the state department of commerce

Resources:

[www.commonwealthfund.org/.../Health-Cooperatives-The-Way-Forward](http://www.commonwealthfund.org/.../Health-Cooperatives-The-Way-Forward)  
[www.mass.gov/Eoca/.../SmallGroupHealthPurchasingCooperatives.pdf](http://www.mass.gov/Eoca/.../SmallGroupHealthPurchasingCooperatives.pdf)

# Why Do Coops Matter?



- SEC has reported that the 10 largest health insurers have reported a profit of 428% from 2000 to 2007.
- Health insurance CEOs averaged \$11.9 million in compensation last year.
- Insurance wages rose 262% higher than the average in the private sector during the same period.
- 27% of the commercial healthcare dollar goes to insurance (Medicare is 5%).

— *Toni Hagan, NY Times 8/17/2009*

# C. Accountable Care Organizations

- An ACO is a health care delivery entity through which physicians, hospitals, and other providers coordinate patient care. ACOs are eligible to receive enhanced payments based on their performance. ACOs would bid for Medicare contracts and receive bonus payments for demonstrating higher quality and lower costs. In an ACO, groups of providers share a financial incentive to control costs and improve quality by closely coordinating care. Using evidence-based medicine, ACOs would share “bundled payments” for entire episodes of care.
- In the new law, ACOs can be organized as long as they serve at least 5000 Medicare lives. They are eligible for enhanced payments for superior results.
- ACOs are eligible for payment in January 2012.

# Essential Features of an Accountable Care Organization

- (1) the ability to provide, and manage with patients, the continuum of care across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post acute care;
- (2) the capability of prospectively planning budgets and resource needs; and,
- (3) sufficient size to support comprehensive, valid, and reliable performance measurement

Resources:

<http://pnhp.org/blog/2011/04/04/hhscms-proposed-rule-for-accountable-care-organizations/>

<http://www.commonwealthfund.org/~media/Files/Publications/Other/2011/Proposed%20Rules%20for%20ACOs%20What%20Do%20They%20Say.pdf>

# D. Patient Centered Medical Home

A concept in which a patient's medical care is coordinated by and funneled through a primary-care provider, so that all providers caring for that patient work together to avoid redundancy and miscommunication. This approach is expected to save money and improve the health of patients.

Read more: <http://www.time.com/time/healthcaredebate#ixzz1JM5BOvtI>

<http://www.ncqa.org/tabid/631/default.aspx>

[http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_home/1483](http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483)

# Patient Centered Medical Homes and Serious Mental Disorders

An essential idea in the reform is incenting successful methods in addressing chronic conditions. This translates to the encouragement of the growth of “Medical Homes” for people with chronic conditions. The big reasons for medical homes include:

- The National Association of State Mental Health Program Directors (NASMHPD) found that 3 of 5 persons with serious mental illnesses die due to a preventable health condition. People with serious mental illnesses have significantly higher rates of diabetes, hypertension, heart disease and asthma, among other chronic health conditions.
- The NASMHPD report estimated that people with serious mental illnesses are dying 25 years earlier than the rest of the population.

# E. Community Health Centers: Federally Qualified Health Centers

- There are 1200 community health centers with 7500 clinic sites (there are 1600 CMHCs).
- They served over 20 million people last year.
  - Over 70% of patients seen are at poverty level
  - (For comparison CMHCs see 6 million people)
- Received special attention in PL 11-148.
  - Have \$22 billion in new targeted (non-Medicaid) federal funding administered through the Health Resources Services Administration ([www.hrsa.gov](http://www.hrsa.gov))
  - CHCs are exempted from meeting many insurance laws
  - CHCs are automatically eligible for Medicaid monies
  - 85 new CHCs are currently in process, with more to follow

Resources:

<http://www.nachc.org/>

[https://www.nhpf.org/uploads/announcements/BP79\\_PrimaryCareSafetyNet\\_09-28-10.pdf](https://www.nhpf.org/uploads/announcements/BP79_PrimaryCareSafetyNet_09-28-10.pdf)

# What Do Community Health Centers Have To Do With Public Behavioral Health?

- 10% of all visits in CHCs are to licensed BH professionals
- 77% of CHCs have special BH programs
- CHCs see 1/3 as many poor people for BH issues as CMHCs see (and over three times as many people in total as CMHCs see)
- The incidence of people seen in CHCs for BH issues has tripled since 2004
- CHCs are the new BH safety net provider
- They are also eligible to be a Health Coop



# F. Mental Health Parity and Addiction Equity Act (MHPAE)

- In January of 2010 the MHPAE took effect as the law of the land and again was specifically reinforced in the new health care reform act (PL 111-148)
- Essence: Mental health and addiction benefits must have same co-pays, deductibles, annual and lifetime limits as “routine” physical medicine elements in a health plan
- Impact: Managed care has reduced the number and duration of people’s access to behavioral healthcare. In 1990 over 9% of all healthcare costs were behavioral healthcare related, now that is under 5%. The law suggests many more people will access care and receive more than they have been.
- Added to healthcare reform in which more people are eligible for healthcare coverage and the demand for behavioral healthcare is likely to rise significantly.

Resources:

[https://www.cms.gov/healthinsreformforconsume/04\\_thementalhealthparityact.asp](https://www.cms.gov/healthinsreformforconsume/04_thementalhealthparityact.asp)

<http://www.dol.gov/ebsa/newsroom/fsmhparity.html>

# G. Meaningful Use

The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

Simply put, "meaningful use" means providers need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity.

Resources:

[https://www.cms.gov/EHRIncentivePrograms/30\\_Meaningful\\_Use.asp#BOOKMARK2](https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#BOOKMARK2)

# Meeting Meaningful Use standards

To qualify for incentive payments, meaningful use requirements must be met in the following ways:

- **Medicare EHR Incentive Program**—Eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must successfully demonstrate meaningful use of certified electronic health record technology every year they participate in the program.
- **Medicaid EHR Incentive Program**—Eligible professionals and eligible hospitals may qualify for incentive payments if they adopt, implement, upgrade or demonstrate meaningful use in their first year of participation. They must successfully demonstrate meaningful use for subsequent participation years.
- **Adopted:** Acquired and installed certified EHR technology. (For example, can show evidence of installation.)
- **Implemented:** Began using certified EHR technology. (For example, provide staff training or data entry of patient demographic information into EHR.)
- **Upgraded:** Expanded existing technology to meet certification requirements. (For example, upgrade to certified EHR technology or add new functionality to meet the definition of certified EHR technology.)

## H. State Demonstrations to Integrate Care for Dual Eligible Individuals

- California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.
- Each of the states will receive up to \$1 million in federal funding to design a system that fully coordinates “primary, acute, behavioral, and long-term supports and services for dual eligible individuals.
- Why? This population's health care costs account for 36% of all Medicare spending, while they make up only 21% of Medicare beneficiaries. This same population utilizes 39% of all Medicaid benefits, but makes up only 15% of the total Medicaid beneficiaries.

### Resources:

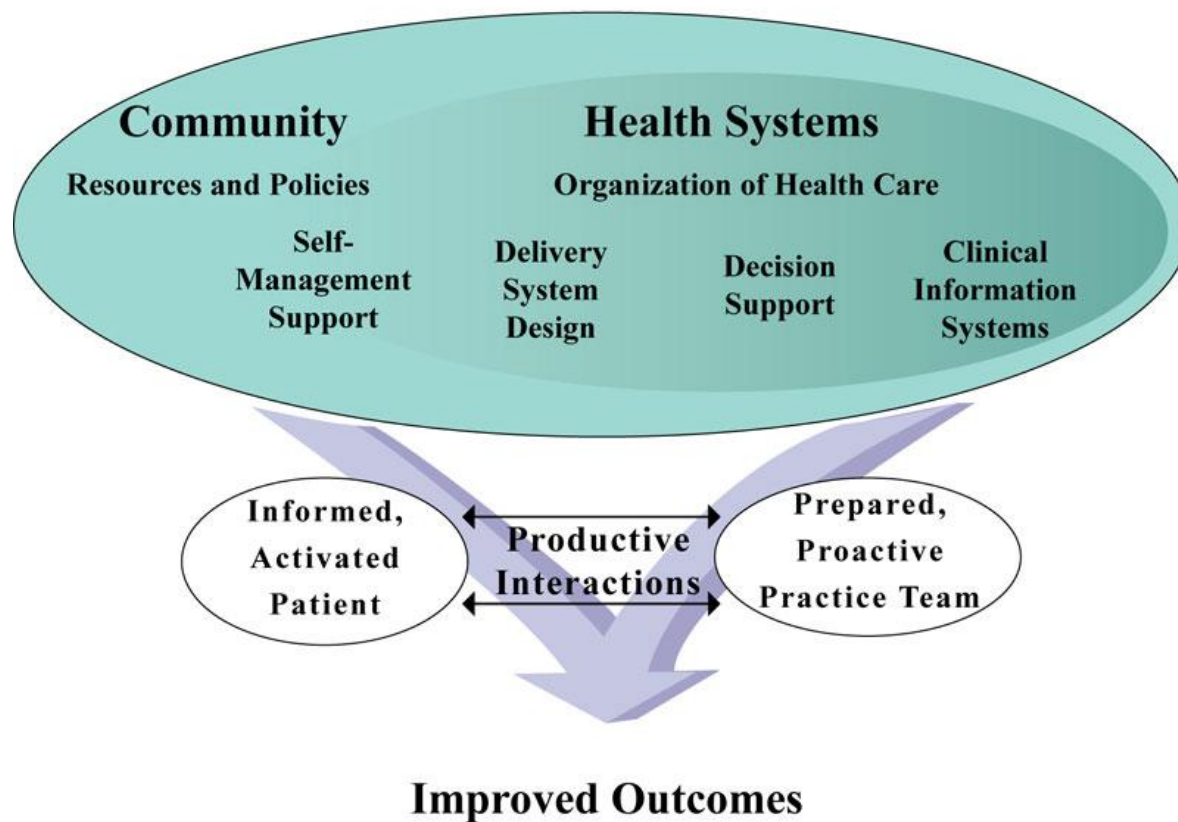
<http://www.cms.gov/ResearchDemoGrantsOpt/Downloads/GrantApplicationGuidelinesDecember2009.pdf>

<http://www.cms.gov/ActiveProjectReports/downloads/2006APRIndexBooklet.pdf>

# Chronic Care Model

[http://www.improvingchroniccare.org/index.php?p=The Chronic Care Model&s=2](http://www.improvingchroniccare.org/index.php?p=The%20Chronic%20Care%20Model&s=2)

## The Chronic Care Model



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

# More Resources on HCR Strategy

## Partnering with/ For ACOs

NACHC: <http://www.nachc.org/AccountableCareOrganizationToolkit.cfm>

NCCBH: <http://www.thenationalcouncil.org/galleries/default-file/ACOs%20and%20Health%20Homes%20Exec%20Summary.pdf>

NCCBH Webinar: [http://www.youtube.com/watch?v=D0z1T3CRh\\_8](http://www.youtube.com/watch?v=D0z1T3CRh_8)

Cigna: <http://www.hc21.org/files/McLaughlin%202011.pdf>

CA Healthcare Foundation:

<http://www.chcf.org/~media/Files/PDF/B/PDF%20BetterFasterSafetyNetProvidersRedesigningCare.pdf>

HealthSystemChange: <http://www.hschange.com/CONTENT/1030/1030.pdf>

Commonwealth Foundation

[http://www.brittenassociates.com/documents\\_pcmh/Commonwealth%20Fund/Commonwealth%20Fund\\_Building%20Medical%20Homes%20in%20State%20Medicaid%20and%20CHIP%20Programs.pdf](http://www.brittenassociates.com/documents_pcmh/Commonwealth%20Fund/Commonwealth%20Fund_Building%20Medical%20Homes%20in%20State%20Medicaid%20and%20CHIP%20Programs.pdf)

## **Partnering with Health Homes and Accountable Care Organizations:**

### **Considerations for Mental Health and Substance Use Providers**

The National Council, 2011

#### **How Will You Position Yourself as a Qualified Partner?**

To ensure their readiness to participate MH/SU providers are urged to undertake the following action steps:

##### **1. Prepare now for participation in the larger healthcare field**

- a. Identify community partners and build relationships, especially with primary care;
- b. Develop competency in team-based care and health homes in particular;
- c. Institute a measurement-based approach to care, incorporating standardized assessment tools into routine service delivery;
- d. Gather data on population served in order to support recognition as a “high-volume” specialty provider; and
- e. Increase skills and knowledge in population health management, including wellness and prevention and disease management

##### **2. Establish credentials as a high performer relative to the triple aim**

- a. Adopt quality tools and train staff in using them to track performance;
- b. Assess clients’ experience of care (including its patient-centeredness and cultural/linguistic competence) and address gaps;
- c. Document MH/SU and general health outcomes (e.g., body mass index) and a plan for improving areas of weaknesses; and
- d. Evaluate the cost and value of the care provided.

##### **3. Ensure information technology readiness**

- a. Institute IT systems that are able to support:
  - i. Exchange of data within and outside the organization;
  - ii. Use of data as a routine part of clinical work;
  - iii. Performance review practices; and
  - iv. Management of new payment structures (including linking performance to payment).
- b. Reach out to community partners to begin forming local or regional health information exchanges.

##### **4. Plan for an extended period of change**

- a. Implement a change management plan;
- b. Identify key resources and support network for staying current around new and emerging practice and financing models; and
- c. Invest in educating board and staff on operational and clinical changes.