

Dear Association Executive,

At the end of September 2010, the first phase of the Patient Protection and Affordable Care Act (ACA) went into effect. While the federal government is charged with implementing and enforcing much of the law, states have a significant role in putting these changes into practice. With few additional resources, major new responsibilities, and dramatic shifts in policies and practices under tight timelines, the challenges are daunting. Yet, states that meet these challenges have the opportunity to transform the healthcare system.

The ACA changes the financing and structure of our healthcare system, putting experimental strategies into practice. And, for the first time in history, this new law treats behavioral healthcare as an essential service in nearly every aspect of the law. How states put this new framework into practice will be of critical importance and will require strategically rethinking many of our traditional advocacy strategies.

This working document is designed to provide tools, strategies, and resources that advocates can use in their efforts to influence the implementation of the ACA in the states. The passage of the ACA underscores the importance of building strategic partnerships not only with state mental health agencies, but also with state Medicaid offices, primary care associations, and insurance commissioners. The new law will require another set of taskforces, committee meetings, and coalitions to track, participate in, and organize. Further, community behavioral health agencies will be required to meet the demands of the new law, including collaborating with other agencies, new billing requirements, and new service demands.

Association Executives can position themselves as key resources for state agencies, state legislators, and other advocacy groups. With some focused coordination with other member agencies, associations can provide specific data points, perspectives and expertise that will aid in creating effective policies and practices with the implementation of the ACA.

Associations do not need to be experts on the entire ACA, but there are key pieces of the ACA that require our attention and expertise. To facilitate this, the National Council has developed a series of fact sheets on the provisions of the law that impact behavioral health issues. By tracking these central portions of the law, and their implementation, associations will be better positioned to ensure that behavioral health issues are not lost in the mix. Key issues that will be addressed in this fact sheet series include:

- Health Insurance Exchanges
- Medical Health Homes
- Medicaid Expansion
- Home and Community Based Waivers
- Accountable Care Organizations

Hopefully, these factsheets will help frame and focus the breadth of information available on these topics.

In many of these areas, the federal government will be issuing grants to assist with implementation, pilot programs, and start-up costs. It will be crucial for state associations to track the release of these grant opportunities and to work with state agencies to ensure that MH/SUD issues are part of the grant applications. The National Council will announce grants as they come available on its blog site (www.mentalhealthcarereform.org), but state associations may want to track the release of RFPs themselves.

There are several core themes that thread throughout the entire ACA implementation. These themes become the approach that Associations need to consider no matter what new initiative we are considering.

- **Get a seat at the table.** Work to ensure that MH/SU interests and perspectives are included throughout the implementation process.
- **Know thyself.** Associations will need to have a detailed and working knowledge of their capacity, technological needs, community needs, and the most effective services for their community to cogently advocate for the right changes in policies.
- **Make new friends.** While the need to work with state Medicaid offices has been true for a long time, the inclusion of MH/SU throughout the ACA makes working with Medicaid, insurance, and primary care essential.
- **Think outside the box.** With new policy changes and more people with access to care, we will have to think creatively about how to increase capacity, reach out to underserved populations, and provide services in a way to meet the demands of the new law.
- **Build new bridges.** With each initiative, community behavioral health organizations will have to think about how to build a greater capacity to provide services, both in terms of service providers but also service locations.
- **Go back to the future.** All of these initiatives will require investment in new technologies, especially technologies that interface with other systems and also measure outcomes.
- **Follow the money.** As always, the money trail will be a deciding factor in how programs will be implemented.

The country is on the cusp of dramatic change to the healthcare system. With behavioral health put on par with other healthcare conditions for the first time in history, we look forward to partnering with you to achieve our shared goal of a healthcare system that meets the overall health needs of individuals being served.

Best Regards,



Linda Rosenberg, MSW
President and CEO

Health Insurance Exchanges

The ACA requires states to establish health insurance exchange(s) or join a regional or national exchange for individuals and small businesses by January 1, 2014. Exchanges will be a portal through which individuals will determine their eligibility for various private insurance plans and federal subsidies.

A health insurance exchange is a government or quasi-government organized body designed to facilitate insurance transparency, promote prevention services, and ensure access to insurance in such a way as to “spread risk” appropriately. Exchanges contract with private insurers, making specific requirements about benefit design, cost sharing, and coverage in order to promote access to affordable, quality coverage.

Several groups have made the analogy that an exchange should function like a travel website, such as Travelocity, that also includes information about quality (e.g., on-time arrivals, lost luggage, and friendliness of the staff).

The ACA requires states to include both bare-bones and more extensive insurance options (bronze, silver, gold, platinum), and MH/SU services are required in even the lowest tiered option. States should:

- Create data-rich health exchanges that require insurance companies to enable consumers to compare costs, benefit levels, and quality of care.
- Structure insurance exchanges to prevent companies from only allowing “healthy” consumers, which will only increase overall healthcare costs.
- Ensure that people without access to the Internet can access the Exchange.

To Do:

- ✓ Gain a working knowledge of Health Insurance Exchanges (See Resource Section)
- ✓ Determine key decision-makers in state exchange design, and whether the state plans to pass any legislation to enact the exchange. The National Association for Insurance Commissioners has released model legislation.
- ✓ Work to ensure that community based behavioral health centers are included in efforts to link data systems.
- ✓ Collaborate with key decision-makers on efforts to reach all populations of individuals.

Resources:

- [American Health Benefit Exchange Draft Model Act](#) (September 2010). National Association of Insurance Commissioners.
- [State Planning Grant Award List](#) (September 30, 2010). Healthcare.Gov.
- [EXPLAINING HEALTH CARE REFORM: Questions About Health Insurance Exchanges](#) (April 2010). The Henry J. Kaiser Family Foundation.
- [Fact Sheet: Using a Health-Insurance Exchange to Pool Risk and Protect Enrollees](#) (April 14, 2009). Center on Budget and Policy Priorities.
- [States Should Structure Insurance Exchanges to Minimize Adverse Selection](#) (August 2010). Center on Budget and Policy Priorities.
- [Implementing Health Insurance Exchanges: A Guide to State Activities and Choices](#) (October 2010). Families USA.
- [Setting Up Health Exchanges is One of the Big Early Tasks for States](#) (October 2010). National Conference of State Legislatures. Rachel Brand.

Medical Homes for Individuals with Chronic Conditions

The ACA authorizes grants for as much as \$25 million to help states plan and implement Medicaid Medical Home pilots to address beneficiaries with chronic conditions, including serious and persistent mental illnesses and substance use disorders. The Medical Home Model of Care shifts the approach of care to one in which the medical team treats the “whole person” rather than a specific diagnosis. Collaboration across disciplines and with the consumer, as well as centralized and organized data, is central to the medical homes approach.

Many states have already explored strategies to increase collaboration between primary care and behavioral health care providers, and the health homes approach builds on the growing recognition that people with mental illness and substance use disorders often have other serious chronic health conditions. With significant amounts of grant money available to states, the concept of health homes is an important area for collaboration.

Key Message Points:

- Research suggests that a health homes model of care is a useful and effective approach to serving people with chronic health conditions, including people with serious mental illnesses and substance use disorders.
- There is no “one size fits all” approach to improving health and health care for persons with behavioral health needs; the appropriate model will depend on patient needs, onsite capacity, the funding environment, and community resources.
- Any health home model developed in a physical healthcare setting needs to account for the patients’ mental health and substance use service needs.
- Any health home model developed in a behavioral healthcare setting needs to account for the patients’ physical health needs.

To Do:

- ✓ Determine if any healthcare home programs or pilots have already been implemented in your state.
- ✓ Identify other programs that promote collaboration between primary care and behavioral health agencies.
- ✓ Collaborate with state mental health agencies, Medicaid office, and appropriate legislators to ensure that mental health issues are included in grant applications.
- ✓ Consider other ways to foster collaboration between CBHOs and primary care.

Resources:

- [Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home](#) (2009). National Council for Community Behavioral Healthcare.
- [Medical Homes Issue Brief](#) (). National Council for Community Behavioral Healthcare.
- [Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Health System](#) (2009). National Council for Community Behavioral Healthcare.
- [Health Policy Issue Brief: Patient Centered Medical Homes](#) (September 2010). Robert Wood Johnson Foundation.
- [Medical Homes and the Integration of Mental Health](#). Bazelon Center for Mental Health Law.

Medicaid Expansion

The ACA includes a significant expansion of Medicaid to an estimated 16 million individuals by January 1, 2014. Under the law, all persons who meet the new national income limit of 133% of the federal poverty level (FPL), regardless of their health status, will be eligible for Medicaid. Research suggests that a significant number of these newly eligible individuals will have behavioral health problems.

States do not have to provide the full array of Medicaid services to these newly eligible people, but may provide “benchmark” benefits. Medicaid expansion benchmark packages must include services relating to mental health and substance abuse treatment to comply with the Mental Health Parity and Addiction Equity Act. Further, while states have significant flexibility in designing benefit packages for these newly eligible individuals, the high reimbursement (100 percent for the first three years and 90 percent thereafter), it incentivizes states to provide these individuals with the full range of care. CMS has not yet issued regulatory guidance on these benchmark benefits.

Ultimately, the expansion of Medicaid will have a major impact on community behavioral health organizations. For some areas of the country, particularly rural areas, the workforce simply does not have the capacity to meet current demands, let alone the anticipated increases in the coming months and years.

Fortunately, the ACA has a series of provisions that invest in the behavioral health workforce to meet the increased demand for services. Provisions include:

- Sec. 5306 allows the HHS secretary to award grants to schools for the development, expansion or improvement of training programs for behavioral healthcare programs.
- Sec. 5203 authorizes funds to repay loans for individuals who work in health professional shortage areas or medically underserved areas for at least two years and provide a pediatric subspecialty service, including pediatric behavioral health services.
- Sec. 5101 established a National Health Care Workforce Commission to evaluate education and training programs to address workforce shortages and needs over time.

To Do:

- ✓ Conduct analysis of current capacity and needs ([Healthcare Reform State Readiness Survey](#)).
- ✓ Meet with state Medicaid office, single state authority and state mental health authority to discuss benefit design for newly eligible individuals.
- ✓ Work with state Medicaid office and state mental health authority to apply for grants to increase behavioral health workforce.
- ✓ Work with mental health authority/single state authority to reach out to individuals lost in the crosshairs of healthcare reform.

Resources

- [Frequently Asked Questions: Health Reform and Medicaid](#) (July 2010). National Council for Community Behavioral Healthcare.
- [Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries](#) (August 2010). The Henry J. Kaiser Family Foundation.
- [Health Reform, Medicaid, and Enrollment](#). The Henry J. Kaiser Family Foundation.
- [Closing the Health Care Workforce Gap: Reforming Federal Health Care Workforce Policies to Meet the Needs of the 21st Century](#) (December 2009). Daniel J. Derksen and Ellen-Marie Whelan. Center for American Progress.
- National Health Service Corps Fact Sheets (2010). The National Council.
http://www.thenationalcouncil.org/cs/public_policy/resources_and_issues/national_health_service_corps

Increased Access to Home and Community-Based Services

Starting October 1, 2010, the ACA enacted changes to Section 1915(i), the Medicaid home- and community-based services (HCBS) option, and established a new state Medicaid option by which states can offer HCBS to individuals who otherwise would require the level of care provided in an institution and broadens the allowable range of services that may be covered. Important aspects of this new option include:

- Individuals no longer have to meet an institutional level of care requirement in order to qualify for HCBS, and these community-based services to persons whose incomes are 300% of the SSI income benefit.
- States may provide a broadly defined range of community-based services to persons with chronic mental illnesses and/or substance use disorders. States can initially provide limited services, and then expand later.
- Benefits can be targeted to specific population groups or specific functional needs groups without violating Medicaid's comparability requirements – this means a state could target persons with chronic mental illnesses.

These provisions provide a key opportunity for community behavioral health organizations to provide the full spectrum of services often needed by individuals with mental health and substance use disorders. Even in the current fiscal downturn, states should consider applying for a Home and Community Based Waiver because it will reduce costs over time, increase federal funds, and maximize state ability to fund a broad range of effective services. A HCBS option can enable more effective care of people with mental illness and substance use disorders and simplify administrative procedures for providers.

To Do:

- ✓ Determine your state's experience with and/or interest in the HCBS waiver (five states have the HCBS waiver, three are currently applying).
- ✓ Become familiar with Medicaid guidance, both recent and forthcoming, and how other states have used the HCBS waiver.
- ✓ Discuss and collaborate with members and other disability advocates on key services essential and a potential framework for a Waiver application.
- ✓ Meet with state Medicaid officials and state mental health officials to explore the potential of applying for the Waiver.

Resources:

- [Dear State Medicaid Director Letter](#) (August 2010). Centers for Medicare and Medicaid Services.
- Focus on Health Reform: [Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law](#) (June 2010). Henry J. Kaiser Family Foundation.
- Slideshow: [Adding Support Services to Medicaid: Now You Can](#) (October 2010). Judge David Bazelon Center for Mental Health Law.

Accountable Care Organizations

As a part of the focus on healthcare quality improvement and cost reduction, the ACA identifies using Accountable Care Organizations (ACOs) as a potential means to attain these goals. Starting January 1, 2012, Medicare providers will be able to form ACOs (Sec. 2706), and Medicaid will establish a demonstration project for pediatric providers to form ACOs (Sec 3022).

ACOs are groups of providers, including primary care physicians, specialists, and hospitals, that agree to be held accountable for the cost and quality of care delivered to a specific population or group of beneficiaries in exchange for financial rewards for cost savings, assuming that certain quality outcomes and consumer protections are met.

In order for an ACO to function effectively, it needs to have a large enough collaboration of providers to cover the continuum of care across different healthcare settings (outpatient, inpatient, rehabilitation); to effectively measure performance outcomes; and to implement significant changes in budget planning. Given how new ACO initiatives are, it will be especially important to ensure that MH/SU is included in the planning process.

The Centers for Medicare and Medicaid Services (CMS) has outlined its expectations for ACOs under its demonstration programs authorized under the ACA. ACOs must:

- Have at least one hospital
- Include a minimum of 50 physicians (primary & specialists),
- be in business at least 3-5 years
- serve at least 5,000 patients.

To Do:

- ✓ Identify who in the state is leading efforts to establish ACOs, both at the agency/legislative level and at the provider level.
- ✓ Determine if there are any ACOs currently operating your state and what the experience for MH/SU providers has been.
- ✓ Use data to offer key strategies to treat people with behavioral health needs in an ACO setting.

Resources:

- [A Guide to Accountable Care Organizations, and Their Role in the Senate's Health Reform Bill](#). March 11, 2010 by Jordan T. Cohen. Health Reform Watch
- [Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries? Timely Analysis of Immediate Health Policy Issues](#)(October 2009) Kelly Devers and Robert Berenson. Robert Wood Johnson Foundation
- [Video Perspective: Creating Accountable Care Organizations](#), with Thomas H. Lee, M.D., Lawrence P. Casalino, M.D., Ph.D., Elliott S. Fisher, M.D., M.P.H., and Gail R. Wilensky, Ph.D.
- N Engl J Med 2010; 363:e. (23October 7, 2010). The New England Journal of Medicine [Accountable Care Organizations in the Era of Healthcare Reform](#). Mark B. McClellan, Director, Engelberg Center for Health Care Reform, American Health & Drug Benefits, Brookings Institute