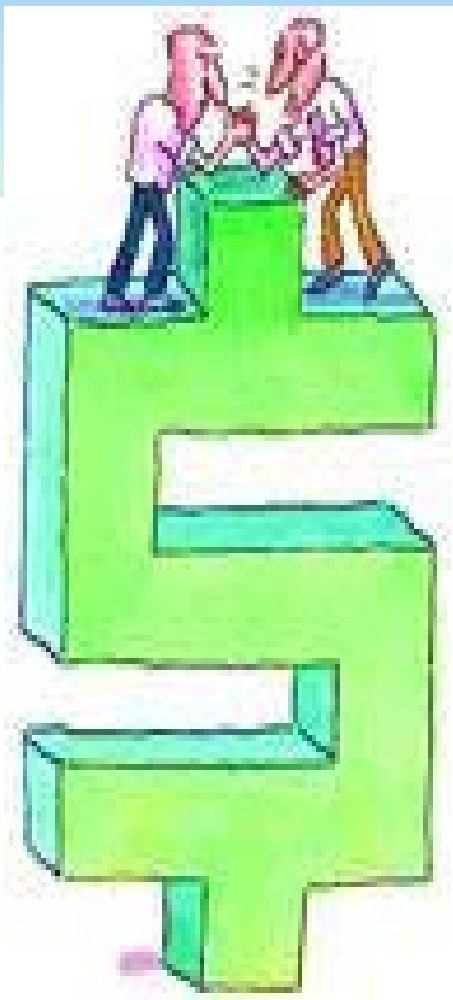


HEALTHCARE REFORM & THE NCSB



September 9, 2011



An epic battle is unfolding
between centers of power
that benefit from a

sick care system

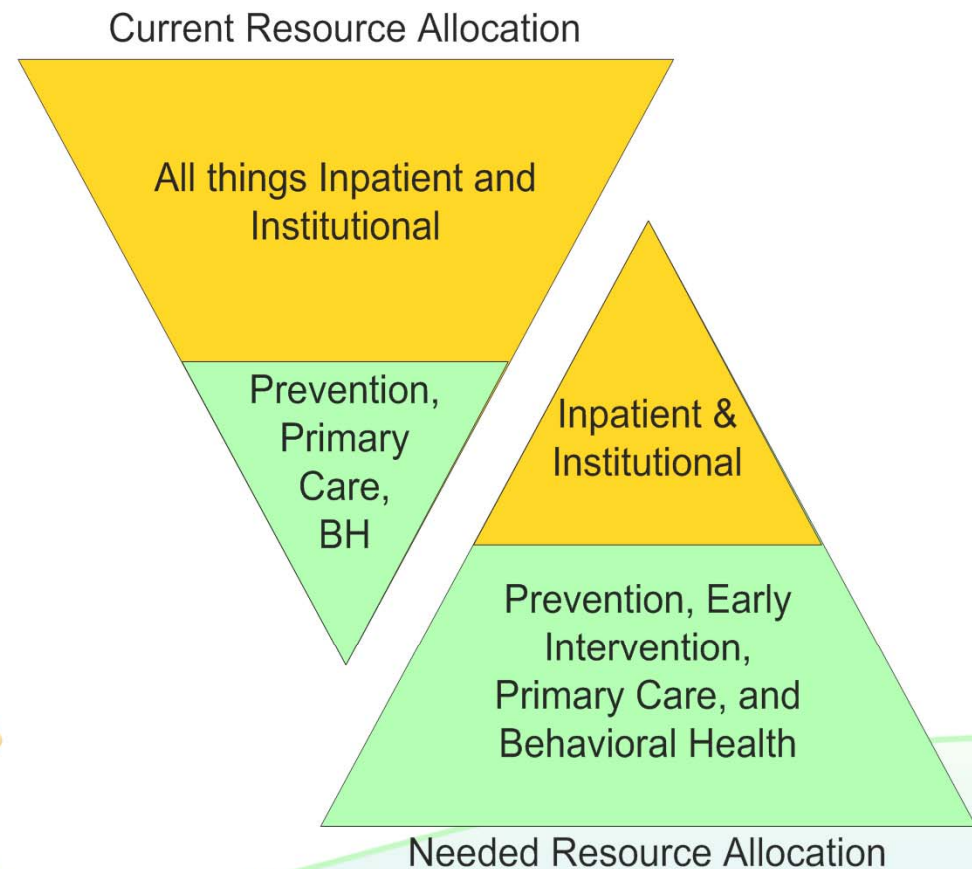
and those that see a
competitive advantage in
creating a true

health care system



Diagramming the Epic Battle

- It's all about Inverting the Resource Allocation Triangle so that:
- **Prevention Activities** are funded and widely deployed
- **Primary Care** budgets in U.S. are doubled
- **Mental Health and Substance Use Disorder Services** are available to all
- in order to **Decrease Demand** in the **High Cost Specialty** and **Acute Care Systems**





Question : If healthcare reform results in the shift from a sick care system to a health care system, how will this affect Americans with mental health and substance use conditions and the organizations that serve them?



HEALTH REFORM

IMPACT OF AFFORDABLE CARE ACT

- **More people will have insurance coverage**
- **↑ Demand for qualified and well-trained BH professionals**
- **Medicaid will play a bigger role in M/SUDs**
- **Focus on primary care & coordination with specialty care**
- **Major emphasis on home & community-based services; less reliance on institutional care**
- **Theme: preventing diseases & promoting wellness**
- **Focus on quality rather than quantity of care**



CHALLENGES & OPPORTUNITIES

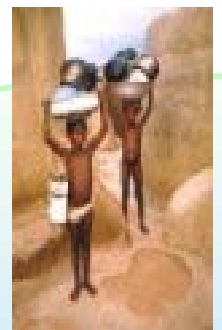
The *Art of Possibility* authors, Rosamund Stone Zander and Benjamin Zander, share this story:

- A shoe factory sends two marketing scouts to a region of Africa to study the prospects for expanding business
- One sends back a telegram saying:

***SITUATION HOPELESS_ STOP_
NO ONE WEARS SHOES***

- The other writes back triumphantly:

***GLORIOUS BUSINESS OPPORTUNITY_ STOP_
THEY HAVE NO SHOES***



DRIVERS OF CHANGE



CONTEXT OF CHANGE

- Budget constraints, cuts and realignments
- Economic challenges like never before
- No system in place to move innovative practices and systems change efforts that promote recovery to scale
- Science has evolved; language is changing
- Integrated care requires new thinking about recovery, wellness, and the related practices and roles of peers in responding to whole health needs
- New opportunities for behavioral health (Parity/Health Reform/Tribal Law and Order Act)



The Triple Aim of Healthcare Reform

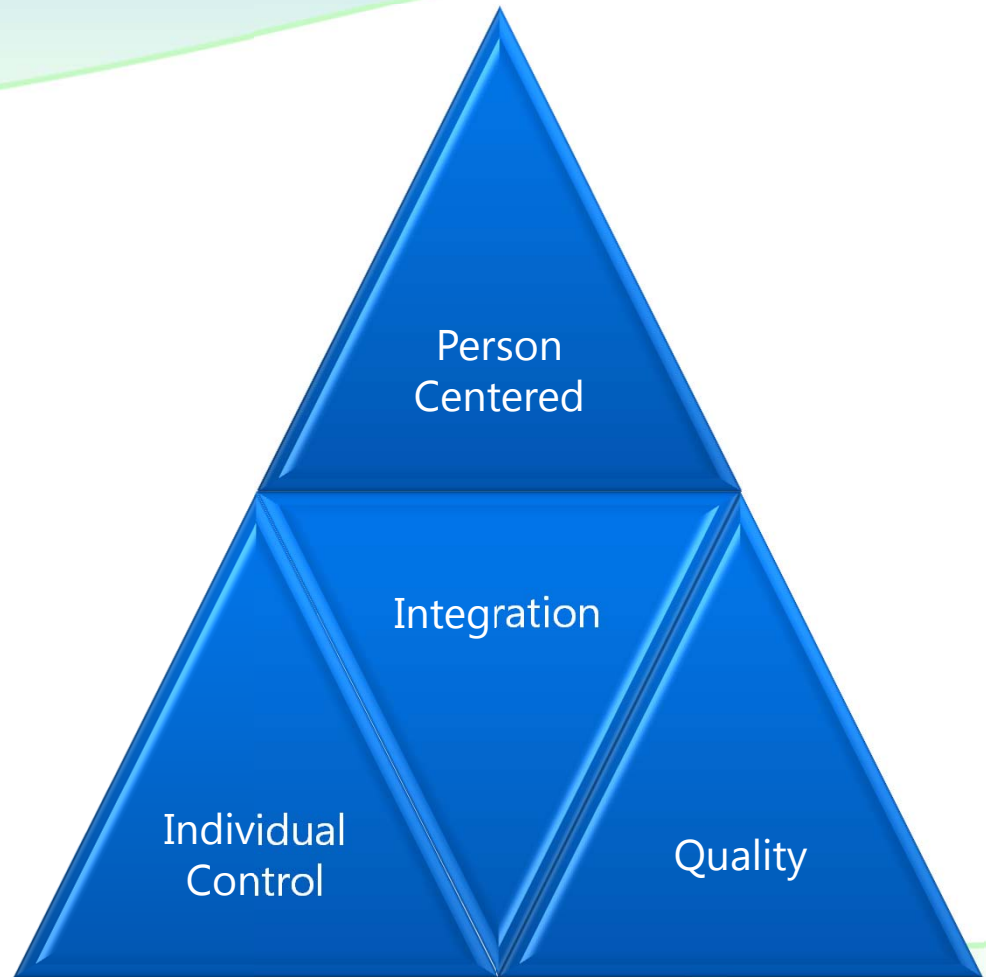
Resulting in recognition that we cannot achieve the Triple Aim *without addressing the health care needs of persons with a SMI and the MH/SU needs of all.*

Better Health

Better Care for All

Reduced Costs

The Foundation for a Redesigned Service System for Individuals with Chronic Conditions



Traditional	The "New" Normal
Inwardly and historically focused	External market orientation
Slow to plan and make decisions	Quick to plan and make decisions
Risk averse	Risk tolerant
Few performance information systems	Widespread real-time performance measurement
Performance data to executives	Performance data to all staff
Compensation based on process and tenure	Compensation based on results
Centralized control	Decentralized empowerment
Bureaucratic and multi-level	Non-bureaucratic with few levels of management
Management training to senior staff only	Widespread staff management training

Common Planning Scenarios For Organizations in Behavioral Health

- **Elimination of 'Safety Net' Funding For Uninsured**
- **Medicaid or Medicare Coverage of SPMI Population Moved To Managed Care or ACOs**
- **Decrease of Fee-For-Service Rates**
- **Expanding Role of Urgent Care Clinics in Community**
- **Payers Increase Coverage of E-Health Services & Remote Monitoring**
- **Increasing Proportion of Behavioral Health Expenditures Paid By Individuals**
- **Mandatory Adoption of EBP Via Comparative Effectiveness Research**
- **Service Provider Organizations Moved To Value Based Payments (VBP's), either Case Rate Contracting, P4P or Global Payments for Primary and Behavioral Healthcare**
- **Widespread Adoption of New Neurotech (Scans, Avatars, Cognitive Retraining, Etc.)**



The New System of Coverage

Medicaid/
CHIP

Employer
Coverage

Exchange



RECOVERY SUPPORT



ACA and Benchmark Plans

- In 2014, benchmark and benchmark equivalent plans must begin providing at least “essential health benefits” (section 1302 (b))
- “Mental health and substance use disorder services, including behavioral health treatment” are included as a category within “essential health benefits”
- MHPAEA/MH Parity applies
- Secretary will issue guidance



- The Affordable Care Act requires that all health insurance plans offered in the state health insurance exchanges – along with Medicaid benchmark plans – offer at least a minimum set of essential benefits. The essential benefit package must include mental health and substance abuse services at parity with other medical/surgical care, prevention services and rehabilitative services – yet the law did not specify specific services that must be covered.



We need to strike a balance between a very narrow benefit that will leave many without essential services and the comprehensive benefits that are covered only by Medicaid. We recommend a skeleton basic benefit, but also suggest that plans be given additional guidance on evidence-based services that can offset unnecessary institutionalization or future treatment costs. The services that we recommend for coverage under the essential benefits package include:

- Inpatient hospital services for mental illness in an accredited institution (plans must comply with federal parity regulation)
- Routine outpatient mental health and substance use services furnished by a licensed practitioner, including psychotherapy and medication management including management of adverse side effects (plans must comply with federal parity regulation)

- Psychotropic and addiction medications (plans must comply with federal parity regulation)
- Psychiatric rehabilitation services consisting at least of skills training to address functional impairments resulting from a serious mental illness, which shall be furnished in any appropriate setting (including on-the-job-site or in the home).
- Screening for suicide ideation in depressed patients



- Patient and family education and self-management assistance for persons with physical and mental disabilities
- Intensive case management
- At least one service designed to avoid institutional placement for chronic and serious mental disorders both for children and adults in order to ensure a sustainable, successful outcome (stability or remission) of a serious or chronic condition.
- Peer support services



NCSB's Proposed Next Steps in Bridging the Gap between Our Current Business Model and Healthcare Reform 2012

To prepare for Value Based Payment(VBP), NCSB must first understand the key VBP principles and models:

- The formation of ASOs- though the Behavioral Healthcare Partnership of Virginia, Inc. The Behavioral Healthcare Partnership of Virginia, Inc. is comprised of the 40 CSB's in the Commonwealth (Harry Bley signed for the NCSB in 1995 – NCSB will continue our membership and will sign an updated partnership agreement.)
- Bundled payments
- Medical home made possible by \$2 million grant

The General Assembly of 2011 wrote intent language for DMAS to privatize by releasing a RFP to managed behavioral healthcare organization (Quad M). It is the current thinking that the award will go to ValuOptions, who has agreed to use the CSB's as the provider network by contracting with the Behavioral Healthcare Partnership of Virginia, Inc.





Final Thoughts on the Implications for NCSB

- I guarantee we are **all** moving into a period of disruption.
- This is going to be hard stuff.
- This will require thinking and acting differently.
- And what unfolds will depend... to a large degree... on what the people in this room do over the next 18 months.



APPROVED

MAR 23 2010

Barack Obama

Are there any Questions?