

SECTION V. TRENDS AND INITIATIVES

IMPACTING PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS

A. Overview of National Trends

While a review of the literature examined for this study reveals numerous trends that currently influence or have the potential to influence public MH/SA systems, three trends, in particular, are likely to have an increasing impact in shaping the future financing of these systems.

Preference for Integrated Care Models

- Payer and consumer preference for integrated services is growing and integrated care initiatives are being implemented and/or proposed in various states.
- Integrated care can result in better coordinated care and outcomes for consumers, as well as administrative simplification and reduced costs for payers of MH/SA services.
- Integration has different meanings and can be defined as integration between one or more of the following:
 - Mental health and substance abuse services
 - MH/SA and physical health care services
 - MH/SA and other human services and disability support services

Role of Medicaid as a Major Funding Source for MH/SA Services

- Medicaid is the largest single source of financing for mental health services and the second largest payer for substance abuse services.
- Given the dominance of Medicaid as a funding source, there may be a shift away from other funding sources, including state general purpose and block grant dollars. The disadvantage to this funding shift is the eligibility and service limits of Medicaid. Other funding sources may provide more funding flexibility to address comprehensive service needs for a broader population.
- Medicaid expansion has resulted in more individuals with MH/SA issues being eligible for Medicaid funded services. However, given the lack of providers in some areas who are willing to accept Medicaid rates, consumers may still lack adequate access to certain covered services, such as psychiatric services and traditional outpatient services.

Financial Incentives and Value-Based Purchasing for MH/SA Services

- Increasingly, payers of MH/SA services and other human services are focusing on strategies to purchase value and to get better results for the funding allocated.
- The focus on performance-based contracting and accountability for consumer outcomes are part of the trend to purchase value as opposed to simply purchasing units of service.

SECTION V. TRENDS AND INITIATIVES

IMPACTING PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS

- In addition, the inclusion of incentives in funding strategies is intended to support and reward systems that implement best practice approaches and achieve improved outcomes.

B. Federal Initiatives and Potential Changes

Public MH/SA systems are also impacted by changes in federal law and regulations. The passage of federal parity legislation for MH/SA and eventual federal health care reform efforts may result in changes that impact the availability and funding for publicly financed MH/SA services. With potentially greater health insurance coverage of MH/SA services through public and private health plans, both parity legislation and health care reform legislation have the potential to decrease demands on safety net provider systems, such as county MH/SA systems. While the specific impacts of these initiatives on Wisconsin's public MH/SA have not been analyzed, this section identifies the key components of the initiatives and their potential impact.

Mental Health and Substance Abuse Parity

- MH/SA parity seeks to equalize MH/SA benefit coverage with physical health benefit coverage, thereby recognizing the importance of MH/SA services as an integral part of most medical conditions. MH/SA parity means that benefits coverage for MH/SA benefits must be at least equal to the coverage provided for physical health benefits. Therefore, any financial requirements and treatments limitations applied to MH/SA benefits cannot be more restrictive than those for physical health benefits. In the past, some health plans have applied higher patient cost sharing and more restrictive treatment limitations to MH/SA benefits than for physical health care benefits.
- The **Mental Health Parity and Addiction Equity Act of 2008** (MHPAEA) substantially increases the mental health benefits protection afforded under the federal Mental Health Parity Act of 1996, which only required parity coverage for lifetime and annual dollar limits and did not apply to substance abuse service benefits. Effective January 1, 2010, MHPAEA requires all group health plans with 50 or more employees to comply with the parity requirements. This means the amount a group health plan covers for physical health benefits, it must also cover for MH/SA benefits.

Impact of Parity on Medicaid

- MHPAEA addresses parity in a variety of settings and programs, including Medicaid health plans and the children's health insurance program (CHIP), thus impacting the BadgerCare Plus and SSI managed care programs (but not Medicaid fee-for-service programs).
- Medicaid Health Plans
 - If a state chooses to cover MH/SA services through Medicaid health plans, these plans must be in compliance with the current law under the Mental Health Parity Act of 1996 (*Ref.* 42 USC s.1396u-2 (b)(8)).
 - If mental health benefits are covered by the Medicaid contract, then all Medicaid managed care organizations must comply with the requirements of MHPAEA and provide for parity for MH/SA benefits.

SECTION V. TRENDS AND INITIATIVES

IMPACTING PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS

- Children's Health Insurance Program (CHIP)
 - Legislation in 2009 reauthorizing CHIP now requires parity. The previous provision to allow states to develop "benchmark equivalent plans" for mental health was eliminated.
 - As of 2008, CHIP applied to 7.4 million children nationally; it is estimated to reach 11 million children by 2013.

- Medicaid Fee-for-Service
 - MHPAEA does not apply to fee-for-service arrangements because the State Medicaid Agency does not meet the definition of a "group health plan," as defined in HIPAA. Section 1932(b)(8) of the Social Security Act (as added by section 4704(a) of the Balanced Budget Act of 1997).
 - The Federal law specifically requires Medicaid managed care organizations to comply with mental health parity by treating them, for that purpose, like health insurance issuers offering group health insurance coverage (as those terms are defined in HIPAA).

- Parity Exemptions
 - The exemptions from the parity provisions in MHPAEA (e.g., exemption for groups with less than 50 employees and cost exemptions in certain situations) apply only to group health plans and to insurance products sold to those plans.
 - The exemptions are not available to Medicaid managed care plans because they are furnishing services in connection with a state Medicaid program, which is not a group health plan. The parity requirements of MHPAEA apply to Medicaid managed care organizations without exemptions.

Status of Parity Regulations

- A Request for Information (RFI) regarding the MHPAEA was published in Volume 74 of the Federal Register (April 28, 2009) by the U.S. Department of Labor (Employee Benefits Security Administration), U.S. Department of Health and Human Services (Centers for Medicare and Medicaid Services), and the Internal Revenue Service. Comments were due by May 28, 2009, and more than 400 groups, government organizations and individuals provided input.

- The federal government is expected to issue its parity regulations by January 2010 when the law is slated to go into effect. It is expected that the regulations will clarify key questions regarding Congressional intent about MH/SA scope of services, medical management deductibles and treatment limitations.

Federal Health Care Reform

Debate continues at the federal level about how to reform the health care system. Achieving comprehensive health care reform has emerged as a leading priority of the President and many members of Congress. Various proposals seek to address health insurance access and affordability, health care costs and/or quality of care issues.

SECTION V. TRENDS AND INITIATIVES

IMPACTING PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS

Expansion of Medicaid:

- Each of the major reform proposals contain provisions for expansion of public programs, including expanding Medicaid to all individuals (children, pregnant women, parents and adults without dependent children) with incomes up to either 133 percent or 150 percent of the federal poverty level (FPL), depending on the proposal.
- Other provisions included in reform proposals require premium assistance to certain Medicaid beneficiaries with access to employer-sponsored insurance, and an increase in the federal medical assistance percentage (FMAP).

Insurance Reforms – Sample Provisions from Different Health Reform Proposals:

- No lifetime and annual benefit limits.
- No coverage exclusion for pre-existing conditions or rejection of applicants for coverage based on their health status.
- Limits on premium rate variation, with no variation on the basis of health status.
- Guaranteed issue and renewal.

MH/SA Protections:

- Both the Senate and House reform proposals, America's Affordable Health Choices Act of 2009 (House Tri-Committee) and the Affordable Health Choices Act (Senate HELP Committee), contain key MH/SA provisions, including strong protections for parity coverage under the health reform.
- Other provisions included in reform proposals require health plans to provide MH/SA and rehabilitation and habilitation services, and require health plans to provide coverage of MH/SA treatment at parity. Initially, there was concern by advocacy groups that the protections afforded by the MHPAEA could be lost in reform proposals unless parity for MH/SA treatment was specifically addressed. And, the proposed requirement that health plans provide MH/SA coverage is a significant achievement, since the current parity law does not require group health plans to cover MH/SA treatment. It only requires that if they cover MH/SA treatment, it has to be at parity with physical health benefits.