



NASMHPD

**CORNERSTONES
FOR BEHAVIORAL HEALTHCARE
TODAY AND TOMORROW:**

**FORGING A FRAMEWORK TO POSITION
STATE BEHAVIORAL HEALTH AGENCIES
TO OPTIMIZE THEIR ROLE
IN THE CHANGING
HEALTHCARE LANDSCAPE**

National Association of
State Mental Health
Program Directors

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NASMHPD

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PREFACE

We are witnessing tremendous change in the financing and delivery of healthcare and behavioral healthcare in the United States. This change will have significant implications for the work of State Behavioral Health Agencies (SBHAs).

In light of these changes and challenges, I am pleased to provide you a new NASMHPD report entitled, “*Cornerstones for Behavioral Healthcare Today and Tomorrow: Forging a Framework to Position State Behavioral Health Agencies to Optimize Their Role in the Changing Landscape of Healthcare*,” (“*Cornerstones*”), which describes 12 major roles SBHAs can contribute over the next two years during this rapidly changing healthcare environment.

In addition, the *Cornerstones* report includes background on key policy issues and several specific state-level actions you can take in an efficient and cost-effective way to be sure that behavioral health concerns and interests are front and center at the state level. Issues addressed in the report include behavioral health and primary care integration, developing new service delivery initiatives, implementing prevention and health promotion programs, improving the quality of behavioral healthcare, and other activities in the delivery and financing of behavioral health services. Further, it includes key suggestions and tools for SBHAs to oversee and implement in the changing healthcare landscape.

We will update this report regularly, and hope that it assists you in advancing your goals and objectives for your agency and the people we serve during this challenging time.

Robert W. Glover, Ph.D.
Executive Director
National Association of State Mental Health Program Directors

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EXECUTIVE SUMMARY

The changing landscape of healthcare delivery and financing is leading to a dramatic shift in the way that behavioral healthcare ¹ services are financed and administered across the nation. States can play a significant role in designing and implementing initiatives to take advantage of opportunities to enhance the quality of and access to all behavioral health services by state residents, particularly those who are the most vulnerable.

This document provides a roadmap for state behavioral health agencies (SBHAs) ² related to service delivery, financing and quality of care. It has been developed to assist SBHAs with planning and implementation of key roles by capitalizing on SBHAs knowledge and experience in the delivery and financing of behavioral health services.

This effort should occur in concert with federal partners at the Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare and Medicaid Services (CMS) and state Medicaid, public health, children's services, housing, employment, aging services, insurance partners and many other agencies.

SBHAs – as they are responsible for overseeing behavioral health services – also will have to track ongoing financed- and delivery-related developments to be well positioned to provide input, make prudent decisions and seize opportunities as they arise in this changing healthcare landscape.

SBHAs have critical contributions to make in the changing healthcare delivery landscape, and supporting consumers and providers. SBHAs understand how to create single points of clinical and financial accountability, how to integrate and align incentives for supportive services that bend the cost curve for healthcare services and behavioral healthcare services, and how to shepherd service delivery system reform.

In the 1970s and 1980s, many SBHAs created single points of access to their care systems embedded at the local level and provided those entities with control over service planning, allocation of resources, and use of high-end services.

¹ For purposes of this document, the term *behavioral health* refers to substance abuse and mental health.

² For purposes of this document, SBHAs is the term used to refer to state substance abuse and mental health agencies.

In those early efforts to integrate access and financial responsibility, the SBHAs were bending the cost curve, away from crisis and institutional care investments and toward more affordable home- and community- based services.

Opportunities abound for SBHAs to be at the table for implementing new healthcare and behavioral healthcare delivery, quality and payment initiatives.

We recommend that SBHAs review all of the key roles and potential actions and prioritize those areas that could significantly address state-specific needs and interests. Once prioritized, SBHAs can begin to directly implement – or assist in promoting – the actions identified under specific roles.

To that end, the following are identified as critical roles for SBHAs:

Cornerstone I

Improve the Coordination of Behavioral Health Services with Primary Care and Supportive Services and Maximize the Use of Available Resources to Effectively Address Behavioral Healthcare Needs by Reducing Fragmentation and Ensuring a Full Spectrum of Care

ROLE 1: Accelerate the necessary linkages between physical healthcare and behavioral health services to promote and achieve recovery for people with mental illnesses and/or substance abuse who also have chronic physical diseases.

ROLE 2: Provide content expertise in the development and implementation of behavioral health aspects of service delivery systems such as medical homes, health homes, and accountable care organizations, as well as related payment initiatives such as bundling and capitation.

ROLE 3: Accelerate the necessary linkages between behavioral healthcare services and the array of supportive services (e.g., supported housing, employment, transportation, education, and training) essential to promote and achieve recovery for persons with persistent mental illness and/or substance abuse.

Cornerstone II

Leverage Mental Illness Prevention, Mental Health Promotion, and Public Health Resources – and Identify and Promote New Public Health Strategies and Practices to Reduce Risks for Behavioral Health Problems – with an Emphasis on Children and Youth

ROLE 4: Develop and implement effective behavioral health promotion, wellness and prevention activities.

ROLE 5: Continue the development and expanded provision of services and supports, including safety-net services that are provided by or under the control of SBHAs, and ensure that proper linkages exist between these services and health and behavioral health services.

Cornerstone III

Coordinate Measurement, Electronic Health Records and Health Information Technology Initiatives as Essential Prerequisites to Improving Behavioral Health Quality in Tandem with a Stable Behavioral Health Workforce that Relies on Explicit Standards of Care and Using Best Practices to Deliver Quality Behavioral Healthcare Services to Maximize Recovery for People with Behavioral Health Disorders

ROLE 6: Provide content expertise on the development of and inclusion of behavioral health quality measures in specifications for electronic health records in the development of health information exchanges and in the public and private sector initiatives to improve the quality of behavioral healthcare.

ROLE 7: Provide leadership to health providers, federal and state policymakers and officials, and national medical societies, including primary care organizations, to ensure the adequacy of providers in the behavioral health workforce to deliver quality behavioral healthcare services.

ROLE 8: Empower consumers to maximize control of their recovery through new and emerging ways to design, apply and organize existing treatments, and by finding new platforms and avenues to deliver new treatments.

Cornerstone IV

Work to Ensure that Public and Private Insurance Plans Operating in the State Adequately Address the Behavioral Health Interests of Eligible Enrollees Through Covered Benefits and Payment Systems

ROLE 9: Serve as the state authority for mental health/substance abuse benefits including, where possible, serving as the contractor for and payer of services on behalf of other state agencies (e.g., state Medicaid program), or by developing the scope and requirements for behavioral health services if contracted for or paid directly by the state Medicaid authority, as well as develop innovative payment systems that recognize and reward performance.

ROLE 10: Provide content expertise on benefits and scope and requirements for behavioral health services – in partnership with state insurance authorities – that are offered in public and private health insurance plans operating in the state.

ROLE 11: Actively ensure the outreach and enrollment of individuals with mental health and substance use disorders so they may receive and maintain health coverage based on their eligibility and are able to easily access care.

ROLE 12: Educate providers, insurance carriers, federal and state policymakers and officials, healthcare providers, consumer organizations and the general public on behavioral health parity within public and private insurance and monitor its implementation.

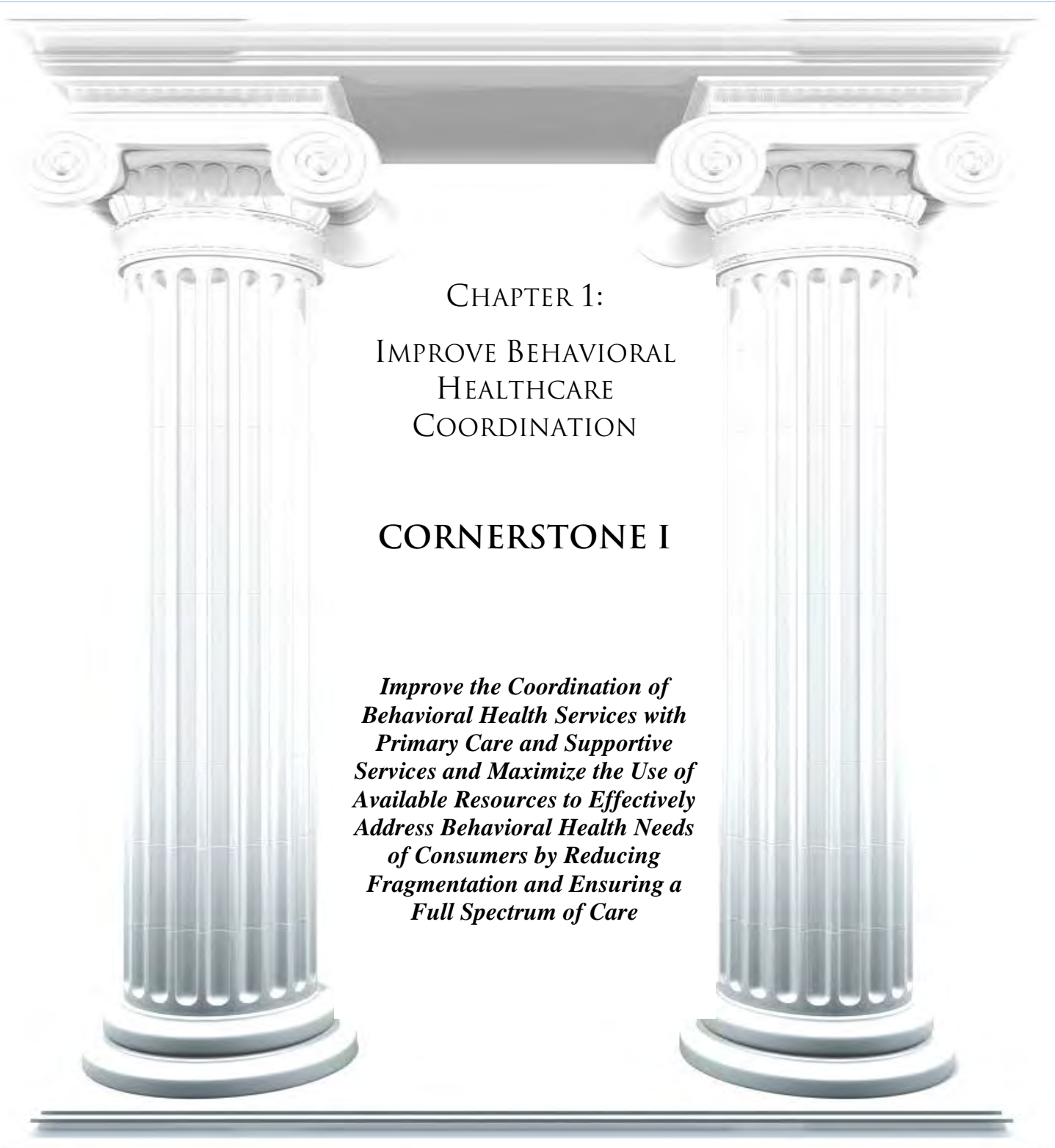
Accepting the Cornerstones Challenge: SBHAs as the Coordinating Voice for Behavioral Health

The overarching role of the SBHA is to serve as a leader within state government focused on coordinating behavioral healthcare across multiple state agencies, involving many state and federal funding streams. As healthcare payment and delivery undergo critical review and evolution, SBHAs understand the need to assure access to adequate housing, employment, vocational, educational supports, and physical health services.

SBHAs are increasingly responsible for coordinating with other agencies to ensure that behavioral health consumers have appropriate and timely access to these services and supports from other systems such as corrections and Medicaid.

The SBHA role is needed within state government to best support policy changes and assure the well-being of people with severe mental illnesses, in an environment of shared responsibility between the SBHAs and other state, local and private entities. That dedicated responsibility takes on an even greater one in the changing landscape of healthcare.

Healthcare delivery and financing reforms cannot succeed in improving access, service quality, or controlling costs without the full inclusion of behavioral health in reforms of financing mechanisms, the delivery system, and the quality of care.



CHAPTER 1:
IMPROVE BEHAVIORAL
HEALTHCARE
COORDINATION

CORNERSTONE I

Improve the Coordination of Behavioral Health Services with Primary Care and Supportive Services and Maximize the Use of Available Resources to Effectively Address Behavioral Health Needs of Consumers by Reducing Fragmentation and Ensuring a Full Spectrum of Care

ROLE 1: Accelerate the necessary linkages between physical healthcare and behavioral health services to promote and achieve recovery for people with mental illnesses and/or substance abuse who also have chronic physical diseases.

Background

The rapidly changing healthcare landscape presents a unique set of opportunities to bring health coverage to more Americans. It brings with it new challenges and opportunities as to how individuals with chronic diseases of persistent mental illness and/or substance use can best receive primary care and behavioral health services.

The needs of individuals with severe mental illnesses, such as schizophrenia, bipolar disorder or major depression, are not dissimilar to the needs of individuals with chronic illnesses, such

The needs of individuals with severe mental illnesses, such as bipolar disorder or major depression, are not dissimilar to the needs of individuals with chronic illnesses, such as diabetes, cancer or cardiac disease.

as diabetes, cancer or cardiac disease. Caring for those struggling to manage long-term illnesses is complex. Good care requires case management and a range of individualized services. Integration of primary care and behavioral healthcare are critically important to positive outcomes. Additionally, rehabilitation, changes in behavior and provision of support services are all important contributors to good outcomes.

Behavioral health conditions are a major driver of increased expenses in healthcare delivery systems and poor to fair health outcomes as the following statistics highlight:

- Over 12 million visits to emergency departments on an annual basis are due to individuals with mental health and substance use disorders; many people are unable to make an appointment to see a primary care physician.¹
- Over 70 percent of primary care visits stem from psychosocial issues. Most primary care physicians are not equipped or lack the time to fully address the wide range of psychosocial issues that are presented by patients.²
- Americans with severe mental illness (SMI), on average, only have a 53-year lifespan – 25 years younger than the average life-span for Americans without mental illness. And according to one study those Americans with co-occurring disorders (substance use) are dying, on average, at age 45.³
- Nearly half of all cigarette consumption is by individuals with behavioral health disorders.⁴

Americans with severe mental illness, on average, only have a 53-year lifespan – 25 years younger than the average life-span for Americans without mental illness.

- Healthcare expenditures of Americans with serious mental illness are two to three times higher than other patients.⁵
- Over 50 percent of all lifetime cases of substance use disorders begin at age 14 (essentially the same for mental health disorders) and three-fourths by age 24.⁶
- Nearly three in four individuals receiving Medicaid coverage with significant mental health and substance use disorders had at least one chronic health condition, nearly half had two chronic diseases and almost one-third had three or more conditions. When individuals have three or more physicians, those physicians usually do not talk with another or share information.⁷
- The annual total estimated societal cost of substance abuse in the United States is \$510 billion.⁸

Increased integration of behavioral health and healthcare services should be a priority at the national, state, local and person levels. Behavioral health conditions are under-diagnosed and under-treated in the U.S. despite their high prevalence in the population and solid research pointing to the fact that treatment works, prevention is possible, and recovery is achievable.⁹ Behavioral health

Behavioral health conditions are under-diagnosed and under-treated in the U.S. despite their high prevalence...but treatment works, prevention is possible, and recovery is achievable.

conditions commonly co-occur with other chronic health conditions in adults and yet services are rarely delivered in concert. These findings suggest the importance of having screening, evaluation and diagnostic services available at multiple access points in primary care and behavioral healthcare networks.

The acute shortage of both behavioral health and primary care providers in many areas makes the provision of care, particularly integrated services, difficult. This problem is compounded by the fact that both primary care and behavioral health providers often are not trained or educated about how to work in an integrated setting, resulting in a disconnect between the two cultures of care. In spite of these challenges and barriers, states have many opportunities to work with stakeholders to help bridge the gaps in primary care and behavioral health delivery systems and promote integration.

There is a new emphasis on innovation and coordinated care, which has spurred investment in new integrated healthcare delivery models. Developing a system of integrated behavioral healthcare is particularly critical for the treatment of individuals with co-occurring mental health and substance use disorders. Behavioral healthcare systems have more frequent contact and more opportunities to change health outcomes.

The Changing Healthcare Landscape that Addresses the Linkage Between Behavioral Health and Primary Care Services

A State Medicaid plan option has been created to provide health homes for persons with multiple chronic conditions. Importantly, two of the six chronic conditions defined in this option are a serious mental health condition and a substance use disorder. Health homes may be established in primary care settings or specialty care settings, depending on the resources available in those settings, the consumers' needs, and established relationships with caregivers.

Over \$50 million in grants has been authorized to co-locate primary and specialty care in community-based behavioral health settings.

The purpose of this grant program is to coordinate and integrate services for adults with mental illnesses who have co-occurring primary care conditions and chronic diseases. Primary and specialty care services in community-based mental and behavioral health settings (such as community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs) will be co-located.

Initiatives that seek to prevent and reduce the incidence of chronic diseases also have the potential to improve the care and outcomes for people with behavioral health disorders. Individuals with serious mental illness should be a focus and the general initiative should be seen as addressing mental illness. The Secretary of Health and Human Services (HHS) has been authorized to award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs, which must be comprehensive and must have demonstrated success in helping individuals in areas such as lowering or controlling cholesterol and blood pressure, losing weight, quitting smoking, and managing or preventing diabetes, may also address co-morbidities, such as depression, associated with these conditions (see Roles 3 and 4 for additional information).

Initiatives that seek to prevent and reduce the incidence of chronic diseases also have the potential to improve the care and outcomes for people with behavioral health disorders.

SBHAs should work with Medicaid officials and healthcare providers to provide the means and incentives necessary to integrate medical and behavioral health services to improve the overall quality of patient care.

The HHS Secretary may also award community transformation grants for programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or behavioral health disorders.

Goals for Role 1

Action. SBHAs could work closely with state Medicaid offices to ensure that behavioral health is included in health homes created for all chronic conditions and to carefully evaluate the potential for health homes for individuals with serious and persistent mental health conditions.

NASMHPD recommends that health homes be established to align with consumer needs and consumer preferences. In addition, NASMHPD promotes a single, integrated point of clinical responsibility for the individual, moving away from fragmented, fee-for-service reimbursement. This concept of a single point of clinical responsibility has long been a foundation of sound community behavioral healthcare systems promoted by SBHAs, although the execution has been challenging given the fragmentation in financing for care.

Action. SBHAs should work with Medicaid officials and healthcare caregivers to provide the means and incentives necessary to integrate medical and behavioral health services to improve the overall quality of patient care. For example, SBHAs could work with the state Medicaid plan to eliminate barriers to integrated behavioral healthcare, such as policies that prohibit billing multiple services on the same day.

Action. SBHAs could consider collaborating with behavioral health providers or other entities in designing and testing new service delivery models. Services provided in health homes, for example, must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral to community and social services. The full inclusion of behavioral health prevention and treatment services should be an essential part of all health homes.

SBHAs should promote the adoption of innovative healthcare delivery models by developing new purchasing practices...

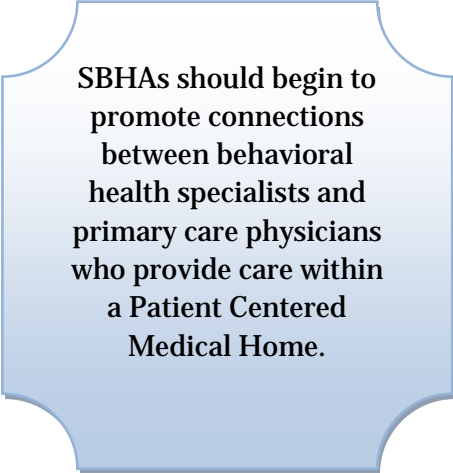
Action. SBHAs should promote the adoption of innovative healthcare delivery models by developing new purchasing practices (e.g., practices that incentivize providers to deliver care for co-occurring mental health and substance use disorders) or using their funds to invest in infrastructure that would support these models. SBHAs could identify and promote value-added roles for behavioral health services in primary care and facilitate a dialogue between providers.

Action. SBHAs could strongly support the continued investment in co-location of primary care services in behavioral health settings and the robust evaluation of these programs and their ability to improve health status, especially those with serious mental illness.

The need for clinical integration and services coordination may be most obvious for those individuals with multiple health conditions, but modern system goals for health promotion and prevention in the broader population are dependent upon greater efforts to integrate and coordinate behavioral health services in primary care and specialty care settings. Research

into the co-location of primary care services within mental health or substance use settings indicates positive outcomes in the form of improved health status.¹⁰

In several settings, the use of nurse care managers provided effective support for individuals with serious mental illnesses. Early research on substance use in the Kaiser Northern California population documents savings in overall healthcare costs as well as improved outcomes. SAMHSA has expanded by \$50 million an existing grant program to co-locate primary care services in specialty MH settings. The initial awards to states provided community mental health organizations with funding to provide primary care services and wellness and prevention services to their clients, either directly or via partnerships with agencies.



SBHAs should begin to promote connections between behavioral health specialists and primary care physicians who provide care within a Patient Centered Medical Home.

Action. SBHAs should begin to promote connections between behavioral health specialists and primary care physicians who provide care within a Patient Centered Medical Home (PCMH). Once health teams are established, SBHAs could also consider ways to collaborate with health teams to foster integration of community-based behavioral health resources within disease prevention and disease management efforts.

NASMHPD's Medical Directors Council developed a technical paper that considered both population-based and person-centered approaches to care.

The report can be accessed at:

http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Consumer%20Involvement%20with%20Persons%20with%20SMI%20Final%20Part%201...rev.pdf

Members of the NASMHPD Medical Directors Council are also leaders in their SBHAs and should engage medical leadership in their state public health and Medicaid authorities to promote integration of health and behavioral health issues in state level health policy, planning and reimbursement.

Action. Medical Directors could disseminate data at the state/local level on the association of behavioral health issues with health risk and chronic disease in the general population.

Action. In regard to strategies to support the integration of behavioral health into primary care, SBHAs could promote and help pediatric practices create a framework strategy for integration. Three broad categories of service models that primary care providers could adopt in order to provide behavioral health services to children are: consultation, co-location and collaboration.

ROLE 2: Provide content expertise in the development and implementation of behavioral health aspects of service delivery systems such as medical homes, health homes and accountable care organizations, as well as related payment initiatives such as bundling and capitation.

Under this role we have separated the background descriptions and key actions associated with health homes and accountable care organizations.

Health Homes and Service Delivery

Background

The concept of a single point of clinical responsibility has long been a foundation of sound community behavioral healthcare systems, although the execution of coordinating services has been challenging given the fragmentation in financing for care in behavioral health systems.

SBHAs pioneered the concept of a single point of clinical and financial responsibility in the 1970s and 1980s, creating local, area and/or regional mental health authorities within their states that managed all funding sources and access to care.

SBHAs pioneered the concept of a single point of clinical and financial responsibility in the 1970s and 1980s, creating local, area and/or regional mental health authorities within their states that managed all funding sources and access to care. Many SBHAs created single points of access to their care systems

embedded at the local level and provided those entities with control over service planning, allocation of resources, and use of high end services. In those early efforts to integrate access and financial responsibility, the SBHAs were bending the cost curve, away from crisis and institutional care investments and toward more affordable home- and community- based services.

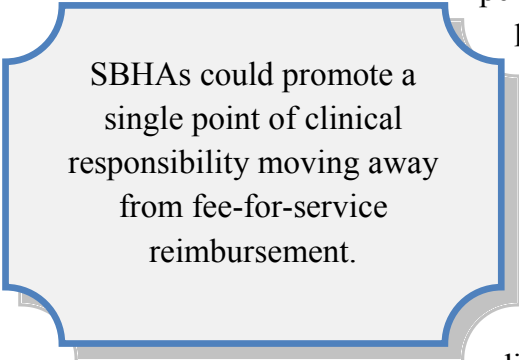
NASMHPD has called for the creation of a "patient-centered medical home" for individuals who have mental illnesses, as these individuals so often have co-morbid substance use and other serious medical conditions.

Health homes are collaborative care models that offer the opportunity to improve coordination and integration of behavioral health and primary care systems. Highly functioning and responsive health homes can enhance efficiency and quality while improving access to needed healthcare and support services, including appropriate referral and linkage with specialty services such as community behavioral healthcare.

In 2008, NASMHPD called for the creation of a "patient-centered medical home" for individuals who have mental illnesses, as these individuals so often have co-morbid substance use and other serious medical conditions.

The call is contained in a report, “*Measurement of Health Status for People with Serious Mental Illnesses.*”¹¹ The report described the medical home as a platform for bringing together a primary care/physical health provider and specialty behavioral health services practitioners to provide collaborative care using disease management strategies based on the chronic care model. SBHAs should assure that financing mechanisms align with, and promote, a single, integrated point of clinical responsibility for the individual, moving away from fragmented, fee-for-service reimbursement.

A key component of health home effort is the availability beginning in 2011 of a new Medicaid state plan option for the provision of health homes (also called medical homes) for Medicaid enrollees with chronic conditions, including mental health disorders under the oversight of SAMHSA. States must use health homes that meet certain defined standards, consult with the SAMHSA about addressing behavioral health issues, monitor and report on performance and outcomes, and develop and implement a proposal for using health information technology in provision of health home services.



SBHAs could promote a single point of clinical responsibility moving away from fee-for-service reimbursement.

In addition to promoting the use of medical homes for Medicaid individuals with behavioral health disorders, SAMHSA supports and promotes the community behavioral health provider’s role in establishing health homes that promote coordination of care for individuals with serious behavioral health disorders.

The Changing Healthcare Landscape that Addresses Delivery System Reforms – Health Homes

Although the health home concept has been around for 40 years, there has been new found attention to this model of care delivery. In a health home, an individual is assigned to a personal physician who manages the individual’s whole healthcare by coordinating with other qualified professionals, including specialists. The personal physician in the health home guides the patient through preventive, chronic, and acute care, and will work with the individual and his or her family to provide appropriate referrals to hospitals, ancillary care services, community care and residential services.

Grants to states are available to establish community-based, interdisciplinary, inter-professional health teams to support primary care practices within the hospital service areas covered by the entity. Each health team must establish contractual agreements with primary care providers who manage care through the health home model. Health home teams must also collaborate with existing state and community-based resources to coordinate disease prevention and disease management.

To further incentivize states to select this option, CMS has been awarding planning grants to states for the purposes of developing a Medicaid state plan amendment and will provide a 90 percent payment match for new services provided during the first eight quarters in which any eligible recipient is enrolled in health home program pursuant to the Medicaid state plan. Importantly, two of the six chronic conditions defined in the law are a serious mental health condition and a substance use disorder.

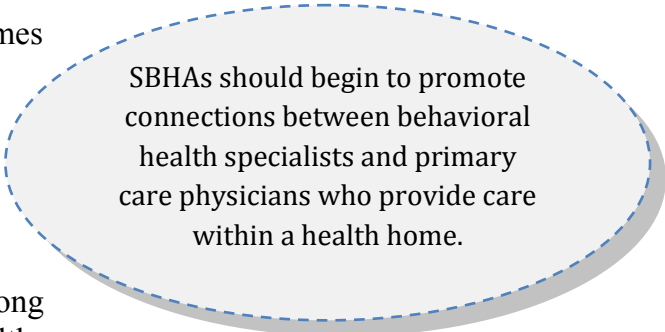
The 90 percent match is significant as Medicaid rates have historically been low and that health home services related to behavioral health services that are eligible for the substantial match include: comprehensive care management; care coordination and health promotion, comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to community and social support services; and the use of health information technology (HIT) to link services.

The health home model holds real potential to improve the care of people with behavioral health problems, especially those with major illnesses and chronic co-morbid conditions that require long-term care provided across acute, transition, and community settings.

Goals for Role 2 – Health Homes

Action. SBHAs could work closely with state Medicaid offices to ensure that behavioral health is included in health homes for all chronic conditions and to carefully evaluate the potential for health homes for individuals with serious mental illnesses. **(Exhibit 1)**

Action: SBHAs should recommend that health homes be established to align with consumer needs and consumer preferences. Financing mechanisms must align with these objectives and promote a single, integrated point of clinical responsibility for the individual, moving away from fragmented, fee-for-service reimbursement. As noted, a single point of clinical responsibility has long been a foundation of sound community mental healthcare systems. Services provided in health homes must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral to community and social services.



SBHAs should begin to promote connections between behavioral health specialists and primary care physicians who provide care within a health home.

Action. Services provided in health homes must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral to community and social services. NASMHPD and SBHAs should recommend the full inclusion of behavioral health prevention and treatment services must be an essential part of all health homes.

SBHAs could begin to promote connections between behavioral health specialists and primary care physicians who provide care within a health home. Once health teams are

established through the grant program, SBHAs could also consider ways to collaborate with health home teams to foster integration of community-based behavioral health resources within disease prevention and disease management efforts. SBHAs could weigh in on or provide training for health home practitioners, who will be receiving increased reimbursement, to provide enhanced services they may not understand or know how to provide or arrange.

Exhibit 1

“The Mental Health and Medical Health Care Program in Community Mental Health Centers” in Missouri pioneered a program for Medicaid beneficiaries with severe mental illness that is based in community mental health centers (CMHCs) and provided care coordination and disease management to address the “whole person,” including both mental illness and chronic medical conditions.

The initiative is a partnership among Missouri’s Departments of Mental Health, MO HealthNet (Missouri’s Medicaid agency), and the Missouri Coalition of Community Mental Health Centers.

CMHCs already see patients as many as several times per month to arrange for mental health and social services, and they foster ongoing, personal relationships with patients, so they have opportunities to coordinate care and help patients adhere to treatment. MO HealthNet also developed a primary care–based health home for people with chronic conditions that do not involve significant mental illness.

Missouri’s CMHC-based health home model leverages an existing mental health system, with added training for providers on chronic conditions as well as the use of data and analytic tools. CMHCs are designated as the central care coordination site for patients without a regular primary care provider. All Missouri CMHCs have a primary care nurse liaison on site to educate the behavioral health staff about physical health issues and train case managers in recognizing and managing chronic medical conditions and coordinating and integrating mental health disease management with Medicaid disease management.

Accountable Care Organizations and Service Delivery (ACOs)

Background

ACOs are comprehensive, vertically and horizontally integrated care systems designed to manage and coordinate care, with strong parallels to public mental health system constructs for a single point of clinical and financial accountability and comprehensive home- and community-based services systems. In some jurisdictions, ACOs are forecast to supplant the functions of managed care plans and managed behavioral health organizations.

With their focus on effective, coordinated care for the whole person, ACOs hold the potential for improving the health and wellness of consumers they serve, including people with serious mental illnesses and other behavioral health conditions. Access to effective behavioral care services will be critical to the effectiveness of both ACOs as well as health homes. Regardless of the ultimate fate of Federal health policy initiatives, health homes and ACOs will be foundational elements of the future healthcare system, and behavioral health providers must immediately begin positioning themselves to be recognized as qualified partners.

The Changing Healthcare Landscape that Addresses Service Delivery Issues -- ACOs

The ACO program, administered by CMS, is required to begin on January 1, 2012. This is not a demonstration project or pilot, but it creates a new entity that can directly contract with Medicare.

An ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve under Original Medicare (that is, those who are not in a Medicare Advantage private plan). The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries, while improving quality and lowering costs. The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions. Patient and provider participation in an ACO is purely voluntary.

The Medicare Shared Savings Program will financially reward ACOs that lower growth in healthcare costs while meeting performance standards on quality of care and putting patients first...

The Medicare Shared Savings Program will financially reward ACOs that lower growth in healthcare costs while meeting performance standards on quality of care and putting patients first by allowing the ACO to share in accrued savings.

To share in savings, ACOs must meet quality standards in five key areas:

- Patient/caregiver care experiences;
- Care coordination;

- Patient safety;
- Preventive health; and
- At-risk population (such as people with mental illnesses)/frail elderly health.

Goals for Role 2 -- ACOs

Action. The changing healthcare landscape is intended to encourage physicians, hospitals, and certain other types of providers and suppliers to form ACOs to provide cost-effective, coordinated care to Medicare beneficiaries. At a basic level, an ACO is a network of physicians, hospitals and other health providers that work together to improve the quality of healthcare services and reduce costs.

SBHAs could advocate that specialty behavioral healthcare providers be included as ACO participants. SBHAs may also want to encourage certain behavioral healthcare providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related. To the extent that SBHAs rely on managed behavioral health organizations (MBHOs) for key care, network, utilization and quality management functions, SBHAs could advocate that these key functions be adopted by any ACOs established to replace MBHOs.

Action. SBHAs could help behavioral healthcare providers decide to potentially merge with an ACO (or health home), or partner with them on a contract basis, by placing providers in the ACO or health home. A behavioral healthcare provider may function as a specialty provider receiving referrals from the health home or ACO, with a business agreement that facilitates the referrals. It may also become a health home for people with severe conditions – obtaining recognition as a health home or partnering with an entity (e.g., a federally qualified health center) that has health home status. Which path the provider chooses to take will depend on the types of services it wishes to provide, how it wants to position itself in the larger health system, and the resources it has available.

SBHAs could help behavioral healthcare providers decide to potentially merge with an ACO **(or health home)**, or partner with them on a contract basis, by placing providers in the ACO or health home.

Action. ACOs will be eligible for enhanced payments based on shared savings if they meet quality performance standards including the adoption of electronic prescribing and health records. This provision underscores the importance of behavioral health records integration, enabling behavioral health providers and care networks to play as full partners in ACOs. SBHAs, with their special knowledge on public systems, could provide expertise which results in the full inclusion of behavioral health in ACOs, including behavioral health records integration.

ROLE 3: Accelerate the necessary linkages between behavioral healthcare services and the array of supportive services (e.g., supported housing, employment, transportation, education and training) essential to promote and achieve recovery for people with persistent mental illness and/or substance use.

Background

SAMHSA has developed a report that is being updated regularly, which lays out a vision for “a good and modern mental health and addiction system.” It is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a “good” and “modern” system of care is to provide a full range of high quality services – from inpatient to home- and community-based services – to meet the range of age, gender, and cultural needs presented.¹²

SAMHSA has developed a report that is being updated regularly, which lays out a vision for “a good and modern mental health and addiction system.”

The interventions that are used in a good system should reflect, according to the report, the knowledge and technology that are available as part of modern medicine and include evidenced-informed practice; the system should recognize the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, education, and transportation.

Services shown to be effective should be available to address current health and behavioral health disparities and respond to the diverse cultures and languages of individuals and families.

Services shown to be effective should be available to address current health and behavioral health disparities and be relevant to, and respond to, the diverse cultures and languages of individuals and families. A wide range of effective services and supports should be available based on a range of acuity, disability, enrollment levels and consumer preferences. The consumer’s resilience and recovery goals in their individualized service plan should dictate the services provided.

The good and modern system should incorporate the different functions that are performed within various parts of the behavioral healthcare delivery system. General hospitals, state mental health hospitals, community mental health centers, psychiatric/psychosocial rehabilitation centers, child guidance centers, private acute inpatient treatment facilities, licensed addiction agencies, opioid treatment providers, individually licensed practitioners, primary care practitioners, and recovery and peer organizations all have key roles in delivering behavioral health services.

The report highlights that changes in the healthcare delivery and financing system will likely push the specialty system to coordinate care among providers of different levels and modalities of care and the mainstream healthcare delivery system, especially for children and youth, where many of the services are provided outside of the specialty mental health and

addiction treatment delivery system. Those linkages include the education, child welfare or juvenile justice systems.

A small percentage of adults with serious mental illness and children with serious emotional disturbances consume a majority of resources.

A small percentage of adults with serious mental illness and children with serious emotional disturbances consume a majority of resources. An integrated system of supports and services should develop improved strategies for these individuals who may be underserved or poorly served in the current system.

A modern system should have prevention, treatment and recovery support services available both on a stand-alone and integrated basis with primary care and should be provided by appropriate organizations and in other relevant community settings. SAMHSA's proposed continuum comprises of nine domains, including:

- Prevention and Wellness Services
- Health Homes
- Enrollment Services
- Outpatient and Medication Assisted Treatment
- Intensive Support Services
- Other Living Supports
- Out of Home Residential Services
- Acute Intensive Services
- Community Supports and Recovery Services

The unemployment rate of persons with severe mental illnesses remains extraordinarily high – up to 80-90 percent, according to some estimates.

Employment and housing should receive special attention by SBHAs. In its final report, the President's New Freedom Commission on Mental Health identified meaningful employment and housing supports as being profoundly vital to the well-being of individuals with behavioral health problems.¹³

Often times limited access to meaningful employment supports, fear of losing government benefits, cognitive impairments that create challenges in the working world, and other factors are associated with this low employment rate. And yet, employment has been shown to play a vital role in social inclusion and feelings of empowerment.

The unemployment rate of persons with severe mental illnesses remains extraordinarily high – up to 80-90 percent, according to some estimates.¹⁴ Persons with severe mental illnesses are one of the largest populations receiving federal disability payments. They are more likely to enter the disability system at a younger age and remain in the system longer than persons with other types of disabilities.

Employment is not the only problem people with serious behavioral health conditions face. The shortage of affordable housing and accompanying support services prevent individuals with behavioral health conditions from achieving recovery and living and fully participating in their communities.

NASMHPD recognizes that housing and housing supports are essential factors in the stability and recovery of people with mental illness, and recently issued a position statement to affirm its commitment to:

- Development and sustainability of decent, safe, and affordable housing;
- Availability of flexible and individualized quality housing services and supports;
- Housing policies that do not tie the status of mental health treatment to the acquisition or preservation and retention of housing;
- More active and determined effort by the federal government to protect and bolster current federal housing policies and programs; and

Individuals with severe behavioral health conditions need to have the option of living in decent, stable, affordable, integrated, and safe housing...

- SBHAs will provide leadership in the housing arena, especially in housing development.

Individuals with severe behavioral health conditions need to have the option of living in decent, stable, affordable, integrated, and safe housing that reflects individual choice and available resources. Options

should maximize opportunities for participation in the life of the community and promote self-care, recovery, wellness and citizenship. Individuals should not be required to change living situations or lose their place of residence if they are hospitalized and they should be able to choose their living arrangements from among those living environments available to the general public.

Housing services and supports, such as discharge planning, case management, on-site crisis interventions, and recovery services, are critical to assist individuals with becoming fully integrated into their community and to promote recovery and should be available at the level and duration required to support the individual in their housing choice. These services and

supports should be flexible, individualized, promote recovery, respect, and dignity, and can be enhanced through partnerships with nontraditional partners such as banks, community foundations and local businesses.

The Changing Healthcare Landscape that Addresses Linking Behavioral Health and Support Services

The Deficit Reduction Act (DRA) of 2005 added section 1915(i) of the Social Security Act, which authorizes states to provide home and community-based services (HCBS) through a Medicaid state plan. Previously, such services could be offered only pursuant to 1115 or 1915 waiver programs. Section 1915(i) enables states to serve individuals with incomes under 150 percent of the federal poverty level (FPL) who need supportive HCBS but whose functional limitations are less severe than those served under 1115 and 1915 HCBS waivers. It is intended to provide states with an opportunity to offer services and supports in the home and community before individuals need institutional care.

A new initiative is intended to provide states with an opportunity to offer services and supports in the home and community before individuals need institutional care.

A new option creates or extends other HCBS that offer a full continuum of services through organized and coordinated delivery system structures, such as Special Needs Plans (SNPs).

A new option is intended to remove barriers to providing robust home- and community-based services (HCBS) to Medicaid recipients. One change is that HCBS Option, unlike a waiver, must apply to the Medicaid eligible population statewide, creating a uniform benefit for those who meet the requirements of the target

population. While providing a broader array of services statewide may be seen as having great value, the current state fiscal crisis may limit the number of states that apply for this option because funds to cover required state match are in short supply. CMS has been encouraged to work with states to develop strategies to both expand HCBS and manage costs.

Opportunities exist to create or extend other HCBS that offer a full continuum of services through organized and coordinated delivery system structures, such as Special Needs Plans (SNPs). If designed appropriately to address the behavioral health needs of people with mental health and substance use disorders, NASMHPD believes that structures such as SNPs and ACOs have great potential to improve quality and reduce healthcare costs. NASMHPD has urged CMS to work with states to reduce barriers that may exist to apply for 1915(i) state plan amendments and increase the viability of this option.

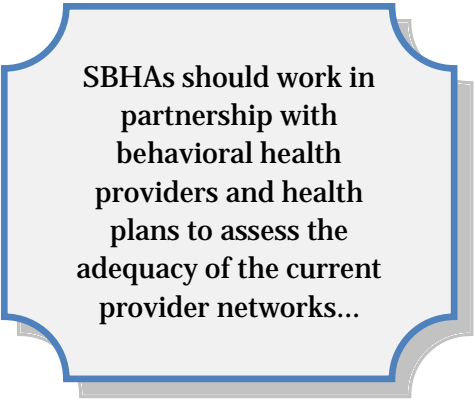
SBHAs have significant experience in bending the medical cost curve with the development and coordination of supportive services for persons with disabling health conditions such as housing and employment. This experience can contribute materially to comprehensive HCBS planning and implementation efforts.

Goals for Role 3

Action. SBHAs should advocate for people with serious behavioral health conditions that typically go beyond what even superior conventional public and private sector health insurance programs cover. These elements include: medications and medication management; screening and treatment; supportive counseling; linkage to social and rehabilitative services; attention to stable housing; supportive employment; psychosocial services including education and family involvement; and, in many cases, assertive community monitoring and treatment.

Action. SBHAs could work with policymakers to promote special coverage provisions for individuals with serious behavioral health conditions. In contrast to traditional Medicaid coverage, private or benchmark coverage is not designed to provide the full range of acute and long-term medical and social support services needed by individuals with disabling conditions. Differences in the scope of coverage of behavioral health services across sources of insurance are likely to persist even with the implementation of behavioral health parity provisions (see parity section later this report). Rather than stipulating a very broad benefits package for all individuals, policymakers could leverage the scope of services currently available under state Medicaid programs to meet the needs of individuals with serious behavioral health conditions.

Action. SBHAs should work in partnership with behavioral health providers and health plans to assess the adequacy of the current provider networks and subsequently develop and implement strategies to rectify any identified gaps in the provider network in order to meet the increased demand for behavioral health services.



SBHAs should work in partnership with behavioral health providers and health plans to assess the adequacy of the current provider networks...

Action. SBHAs could work closely with state agencies to find ways to assist individuals with behavioral health conditions and other disabilities to consistently obtain jobs that pay more than minimum wage, that offer benefits such as health insurance, and that make them feel socially included in their work environment.

Action. SBHAs could have influence over setting standards and ensuring adherence to the standards of supported employment at all levels.

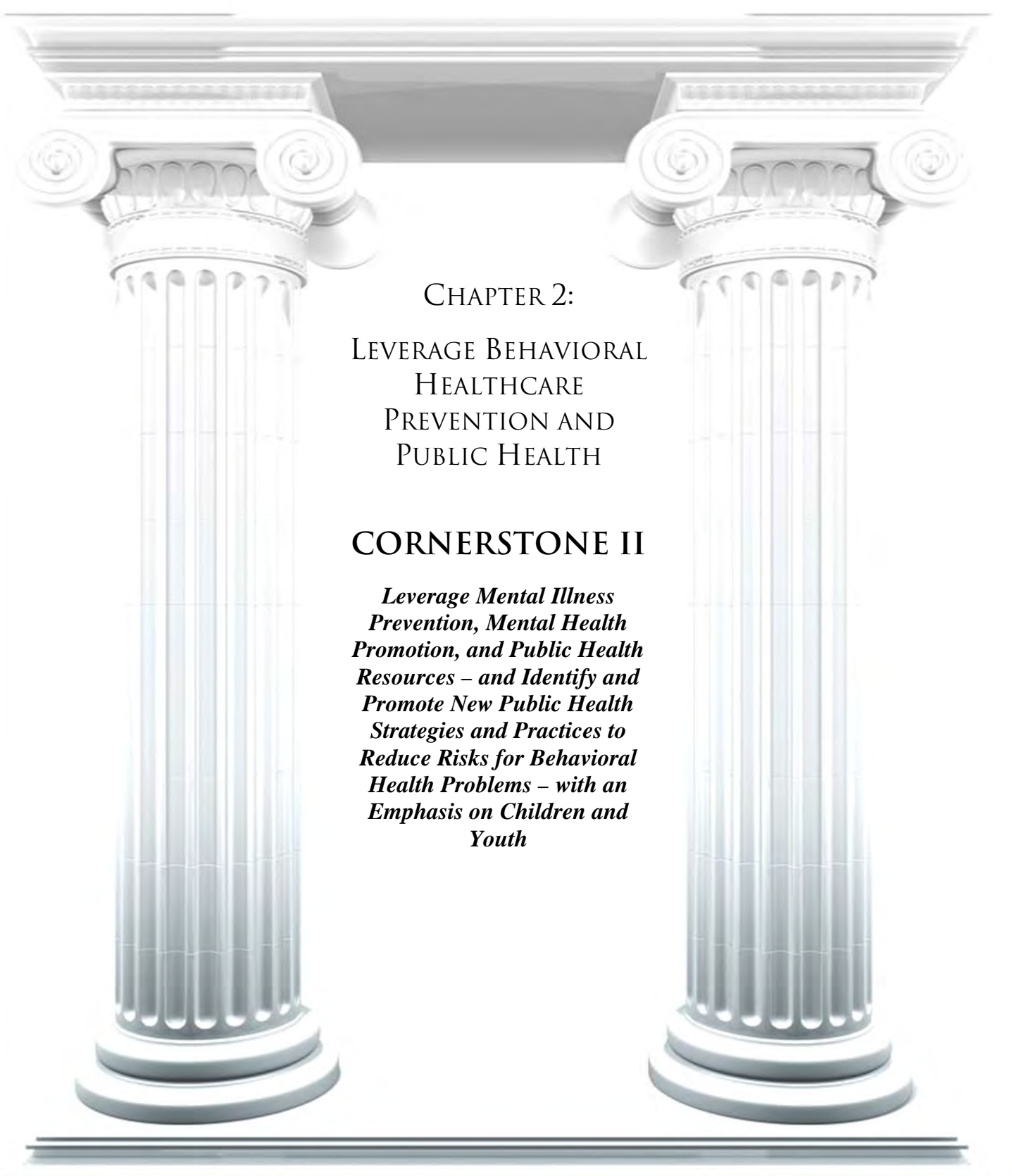
Action. SBHAs could collaborate with state officials to fund supported employment programs and to establish standards according to evidence-based practices and have them incorporated in licensing standards, requests for proposals for grant funds, and so on.

Action. SBHAs should exercise leadership in the housing arena by addressing housing and support needs and expanding affordable housing stock. This is a responsibility shared with consumers, housing authorities, and all levels of government. In addition, it requires coordination and negotiation of mutual roles of SBHAs, public assistance and housing

authorities, and the private sector. For example, NASMHPD has noted through previous technical assistance efforts that coordination with a state housing finance agency can be tremendously productive in creating mutual understanding, barrier elimination, and increased housing for consumers.

Action. SBHAs could also work with local behavioral health and housing agencies to secure additional housing resources, such as local trust funds and rental subsidies and to increase access to supportive services, including working on homelessness issues through local Continuums of Care and Plans to End Homelessness.

Action. SBHAs could be educating state and local leaders and providers on: 1) the need for housing and housing services and supports; 2) how the housing system works; and 3) the opportunities and resources in housing.



CHAPTER 2:
LEVERAGE BEHAVIORAL
HEALTHCARE
PREVENTION AND
PUBLIC HEALTH

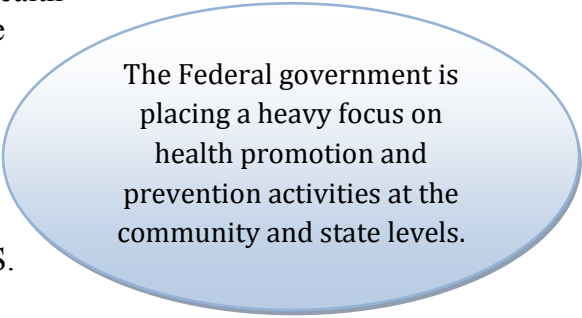
CORNERSTONE II

*Leverage Mental Illness
Prevention, Mental Health
Promotion, and Public Health
Resources – and Identify and
Promote New Public Health
Strategies and Practices to
Reduce Risks for Behavioral
Health Problems – with an
Emphasis on Children and
Youth*

ROLE 4: Develop and implement effective behavioral health promotion, wellness and prevention activities.

Background

Healthcare purchasers and payers are placing a heavy focus on health promotion and prevention activities at the community and state level. Health promotion is a significant component of a comprehensive prevention and wellness plan, and plays a key role in efforts to prevent behavioral health conditions from developing.



The Federal government is placing a heavy focus on health promotion and prevention activities at the community and state levels.

Medicaid will receive extra federal funds if they choose to cover the preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and the adult immunizations recommended by the Centers for Disease Control (CDC) Advisory Committee on Immunization Practices. For example, the USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up, as well as the implementation of screening, brief intervention, referral and treatment (SBIRT) for alcohol misuse.

SAMHSA, as well as many behavioral health experts and observers, believe that creating strong bi-directional linkages between preventive services and primary and behavioral healthcare services is a critical step to achieving improved patient outcomes. Historically, health promotion and prevention research and services have been under-funded. Significant funding is available for states to focus more on behavioral health prevention and the integration of community-based programs and primary and specialty care.

As federal efforts produce evidence-based efforts on the use of clinical and community prevention services – prevention and integration – states should seek to adopt these recommendations and track opportunities for funding.

SBHAs have been committed to educating health professionals and the general public about the importance of behavioral health promotion and prevention practices, adopting proven promotion and prevention strategies, and incorporating them into the state mental health plan.

SBHAs have been further committed to sustaining and improving performance in promotion and prevention activities, while meeting the demands of serving a public behavioral health population, by monitoring program implementation, evaluating program outcomes and effectiveness, and by conducting surveillance of population-level indicators.

The Changing Healthcare Landscape that Addresses Health Promotion and Prevention Activities

An interagency council has been dedicated to promoting health and wellness policies at the Federal level. The Council will consist of representatives of Federal agencies that interact with Federal health and safety policy, including the Departments of Health and Human Services, Agriculture, Education, Labor, Transportation, and others. The Council is charged with establishing a national prevention and health promotion strategy and developing interagency working relationships to implement the strategy. The Council will report annually to Congress on the health promotion activities of the Council and progress in meeting goals of the national strategy that will include ensuring that behavioral health best practices are included.

A Prevention and Public Health Investment Fund is intended to provide a sustained investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector healthcare costs. This will involve a dedicated, stable funding stream for prevention, wellness and public health activities authorized by the Public Health Service Act.

New prevention efforts provide an expanded national investment in prevention and public health programs that ensure that behavioral health best practices are included.

The U.S. Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness of clinical preventive services such as colorectal cancer screening or aspirin to prevent heart disease, and develops recommendations for their use. The Community Preventive Services Task Force uses a public health perspective to review the evidence of effectiveness of population-based preventive services such as tobacco cessation, increasing physical activity and preventing skin cancer, and develops recommendations for their use.

The HHS Secretary convened a national public/private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign. The goal of the campaign is to raise awareness of activities to promote health and prevent disease across the lifespan. The Secretary will conduct a national media campaign on health promotion and disease prevention focusing on nutrition, physical activity, mental health, and smoking cessation using science-based social research.

The Secretary will also maintain a web-based portal that provides informational guidelines on health promotion and disease prevention to healthcare providers and the public as well as a personalized prevention plan tool for individuals to determine their disease risks and obtain tailored guidance on health promotion and disease prevention.

In addition, the Secretary will provide guidance and relevant information to States and healthcare providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. Each

State would be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services.

A new grant program for the operation and development of School-Based Health Clinics will provide comprehensive and accessible preventive and primary healthcare services to medically underserved children and families.

A new oral healthcare prevention education campaign at CDC will focus on preventive measures and targeted towards key populations including children and pregnant women. New demonstration programs will focus on oral health delivery and strengthen surveillance capacity.

A new initiative establishes an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women.

The current Medicaid State option to provide other diagnostic, screening, preventive and rehabilitation services will be expanded to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services.

New programs within the changing healthcare landscape provide coverage of comprehensive tobacco cessation services for pregnant women in Medicaid. States are required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. Such services would include diagnostic, therapy services, and prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration (FDA) for cessation of tobacco use by pregnant women. This section would also prohibit cost-sharing for these services.

Under the changing healthcare landscape, the Secretary can award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or mental illness; or other activities that are consistent with the goals of promoting healthy communities.

CDC will provide grants to States or large local health departments to conduct pilot programs in the 55-to-64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. Pilot programs would be evaluated for success in controlling Medicare costs in the community. Additionally, CMS would conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases.

Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment...

Goals for Role 4

Action. Under the changing healthcare landscape, SBHAs could work with several public and private sector stakeholders at the state level, including major health purchasers, to take advantage of the public policy and private sector opportunities and the growing evidence base behind prevention with a focus on children and youth.

Action. SBHAs could consider partnering with state Medicaid officials and other stakeholders to help design appropriate public awareness campaigns, incentives and programs for individuals with behavioral health conditions.¹⁵

Action. SBHAs could partner with state Medicaid officials to define and implement universal and evidence based screening for mental health and substance use conditions, working to embed the function in medical homes, health homes, safety net programs and school based clinics, developing standard-screening protocols, and defining valid screening tools for standard use in the state.

SBHAs should continue to work to prevent or reduce consequences of underage drinking and adult problem drinking.

Action. SBHAs should communicate with pediatric and primary care professional organizations, as well as state medical boards and medical schools, to promote universal adoption of standardized screening and assessment for mental health and substance use conditions.

Action. SBHAs should continue to work to prevent or reduce consequences of underage drinking and adult problem drinking; working to prevent suicides and attempted suicides among populations at high risk, especially service members, veterans and their families, LGBTQ youth, and American Indians and Alaska Natives; and working to reduce prescription drug misuse and abuse.

Action. SBHAs have been moving their behavioral health systems toward a broader definition of health by recognizing the importance of wellness and prevention services as

integral to positive behavioral health outcomes. SBHAs could be encouraging an integrated behavioral health model that incorporates mental healthcare, substance abuse treatment and physical healthcare services into coordinated care systems.

Action. SBHAs could promote a data-driven strategic prevention framework that comprises representatives from multiple community sectors, including education, business, justice, housing, healthcare, and other relevant fields, and work to enhance workforce capacity to deliver specialized prevention services and with the broader human services workforce to support prevention and the promotion of social and emotional health.

Action. SBHAs could work in partnership with key stakeholders to eliminate tobacco use among youth and prevent and reduce tobacco use among persons with behavioral health disorders.

ROLE 5: Continue the development and expanded provision of services and supports, including safety-net services that are provided by or under the control of SBHAs, and ensure that proper linkages exist between these services and health and behavioral health services.

Background

SBHAs have developed and manage a diverse portfolio of systems, services and programs focused on responding to, and serving, persons with behavioral health needs; provider organizations; consumers; families; planning and advisory councils, and systems of higher education.

SBHAs have developed and manage a diverse portfolio of systems, services and programs focused on responding to, and serving, persons with behavioral health needs; provider organizations...

Through community-based and psychiatric state hospital systems and related services, the SBHAs serve as safety-net providers for vulnerable populations. This assistance covers a variety of administrative, policy, financial, clinical, and program areas. Examples include: the planning and implementation of evidence-based practices; promoting an understanding of the impact of trauma and the need for trauma-informed care; clinical protocols and program design that support recovery and enhance resilience for individuals across the lifespan; financing strategies; workforce development; cross-system collaboration; and consumer empowerment, including the use of consumer-directed care and the expansion of meaningful roles for consumers in all stages of program/service planning, delivery and evaluation.

A mix of systems and providers, including community behavioral health centers, community health centers, hospitals, schools, correctional facilities and other community-based organizations, serve as behavioral healthcare systems in several states. Many of these providers act as the *behavioral health safety net* for their lower-income and medically indigent individuals. For individuals who are eligible because of their income and who are otherwise uninsured, enrollment in the Medicaid program provides a major payment source for outpatient behavioral healthcare providers and in-patient treatment facilities. Many low-income medically indigent individuals, however, have no source of insurance coverage for mental health treatment.

Many low-income medically indigent individuals have no source of insurance coverage for mental health treatment.

For many individuals with a diagnosed behavioral health conditions, including those with a co-occurring diagnosis of substance abuse, having access to a full continuum of services from prevention and early intervention to diagnosis and treatment to long-term therapeutic care management can substantially improve their quality of life. When individuals with serious mental illness do not have access to this full continuum of care, untreated symptoms

are often exacerbated, resulting in unnecessary hospitalizations and emergency department visits, and/or incarceration.

Hospital emergency departments have increasingly become de facto sites of behavioral healthcare for individuals with chronic and serious mental illness and substance abuse problems who find themselves in crisis.

Federally qualified health centers (FQHCs) and community health clinics, provide comprehensive primary healthcare services to low-income populations of all ages. FQHCs receive an annual grant from the federal government to subsidize care for uninsured or underinsured people once they have met certain criteria, including being located in a federally designated medically underserved area (MUA) or serving a medically underserved population (MUP). A large proportion of FQHC patients are enrolled in the Medicaid program, particularly children. Some FQHCs also provide mental health, substance abuse, and oral healthcare services.

Hospital emergency departments have increasingly become de facto sites of behavioral healthcare for individuals with chronic and serious mental illness and substance abuse problems...

Users of the behavioral health safety net include some of the most vulnerable citizens. Vulnerability is first defined by lower-income status and then combined with other factors that increase the likelihood that an individual in need of behavioral healthcare services will not get the care they need when they need it.

Vulnerability from a behavioral health perspective also includes individuals who are homeless, returning war veterans who may or may not have mental health benefits depending on their military status, and emancipated children and youth from the foster care system.

Another dimension of vulnerability for individuals with behavioral health disorders is the discrimination and stigma that often accompanies their diagnoses.

Vulnerability from a behavioral health perspective also includes individuals who are homeless, returning war veterans and youth from the foster care system.

Finally, huge disparities exist in both access to and the quality of behavioral healthcare for racial and ethnic minority groups in the U.S. Millions of individuals from minority groups rely on the safety-net systems to receive needed care.

The Changing Healthcare Landscape that Addresses Safety Net Issues and Disparities

There is a need for an increased effort to tackle racial and ethnic healthcare disparities. The most important provisions to drive this effort are those that will raise the profile of minority health. The Office of Minority Health at the Department of Health and Human Services and a network of minority health offices located within HHS will monitor health, healthcare trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives. It will be crucial that behavioral health is a key focus in this work, as racial and ethnic minorities who have behavioral health disorders are doubly disadvantaged.

It will be crucial that behavioral health is a key focus in this work, as racial and ethnic minorities who have behavioral health disorders are doubly disadvantaged.

Efforts to support greater racial diversity and cultural competency in the behavioral health workforce will also be important and should be prioritized. In many minority communities, community health workers can help to provide needed assistance with interpretation and translation services and culturally appropriate health education and information. They can also offer informal counseling and guidance on health behaviors

and be advocates for individual and community health needs. The HHS Secretary can award grants to states, public health departments, clinics, hospitals, federally qualified health centers, and other nonprofits to enable them to use community health workers.

Improved collection and use of data is essential to drive better understanding of healthcare disparities. The HHS Secretary has responsibility for the analysis of the data and the dissemination of the information derived from the analysis.

The States' disproportionate share hospital (DSH) allotments will be reduced by 50 percent once the rate of uninsurance in a State decreases by 45 percent (low DSH allotment States would receive a 25 percent reduction). As the rate of uninsurance continues to decline, the States' DSH allotments would be reduced by a corresponding amount. At no time could a State's DSH allotment be reduced by more than 65 percent compared to its FY2012 allotment.

The DSH payment reduction, cutting supplemental Medicaid payments to hospitals with high proportions of publicly insured and uninsured patients on the theory that expansions in health insurance will lower uncompensated care costs in safety net facilities, will create perhaps an unintended risk to the behavioral health safety net system. Due to Medicaid's prohibition on reimbursing institutions for mental disease (IMDs) or state psychiatric hospitals for care provided to recipients between 21 and 64 years of age, these institutions will not be able to collect Medicaid reimbursement for care to currently eligible or newly eligible beneficiaries.

New DSH payment reductions will create perhaps an unintended risk to the behavioral health safety net.

Goals for Role 5

Action. SBHAs could ensure that behavioral health delivery safety-net systems meet a core set of competencies (see information on the **California Integrated Behavioral Health Project Phase III Project Description**) in order to continue being an important part of the healthcare delivery system. **(Exhibit 2)**

Exhibit 2

California Integrated Behavioral Health Project Phase III Project Description

The “Integrated Behavioral Health Project”, an initiative of The California Endowment and the Tides Center, has published “Partners in Health: Primary Care/County Mental Health Tool Kit,” which is designed to help primary care clinics and government mental health agencies forge collaborative relationships. The 180-page Tool Kit provides practical, operational advice, forms, strategies and prototypes for integrating mental and physical services. Though the focus is on California counties, much of the Tool Kit information can be generalized to other locales.

Included are sample formal agreements and contracts reached between primary care agencies and county mental health agencies; advice from those who have established these working relationships; checklists for MOU and contract content; issues to consider when brokering agreements; mutual role descriptions; and much more.

1. A full array of specialty behavioral health services;
2. A well-defined assessment process and level of care determination system;
3. A solid approach to prevention, early intervention, and recovery;
4. The ability to practice as a team to coordinate care;
5. Demonstrated use of clinical guidelines;
6. Measurement systems and tools that measure consumer improvement;
7. A robust EHR that includes patient registries;
8. Quality improvement processes and supporting data systems;
9. Financial systems to manage case rate payments; and
10. Ability to market services in response to increased competition.

Action. SBHAs are assuming new regulatory responsibilities including addressing the employment, housing, and general health needs of mental health consumers and providing suicide prevention and behavioral health early intervention services.

SBHAs should be actively involved with other key agencies in keeping persons with severe behavioral health conditions out of prisons and jails by funding criminal justice diversion programs, mental health and drug courts, using outpatient commitment statutes, and operating services for sex offenders.

... SBHAs are striving to help those in the public behavioral health system receive the most appropriate services in the most suitable settings.

Action. As the behavioral healthcare environment continues to change, SBHAs are striving to help those in the public behavioral health system receive the most appropriate services in the most suitable settings. The ultimate goal is to help recipients return to their communities and lead more healthy and productive lives.

SBHAs could be empowered to design behavioral health systems that effectively coordinate unrelated funding streams, coverage options and eligibility requirements; and that provide public mental health clients with a seamless continuum of care throughout the safety net system.

Action. SBHAs should maintain funding and services for State/Local Behavioral Health Programs. Even with robust enrollment expected over the next few years, there will still be uninsured individuals and many services important to behavioral health prevention, treatment and recovery are likely to remain uncovered by insurance. Therefore, it is critical for SBHAs to maintain funding and services for vulnerable populations. State agencies should try to leverage as much as they can at this point in the process.

... SBHAs will need to determine what specific behavioral health services they can cover in addition to what is being covered by insurers.

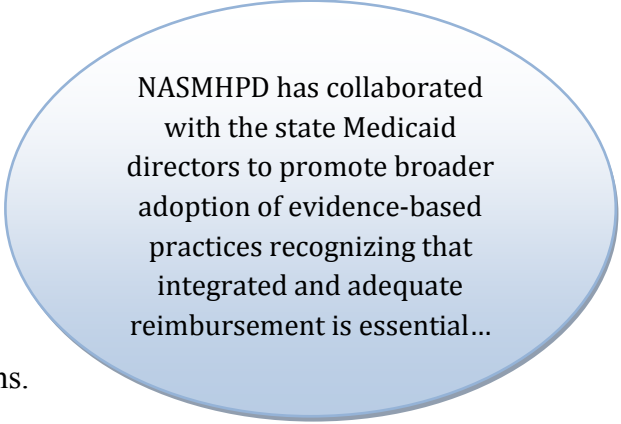
Action. In order to identify gaps in the continuum of services, SBHAs will need to determine what specific behavioral health services they can cover in addition to what is being covered by insurers. SBHAs could create a crosswalk listing, to identify gaps in both insurance coverage or in specific behavioral services, by population group.

Action. SBHAs could support local authorities in meeting the challenges of the dynamic delivery system. Strong and effective local authorities (at the city, county and regional level) with a focused role on planning can bolster behavioral health's prominence in state implementation efforts.

NASMHPD has collaborated with state Medicaid directors to promote broader adoption of evidence-based practices, recognizing that integrated and adequate reimbursement is essential to ensuring not only widespread adoption, but also implementation of practices with fidelity to the evidence standards.

SBHAs could urge CMS to examine the role of financing mechanisms such as bundled payments in expanding the use of EBPs in the core services provided in the rehabilitation and clinic options.

Action. A number of SBHAs depend on DSH payments as a significant source of Medicaid funding for state psychiatric hospitals, totaling approximately \$3 billion in 2007, of which approximately \$1.73 billion were federal dollars.¹⁶ These dollars represent a sizeable share of the \$37 billion under the direction of SBHAs, and losses of this magnitude will further erode resources available to individuals in state hospitals and community based safety net programs.



NASMHPD has collaborated with the state Medicaid directors to promote broader adoption of evidence-based practices recognizing that integrated and adequate reimbursement is essential...

NASMHPD members have substantial concerns about the fragility of inpatient psychiatric and residential care. In those states that use DSH payments to fund home- and community-based waiver programs, there will be larger constraints on the ability to meet *Olmstead* community integration objectives. These concerns are exacerbated by recent losses sustained in state funding to mental health programs, approaching \$3.4 billion across three fiscal years in 45 states.¹⁷

Under the changing healthcare landscape, the Secretary of HHS to develop a methodology to distribute DSH reductions that consider several factors: the percentage of uninsured in a state; the rate at which states target DSH payments to hospitals with high volumes of uncompensated care; low-DSH states; and the portion of DSH that finances Section 1115 waivers. Legislation is, however, silent on IMDs as a factor.

NASMHPD could ask the HHS Secretary to consider the impact of a disproportionate loss of DSH revenue on the further erosion of safety-net behavioral health services at a time when the states are facing continued reductions in state revenues. SBHAs should urge consideration of these unique circumstances and the differential impact of cuts on states.

Since state psychiatric hospitals will not benefit from the increased Medicaid expansion because of the IMD exclusion, SBHAs could urge the Secretary to consider the time that states will need to develop community-based alternatives to hospitalization and to secure other funding to support inpatient services for individuals who require these services.

In addition, SBHAs could urge HHS to take a broader look at the impact of the IMD exclusion on healthcare delivery for populations served by the public mental health system.
(Exhibit 3)

Exhibit 3

Medicaid IMD Exclusion

Since the Medicaid program was first enacted, there has been a preclusion of funding for inpatient treatment of adults between the ages of 21 and 64 in any institution for mental diseases (IMD) with 17 or more beds (or any other needed care for such inpatients). The movement toward deinstitutionalization of long-term psychiatric inpatients, and the closure of state psychiatric hospitals, has meant that fewer patients are served in large institutions for behavioral health disorders. Instead, an increased number of patients receive emergency psychiatric care in overcrowded emergency departments in general acute care hospitals. This increased use has forced many hospitals to resort to “psychiatric boarding” – the delay of care of a person with behavioral health conditions until a hospital bed becomes available.

A new demonstration will assess whether the expansion of Medicaid coverage to include certain emergency services provided in private inpatient psychiatric hospitals improves access to medically necessary care.

The Demonstration will also test whether such expanded coverage will reduce the burden on general acute care hospital emergency rooms and whether and how differences in behavioral health delivery systems including the availability of various types and combinations of beds in the state, the level and types of investments in community-based behavioral health services by the state (e.g., Assertive Community Treatment) and the design of the state’s Medicaid program itself (including the degree of specialized managed behavioral healthcare) fundamentally affect the impact of any IMD policy changes on cost, quality, and access to behavioral healthcare.

The Demonstration will be conducted for a period of 3 consecutive years. Payments to participating States will be an amount each quarter equal to the Federal medical assistance percentage of expenditures for services provided under this Demonstration. A total of \$75 million in matching funds has been appropriated for the conduct of the Demonstration.

Although applicants for the Demonstration are limited to Medicaid agencies only, there are roles that SBHAs can play, including engaging Medicaid Directors in your state and alerting them to the Demonstration initiative. SBHAs could begin to evaluate whether public psychiatric hospitals in your state would benefit if a private hospital in the area received one of the Demonstration grants. SBHAs also could begin collaborating with state entities to develop innovative proposals, and reach out to institutions that provide inpatient emergency psychiatric treatment –and other stakeholders – for their input and potential collaboration.

SBHAs could begin to evaluate whether public psychiatric hospitals in your state would benefit if a private hospital in the area received one of the Demonstration grants.

In selecting participating institutions and developing evaluation criteria, NASMHPD and SBHAs should urge HHS to include an assessment of the impact on state psychiatric hospitals even though they are not eligible for direct funding. NASMHPD recommends that several institutions in the demonstration be located in a service area where there is also a public institution that could be impacted by the new funding stream. This would allow for an assessment of new funding on access to inpatient services, emergency room visits, continuity of care and other factors across public and private institutions.

Action. While the IMD exclusion has prevented using the grant to deinstitutionalize non-elderly adults, there are large and

growing numbers of people with behavioral health disorders in nursing facilities who can benefit from a new demonstration called “The **Money Follows the Person** (MFP)”.

Innovations developed under these projects should be disseminated nationally with technical assistance to states to enable them to incorporate the innovations in their state Medicaid programs. NASMHPD and SBHAs could encourage and promote more state projects under the MFP demonstration which integrate evidence-based behavioral health services and supports into home- and community-based service systems.

... SBHAs could encourage and promote more state projects under the MFP demonstration which integrate evidence-based behavioral health services and supports into home- and community-based service systems.

... SBHAs should urge CMS to examine the role of financing mechanisms such as bundled services in expanding the use of EBPs in the core services...

Action. Under the changing healthcare landscape, the **Project to Evaluate Integrated Care around a Hospitalization in Medicaid** demonstration will evaluate use of bundled payments for paying providers with respect to an episode of care that requires a Medicaid enrollee to be hospitalized. Several evidence-based practices in the behavioral health field are complex, multiple component interventions.¹⁸

SBHAs have collaborated and should continue to engage state Medicaid directors to promote broader adoption of evidence-based practices, recognizing that integrated and adequate reimbursement is essential to ensuring not only widespread adoption, but also implementation of practices with fidelity to the evidence standards.

NASMHPD and SBHAs should urge CMS to examine the role of financing mechanisms such as bundled services in expanding the use of EBPs in the core services provided in the rehabilitation and clinic options.

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CHAPTER 3:

COORDINATE BEHAVIORAL
HEALTHCARE QUALITY
IMPROVEMENT EFFORTS
AND DEVELOP A STABLE
BEHAVIORAL HEALTHCARE
WORKFORCE TO
ACCELERATE RECOVERY
FOR PEOPLE WITH
BEHAVIORAL HEALTH
DISORDERS

CORNERSTONE III

*Coordinate Measurement,
Electronic Health Records and
Health Information Technology
Initiatives as Essential Prerequisites
to Improving Behavioral Health
Quality in Tandem with
Maintaining a Stable Behavioral
Health Workforce that Relies on
Explicit Standards of Care and
Using Best Practices to Deliver
Quality Behavioral Health Services
to Maximize Recovery for People
with Behavioral Health Disorders*

ROLE 6: Provide content expertise on the development of and inclusion of behavioral health quality measures in specifications for electronic health records in the development of health information exchanges and in public and private sector initiatives to improve the quality of behavioral healthcare.

Background

Many SBHAs have developed performance and outcome measures for behavioral health treatments and recovery supports. Under the changing healthcare landscape, SBHAs now have the opportunity to integrate behavioral health metrics into measurement systems across payers. SBHA efforts to develop targeted measurements and policies to improve the quality of behavioral healthcare should complement larger state-wide goals and joint health policy agendas.

Health Information Technology (HIT) is a critical component in the move to modernize healthcare to increase quality, reduce medical errors, and “bend the cost curve” by making healthcare more efficient.

Health Information Technology (HIT) is a critical component in the move to modernize healthcare to increase quality, reduce medical errors, and “bend the cost curve” by making healthcare more efficient.

Rapid delivery changes will have a major impact on overall healthcare and HIT, and inclusion of mental health and substance abuse. First, as part of the American

Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) contains over \$22 billion to promote the adoption of Electronic Health Records (EHRs) by physicians, hospitals and other health providers plus funding for the implementation of Health Information Exchanges (HIEs – same acronym as Health Insurance Exchanges) that will allow health providers to share their EHR data to better coordinate and improve care.¹⁹

Second, the changing behavioral healthcare landscape relies heavily on the use of Electronic Health Records (EHRs) and HIEs to bend the cost curve by making expanded health insurance coverage affordable to all. The legislation will focus on outcomes through the enhancement of ACOs and Health Homes as well as investing in prevention and wellness by giving service recipients more control over their own care.

Recent initiatives will guide local, state, and national efforts to improve healthcare quality through three major aims:

Better Care: Improve the overall quality, by making healthcare more patient-centered, reliable, accessible and safe.

Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and environmental determinants of health in addition to delivering higher-quality care.

Affordable Care: Reduce the cost of quality healthcare for individuals, families, employers and government.

As the National Quality Strategy is implemented in 2012 and beyond, HHS will work with stakeholders to create specific quantitative goals and measures for each of these priorities:

- Making care safer by reducing harm caused in the delivery of care;
- Ensuring that each person and family are engaged as partners in their care;
- Promoting effective communication and coordination of care;
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
- Working with communities to promote wide use of best practices to enable healthy living; and
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

SAMHSA has developed a “National Framework for Quality Improvement in Behavioral Health Care” which identifies national priorities... for improving the delivery of behavioral health services, achieving better behavioral health outcomes...

SAMHSA has developed a National Framework for Quality Improvement in Behavioral Health Care which identifies national priorities—and goals and opportunities—for improving the delivery of behavioral health services, achieving better behavioral health outcomes and improving the behavioral health of the U.S. population, especially those struggling with or at risk for mental illnesses and substance abuse.²⁰

Efforts to implement quality measures successfully will require an understanding of the current behavioral health status and needs of both populations and delivery systems, as well as the ability to anticipate the data and informational requirements necessary to assess adequately and monitor changes in the healthcare environment on these same populations and delivery systems over time.

Quality measurements developed by SBHAs should be synchronized with the goals and priorities of the National Quality Strategy.

According to SAMHSA, the creation of a National Behavioral Health Quality Framework represents an important step in achieving the overarching purpose of SAMHSA's Strategic Initiative for Data, Outcomes, and Quality—namely, “realizing an integrated data strategy and a national framework for quality improvement in behavioral healthcare that will inform policy, measure program impact and lead to improved quality of services and outcomes for individuals, families, and communities.”

As improving the quality of behavioral healthcare is a primary aim of the Strategy, SBHAs could help develop state-specific quality strategies to help meet the priorities of the National Quality Strategy.

Quality measurements developed by SBHAs should be synchronized with the goals and priorities of the National Quality Strategy. SBHAs should consider organizing the many behavioral health metrics into a single streamlined measure set.

The Changing Healthcare Landscape that Addresses Quality of Care Issues

A broad vision for quality measurement and reporting in the Medicare program exists. Components of this vision include: 1) Quality Measure Development; 2) Quality Measurement (including payment incentives); and 3) Public Reporting. The changing healthcare landscape greatly expands existing efforts noted above while introducing new tools for the Medicare program to identify, measure and pay for quality care.

Quality Measure Development

A “quality measure” is a “standard for assessing the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of healthcare services.”

CMS is required to identify gaps where no quality measures exist and to identify existing quality measures that need improvement, updating or expansion for use in federal healthcare programs (including Medicare, Medicaid, and CHIP).

Under the changing healthcare landscape, identified gaps must be reported on a publicly available website and the HHS Secretary must make awards to develop, update or expand quality measures. In developing new measures, priorities must include measures that assess outcomes, functional status, coordination of care across episodes, shared decision-making, use of health information technology, efficiency, safety, timeliness, equity, and patient experience. Outcomes measures will be developed for acute and chronic diseases and primary and preventative care for hospitals and physicians.

Updated provider-level outcome measures for hospitals and physicians will be developed as well as for other providers as appropriate. The measures should address the five most prevalent and resource-intensive acute and chronic medical conditions and care for distinct patient populations such as healthy children, chronically ill adults or infirm elderly individuals.

A *new* entity selected by the Secretary will develop quality measures (currently the National Quality Forum [NQF]) and convene multi-stakeholder groups to provide input on the selection of quality measures and national priorities through an open and transparent process. Selected measures will be used for existing and new Medicare (as well as Medicaid and CHIP) quality reporting and payment programs described below.

Quality Measurement

The Physician Quality Reporting Program will institute a penalty for failure to report beginning in 2015 (maximum two percent). An additional incentive payment (one-half percent) is available for eligible professionals who satisfactorily submit data on quality measures through a Maintenance of Certification Program (such as a qualified American Board of Specialties Maintenance of Certification Program).

Under the changing healthcare landscape, CMS will provide feedback to eligible professionals on their performance on reported quality measures and to develop a plan to integrate reporting on quality measures with reporting on the meaningful use of EHRs.

The HHS Secretary will provide feedback to eligible professionals on their performance on reported quality measures and to develop a plan to integrate reporting on quality measures with reporting on the meaningful use of EHRs.

A Quality Reporting for Psychiatric Hospitals is a new quality measurement and reporting program. Once operational, if a facility does not report selected quality measures, the facility's annual update will be reduced by two percentage points.

Under the changing healthcare landscape, "Value-based Purchasing Programs" link payment rates to performance (not just reporting) on specific quality measures and/or improvements in performance.

Existing and newly developed quality measures will be used to determine whether participating providers are "meaningfully using" EHRs to improve the quality of care delivered and qualify for incentive payments.

Implementation of value-based purchasing programs for hospitals (other than psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals and certain cancer treatment and research facilities) and for physicians (through the use of a payment modifier) will be in place. CMS will develop plans to implement value-based purchasing

programs for ambulatory surgery centers, skilled nursing facilities and home health services.

Existing and newly developed quality measures also will be used to determine whether participating providers are "meaningfully using" EHRs to improve the quality of care delivered and qualify for incentive payments.

Public Reporting

CMS will establish a "Physician Compare" website that will publicly report information on physicians and other eligible professionals who participate in the Physician Quality Reporting Program. Information reported must include the quality measures collected under

the Physician Quality Reporting System as well as assessments of patient health outcomes, risk-adjusted resource use, efficiency, patient experience, and other relevant information deemed appropriate by the HHS Secretary. Physicians must have a reasonable opportunity to review their results before the information is made public.

A newly authorized quality reporting programs for psychiatric hospitals, long-term care hospitals, inpatient rehabilitation hospitals, hospice programs, and non-PPS cancer hospitals will require the Secretary to make reported quality information available to the public after the providers have had an opportunity to review.

Under the changing healthcare landscape, a “Patient-Centered Outcomes Research Institute”, or PCORI, as a nonprofit corporation that is not an agency or establishment of the U.S. Government will be created. The institute’s purpose is “to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of medical treatments, services, and items.”

SAMHSA will award grants to centers of excellence in the treatment of depressive disorders. The work from these centers of excellence could help with the development of evidence-based depression treatment guidelines.

In this dynamic healthcare environment, the PCORI must ensure that subpopulations are appropriately accounted for in research designs, so this would cover individuals with behavioral health conditions, and they (and their families and careers) should also be represented in the patient and consumer representatives on the advisory panels.

SAMHSA can award grants to “Centers of Excellence” in the treatment of depressive disorders. The work from these centers of excellence could help with the development of evidence-based depression treatment guidelines.

The development of a National Strategy to Improve Health Care Quality to improve the delivery of healthcare services, patient health outcomes and population health will be critically important to the behavioral healthcare community and SBHAs.

Goals for Role 6

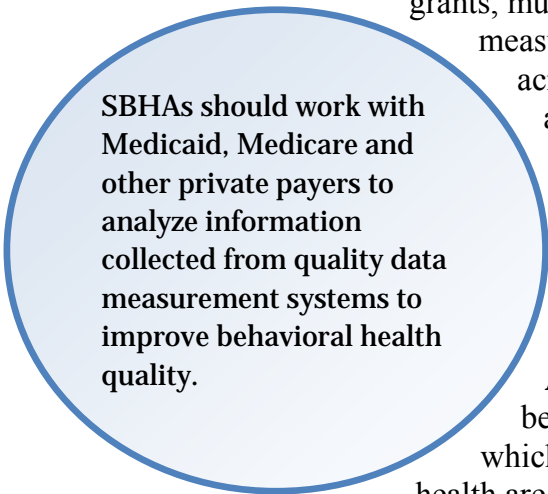
Action – Be At the Quality Improvement Table. SBHAs and providers need to make inroads in demonstrating the value of behavioral health’s role in emerging systems and identifying then leading what type of delivery model a state is moving toward. To have a viable seat at the table on providing value and robust quality of care the following conditions should be in place in behavioral health organizations:

- Accessibility to treatment;
- Identify an organization’s costs and demonstrate how well they are understood – both in terms of cost effectiveness and efficiency;
- The ability to provide episodic care under bundled rates, rather than a more open-ended approach. The term “*treat to target*” is being used to describe a scenario in which agencies and providers can, for example, document a client’s concrete improvement in 6 to 12 months, rather than simply renew a client’s static treatment plan over and over again;
- Health information technology capacity to allow full communication with primary care; and
- The ability to produce “*Outcomes to our Outcomes*” where it can be shown, for example, that a community provider’s effective services, directly reduce the need for higher-cost, more disruptive treatments for behavioral health consumers.²¹

Action. SBHAs should consider developing partnerships, or join existing partnerships, with Medicaid, private insurers, providers and other critical stakeholders, to collaborate on developing a comprehensive quality strategy for the state that includes metrics to assess the quality of behavioral health services.

Action. SBHAs should work with Medicaid, Medicare and other private payers to analyze information collected from quality data measurement systems to improve behavioral health quality.

Action. The Agency for Healthcare Research and Quality (AHRQ), through the issuance of grants, must identify areas in which gaps exist in quality measurement reporting, including behavioral health measures, across episodes of care and care transitions for patients across the continuum of providers, healthcare settings and health plans, equity of health services and health disparities. SBHAs should consider collaborating with behavioral health providers to apply for AHRQ grants to develop new innovative behavioral health quality metrics measures.²²



SBHAs should work with Medicaid, Medicare and other private payers to analyze information collected from quality data measurement systems to improve behavioral health quality.

Action. To optimize individualized care, a modern behavioral health system should include a structure in which all holistic outcomes, measures and indicators of health are collected, stored and shared with the individual and all of the providers who are associated with care of the individual. SBHAs should support and participate in the development of interoperable, integrated electronic health records that will be necessary, as will community-wide indicators of mental health and substance use disorders. Under the changing healthcare landscape, all healthcare providers should be required to participate in the health information exchanges.

Action. As states braid current and future funding streams and methodologies, SBHAs could work with partners and stakeholders—including representatives of diverse ethnic, racial and sexual minority populations—to incorporate behavioral health into the design, implementation and use of EHRs and HIEs. Additionally, SBHAs should implement a set of quality and performance indicators identified by SBHAs to improve outcomes and accountability, while eliminating redundancy and burden in reporting.

SBHAs should support and participate in the development of interoperable, integrated electronic health records...

Action. SBHAs could initiate conversations with state Health Information Exchanges regarding the use of these data for research. SBHAs could consider how this information will be used to improve the quality of behavioral health services within their state. Information from Exchanges and qualified health plans could be excellent sources of data for assessing behavioral health trends in the state, including healthcare disparities.

Please see **Appendix 1** for a set of specific issues and populations of high priority, such as co-occurring health conditions, the health of children and adolescents, and the behavioral health recovery movement. SBHA providers should be required to use the measures outlined in **Appendix 1**. SBHAs could support the inclusion of these measures in the development of EHRs and health information technology systems.

For opportunities for SBHAs to engage local organizations to leverage health information technology to improve access and coordination of the treatment of behavioral health disorders, please see **Appendix 2**.

ROLE 7: Provide leadership to health providers, federal and state policymakers and officials, and national medical societies, including primary care organizations, to ensure the adequacy of providers and the behavioral health workforce to deliver quality behavioral healthcare services.

Background

There has been a widely recognized workforce shortage in the field of behavioral health for many years. It involves both specialty-level providers in mental health and addiction services as well as primary care providers who frequently are needed to respond to the physical health needs of persons with behavioral health conditions. According to the Health Resources and Services Administration (HRSA), 77 million Americans live in areas that are not adequately served by substance abuse or mental health professionals, the majority of which are rural and remote.²³

There has been a widely recognized workforce shortage in the field of behavioral health for many years.

That shortage could enter a crisis phase as the practical implications of behavioral health parity and the changing healthcare landscape take hold over the coming months and years. The role of the specialty behavioral health sector will continue to change and modify, as it has in recent decades, but perhaps with more rapidity. The need for behavioral health services within primary care settings will be in much higher demand.

Effective workforce development strategies must address the following challenges:

- Recruitment and retention;
- Accessibility, relevance, and effectiveness of training;
- Staff competency in integrated care, evidence-based practices, and recovery-oriented approaches;
- Attitudes and skills in prevention and treatment of persons with mental and substance use conditions;
- Leadership development; and
- Workforce roles for persons in recovery and family members.

Advancements in technology offer great promise. Technology facilitates the ability to provide real-time access to culturally competent providers of services to highly diverse communities.

Advancements in technology offer great promise. In addition to bringing greater access to general and specialty behavioral health services in underserved areas (which will experience

even greater challenges in the coming years), technology facilitates the ability to provide real-time access to culturally competent providers of services to highly diverse communities.

Technology also dramatically increases efficiency for the workforce, allowing for greater productivity, and can offer additional part and full-time employment opportunities for providers who wish to work from home or while traveling.

There is an urgent need to plan for the increased demand in behavioral health services, both in primary care settings as well as in specialty clinic environments.

There is an urgent need to plan for the increased demand in behavioral health services, both in primary care settings as well as in specialty

clinic environments. An emphasis on and strong commitment to the use of technology must be a cornerstone to addressing this rapidly growing workforce shortage. Alternatives to face-to-face interaction, i.e., tele-health and tele-psychiatry, must be optimized, which requires funding to facilitate further development of technological advancements as well as adequate reimbursement for provision of such services.

The Changing Healthcare Landscape that Addresses Workforce Issues

The changing healthcare landscape has the capacity to address shortage and mal-distribution of the behavioral health workforce. Several strategies could increase the supply and the range of behavioral health professionals.

In particular, the establishment of a national commission tasked with reviewing healthcare workforce and projected workforce needs could dramatically help with the alignment of federal healthcare workforce resources with national needs.

Competitive grants have been created for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive healthcare workforce development strategies at the state and local levels. Grants will support innovative approaches to increase the number of skilled healthcare workers such as building healthcare career pathways for young people and adults.

Several regional centers could coordinate with State and local agencies by collecting labor and workforce statistical information and coordinating and providing analyses and reports on Title VII.

Priority should be given to programs that educate students in team-based approaches to care, including the patient-centered medical home.

Grants have been created to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain and improve academic units in primary care.

Priority should be given to programs that educate students in team-based approaches to care, including the patient-centered medical home.

Behavioral health education and training grants have been created across a broad range of professions, and ensure that some of these grants go to historically black colleges or universities or other minority-serving institutions.

There has been an expansion of programs to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.

Progress toward the better integration of physical and behavioral health services means that all health professionals need to have adequate training in managing behavioral health issues.

Programs are available that include scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, and some of these programs expand loan repayments for individuals who will serve as faculty in eligible institutions.

New funding is available to establish community-based training and education grants for Area Health Education Centers (AHECs) and Programs. Two programs are supported – Infrastructure Development Awards and Points of Service Enhancement and Maintenance Awards – targeting individuals seeking careers in the health professions from urban and rural medically underserved communities.

The HHS Secretary will establish a comprehensive methodology and criteria for designating medically underserved populations and health professional shortage areas. This work must include a consideration of behavioral health needs. It is important to ensure that current and new education and training programs and recruitment and retention programs have a behavioral health focus that reflects the current and projected needs.

Progress toward the better integration of physical and behavioral health services means that all health professionals need to have adequate training in managing behavioral health issues. And, given the shortages and recruitment challenges in rural areas, there is a need to consider training for non-physician professional and non-professional groups, including peers, to serve as physician and specialist extenders.

Goals for Role 7

Action. The data on stability in the front-line workforce (the backbone of public systems) suggests that if there are limited strategic actions available because of constrained resources, then those resources are best targeted at supporting the effectiveness of first-line supervisory staff. SBHAs could provide technical assistance to help provider organizations with retention and competency of staff, including continuing education opportunities, strengthening career ladders and targeting front line supervisors.

SBHAs could look to expand the use of e-Learning strategies to strengthen and expand access to practice development curricula designed specifically to target public safety-net providers such as state behavioral health providers.

Action. SBHAs, with SAMHSA, HRSA, CMS and NASMHPD, could collaborate along with other systems, to develop pilot reimbursement models that incorporate on-going training and supports (especially those linked to evidence-based practices), including reimbursement for clinical supervision, into rate structures. The Pennsylvania Health Home demonstration provided differential payments for primary care physician participation in training.

Action. SBHAs could seek to facilitate collaboration between workforce development partnerships and local educational institutions (including community colleges), provider groups, and behavioral health organizations to reinforce state planning and implementation activity and promote career development opportunities. These strong partnerships may help behavioral health organizations in their State seek additional workforce funding.

Action. SBHAs could form strategic partnerships at the state level with Primary Care Associations to address workforce issues. These organizations will be facing the same increased demand for basic care and will be unable to address the demand for behavioral health services that will come with that increased demand. Given that workers frequently cross back and forth across these systems – especially at the direct service workforce level – joint efforts to train and support the workforce would be beneficial in terms of both costs and client outcomes.

Action. SBHAs could look to expand the use of e-Learning strategies to strengthen and expand access to practice development curricula designed specifically to target public safety-net providers such as state behavioral health providers.

Action. SBHAs also could report on efforts and applicability to increase the use of available and emerging technology such as tele-medicine, on-line/web-based healthcare, smart phones and electronic medical records at the community level to address behavioral workforce shortages.

Action. SBHAs could begin to document the need for additional recruitment and training opportunities for behavioral health professionals. That way, when HHS opens this education and training grant program, SBHAs will be prepared to support institutions of higher education in their state to apply for grant funding.

In general, SBHAs could encourage institutions of higher education to develop training curriculums that can support enhanced licensing and credentialing standards so that the behavioral health workforce can meet the credentialing standards necessary to garner insurance coverage.

Action. SBHAs could facilitate efforts to increase the role of peer and family supports and recovery supports through systematic adoption of payment strategies (Medicaid and other third party insurance) that provide meaningful employment for certified peer, family and recovery workers.

Action: NASMHPD could promote an effort to improve data collection about the behavioral health workforce to standardize job descriptions and create a national database on the specialty workforce.

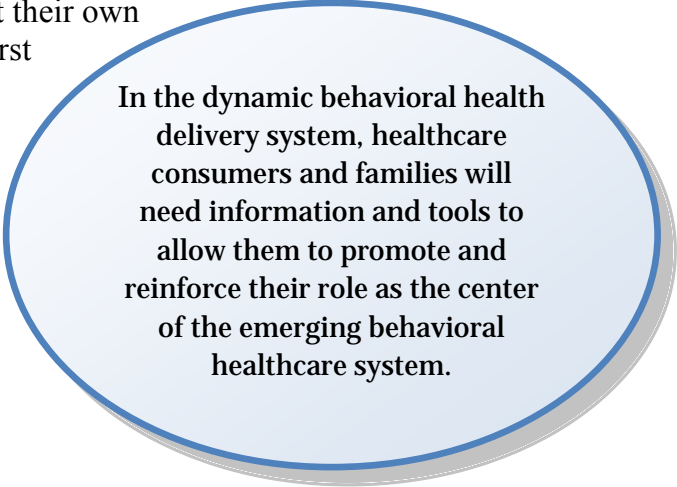
ROLE 8: Empower consumers to maximize control of their recovery through new and emerging ways to design, apply and organize existing treatments, and by finding new platforms and avenues to deliver new treatments.

Background

The promise and process of recovery is embodied in many of the roles described in this report, but we felt further compelled to highlight the role of SBHAs in additional detail to maximize the recovery process for people with behavioral health disorders.

In the dynamic behavioral health delivery system, healthcare consumers and families will need information and tools to allow them to promote and reinforce their role as the center of the emerging behavioral healthcare system and overall healthcare system. At a minimum, this will include a system that supports health literacy, shared decision-making, and strategies for consumers and families to direct their own behavioral healthcare. Health literacy is the first building block of self-care and wellness.

Shared decision-making should become the standard of care for all treatment services. Participant direction of services allows individuals and their caregivers (when appropriate) to choose, supervise and in some instances, purchase the effective supports they need rather than relying on professionals to manage these supports.



In the dynamic behavioral health delivery system, healthcare consumers and families will need information and tools to allow them to promote and reinforce their role as the center of the emerging behavioral healthcare system.

SAMHSA “Working Definition of Recovery for Mental Disorders and Substance Use Disorders”

SAMHSA has released a report on “**Working Definition of Recovery for Mental Disorders and Substance Use Disorders**”, that recognizes there are many different pathways to recovery and each individual determines his or her own way. SAMHSA engaged in a dialogue with consumers, persons in recovery, family members, advocates, policy-makers, administrators, providers, and others to develop the following definition and guiding principles for recovery. Changes in the healthcare landscape compelled SAMHSA to define recovery and to promote the availability, quality, and financing of vital services and supports that facilitate recovery for individuals. In addition, the integration mandate in Title II of the Americans with Disabilities Act and the Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) provides legal requirements to promote a high-quality and satisfying life in the community for all Americans.

The following items compose SAMHSA’s “**Guiding Principles of Recovery**”:

Recovery emerges from hope;

Recovery is person-driven;

Recovery occurs via many pathways;

Recovery is holistic;

Recovery is supported by peers and allies;

Recovery is supported through relationship and social networks;

Recovery is culturally-based and influenced;

Recovery is supported by addressing trauma;

Recovery involves individual, family, and community strengths and responsibility; and

Recovery is based on respect.

Please see **Appendix 3** for the complete SAMHSA statement on recovery.

The Changing Healthcare Landscape that Addresses Recovery Issues

SBHAs have been working diligently to implement the recommendations of the New Freedom Commission especially related to enhancing recovery and promoting consumer involvement in their care. SBHAs recognize that self-directed care, implemented on a large scale, offers the potential of helping the behavioral health system move in this direction.

The U.S. Supreme Court, in its 1999 *Olmstead v. L.C.* decision, determined that the unnecessary segregation of individuals with disabilities in institutions -- such as public hospitals -- may constitute discrimination based on disability.

Self-directed care is of particular importance to the behavioral healthcare system because it represents one tool that can help transform the system to achieve the intent of the *Olmstead* decision and the President’s New Freedom Commission on Mental Health.

The U.S. Supreme Court, in its 1999 *Olmstead v. L.C.* decision, determined that the unnecessary segregation of individuals with disabilities in institutions – such as public hospitals may constitute discrimination based on disability. The Court ruled that the Americans with Disabilities Act may require States to provide community-based services rather than institutional placements for consumers with disabilities.

The New Freedom Commission on Mental Health’s Goal #2, “Mental Health Care is

Consumer and Family Driven” incorporates a series of recommendations, several of which relate to self-directed care:

- Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance;
- Involve consumers and families fully in orienting the behavioral health system toward recovery;
- Align relevant Federal programs to improve access and accountability for behavioral health services; and
- Protect and enhance the rights of people with behavioral health conditions.

In the Commission’s vision, these plans “should form the basis for care that is both consumer-centered and coordinated across different programs and agencies. The funding for the plan would then follow the consumer, based on their individualized care plan.”²⁴

In its already classic report, *Crossing the Quality Chasm*, the Committee on Quality of Health Care in America of the Institute of Medicine (IOM) of the National Academy of Sciences proposed six major aims for the healthcare system. It should, they said, be “safe, effective, patient-centered, timely, efficient, and equitable.” The report, focused primarily on the physical healthcare system, and identified several dimensions of patient-centered care including:²⁵

1. Respect for patients’ values, preferences, and expressed needs;
2. Coordination and integration of care;
3. Information, communication, and education; and
4. Physical comfort.

Goals for Role 8

SBHAs should continue to apply many of the principles of self-directed care highlighted in the NFC and IOM reports in their programs and policies.

Action. SBHAs should continue to apply many of the principles of self-directed care highlighted in the NFC and IOM reports in their programs and policies. The Comprehensive Community Mental Health

Services Program for Children and Their Families (Systems of Care) that SBHAs promote, include involving families of children, and children themselves when feasible, in making decisions about services.

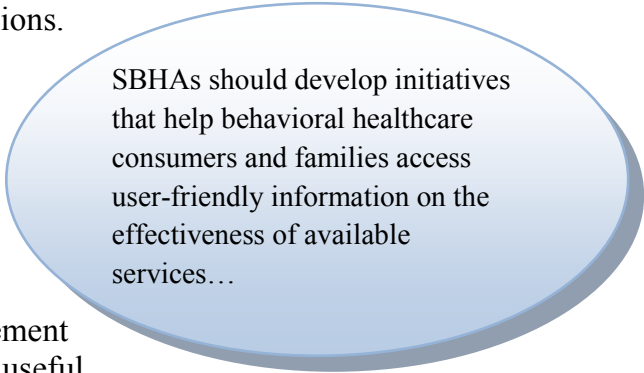
Action. SBHAs should work to ensure that shared decision-making is the standard of care for all treatment services.

Action. SBHAs should continue to emphasize peer-to-peer recovery support services that help prevent relapse and promote sustained recovery from severe behavioral health disorders.

Action. SBHAs should develop initiatives that help behavioral healthcare consumers – and families – access user-friendly information on the effectiveness of available services in order that they may truly make informed healthcare decisions.

Action. An empowered consumer can exercise maximum control over her or his recovery, including choosing which behavioral health professionals are on the team, sharing in decisions, and having the option to agree with, modify, or reject the service or treatment plan.

SBHAs should offer appropriate education, enforcement of respect for individual’s self-determined choices, useful information to make relevant choices, and specific tools and models that assure empowerment remains in effect (e.g., shared decision-making tools and person centered planning).



SBHAs should develop initiatives that help behavioral healthcare consumers and families access user-friendly information on the effectiveness of available services...

The changing healthcare landscape has the potential to significantly augment a person’s successful recovery pathway and encourage better management of chronic diseases including severe mental illnesses.

Action. SBHAs should work to include effective strategies for the meeting the needs of people with serious mental illness. These strategies should recognize that people with serious mental illness need an array of clinical services, and may need a mix of services and supports to maximize the likelihood of recovery and to improve their ability to function and care for themselves in the community.

Action. States should form, as appropriate, strategic partnerships in order for individuals to have access to “good and modern services system.” Collaboration should foster a long-range view and encourage knowledge sharing and consider all stakeholder concerns and priorities. Services should be delivered in a manner that promotes recovery and resiliency. Individuals that have personal experience should play an increasingly important role in the delivery of recovery-oriented systems of care.

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CHAPTER 4:

REPRESENT BEHAVIORAL
HEALTHCARE COVERAGE,
BENEFITS AND PAYMENT
SYSTEM INTERESTS

CORNERSTONE IV

*Work to Ensure that Public and
Private Insurance Plans
Operating in the State Adequately
Address the Behavioral Health
Interests of Eligible Enrollees
Through Covered Benefits and
Payment Systems*

ROLE 9: Serve as the state authority for mental health/substance abuse benefits including, where possible, serving as the contractor for and payer of services on behalf of other state agencies (e.g., state Medicaid program), or by developing the scope and requirements for behavioral health services if contracted for or paid directly by the state Medicaid authority, as well as develop innovative payment systems that recognize and reward performance.

Serving as the Statewide Authority and Contractor for Behavioral Health Benefits

Background

SBHAs vary widely in the specific array of behavioral health services they are responsible for. Some are responsible for behavioral health services across the life span—children, adults, and older adults. In some states, responsibilities for specific types of mental health services, such as forensics, brain injuries, or Alzheimer’s disease, are carved out to a different state agency and are not part of the SBHA’s mission. In most states, the SBHA is responsible for both adult and child/adolescent mental health and substance abuse services.

SBHAs vary widely in the specific array of behavioral health services they are responsible for. Many are responsible for behavioral health services across the life span—children, adults, and older adults.

In every state, there are state-owned-and-operated psychiatric inpatient beds that are used for persons in need of the most intensive level of mental health services. In most states (47), the operation of state psychiatric hospitals is part of the SBHA’s responsibilities. In five states, a separate state government agency has this responsibility. In these states, the SBHA works with the state psychiatric hospitals and the other state agency to coordinate care between the state psychiatric hospital(s) and the SBHA’s community behavioral health system. These states describe having special initiatives to help coordinate the movement of consumers out of the psychiatric facilities back into community mental health services.²⁶

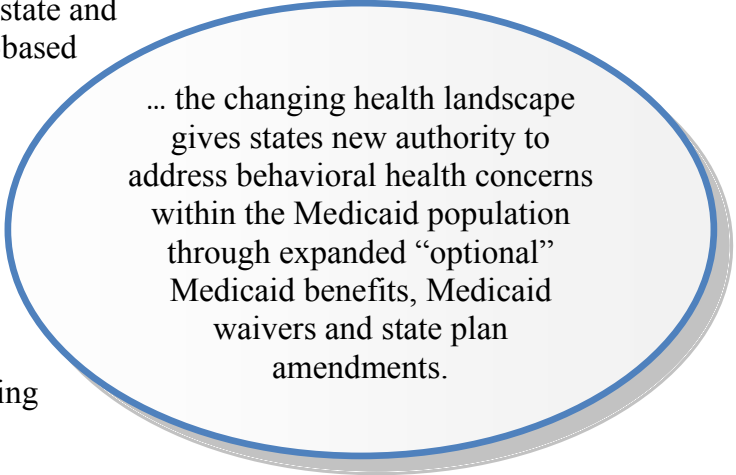
SBHAs use three primary methods to pay for or deliver community-based mental health services, with several states using combinations of these methods: SBHAs directly contract with local (usually not-for-profit) community-based mental health providers. This method is used in 38 states and is the primary method of funding community services in 27 states.²⁷

SBHAs fund local government services (city and county) mental health authorities, which in turn operate and contract for community mental health services. This method is used in 20 states and is the primary method used in 17 states. SBHAs provide direct care using state employees in state-operated community mental health centers. This method is used in 16 states.

SBHAs are increasingly responsible for coordinating with other agencies to ensure that mental health and substance abuse consumers have appropriate and timely access to key services and supports from other systems such as corrections and Medicaid.²⁸

In 2008, 96 percent (5.6 million persons with 49 states, the District of Columbia, and 4 territories reporting) of mental health consumers served by SBHA systems received community mental health services. Some individuals who received community mental health services also received care in state psychiatric hospitals (3 percent) or other psychiatric inpatient settings (7 percent) during the year, but the vast majority were served only in community settings. In 2007, SBHAs expended over 70 percent of their funds (\$20.7 billion) for mental health services provided in communities.²⁹

In 2009, SBHAs funded and/or operated nearly 20,000 behavioral health organizations.³⁰ SBHAs work with a mix of types of mental health and substance abuse providers ranging from state psychiatric hospitals staffed by the state and operated by the SBHA, to a variety of county-based or city-based providers. Most of the organizations making up the SBHA system are not operated by the SBHA, but are funded by the SBHA. These providers receive funds from a mixture of for-profit and not-for-profit community organizations. In a few states, the SBHA operates community mental health organizations that are state-owned (with state employees delivering the mental health services).



... the changing health landscape gives states new authority to address behavioral health concerns within the Medicaid population through expanded “optional” Medicaid benefits, Medicaid waivers and state plan amendments.

In addition to funding and operating behavioral health organizations, in 21 states, the SBHA is responsible for licensing or certifying private mental health providers. In 18 of these states, the SBHA receives reports on the services provided by the private behavioral health providers. Thirty-eight SBHAs reported the initiatives the SBHAs were undertaking to integrate public and private providers over the next year.³¹

Developing the Scope and Requirements for Behavioral Health Services if Contracted for or Paid Directly by the State Medicaid Authority

Background

The changing healthcare landscape will expand the Medicaid program. Starting January 1, 2014, Medicaid will be expanded to cover all individuals essentially below 133 percent of the Federal Poverty Level (FPL). Under the new Medicaid eligibility criteria, an estimated 17 million uninsured nonelderly adults and children will be eligible for Medicaid in 2014.

In addition to a significant expansion in Medicaid eligibility, the changing healthcare landscape gives states new authority to address behavioral health concerns within the

Medicaid population through expanded “optional” Medicaid benefits, Medicaid waivers and state plan amendments.

The changing healthcare landscape provides an unprecedented opportunity for millions of individuals with behavioral health needs to gain insurance coverage and benefits for crucial services...

States have the option to provide newly-eligible Medicaid beneficiaries with a “benchmark” benefits package –typically more limited than traditional Medicaid benefits – rather than the full Medicaid benefit package.

The changing healthcare landscape requires that states provide a “benchmark benefit package” of covered services to those consumers who become newly eligible pursuant to the Medicaid expansion. Benchmark benefits may be less generous than a state’s standard Medicaid benefit package, but must be at least as robust as the essential benefit package mandated for plans offering private coverage in the state insurance pools. Benchmark benefits must include certain benefits beyond those in the essential benefit package, including Early Periodic Screening, Diagnosis and Treatment (EPSDT) for children, nonemergency transportation and family planning services.

Under the changing healthcare landscape, benchmark benefits may include additional services.

Newly eligible Medicaid beneficiaries who must receive benchmark benefits include all childless adults, and parents above the state’s 1996 welfare level and below 139 percent of the FPL. States also have the option of extending benchmark benefits to some currently eligible populations. Finally, some populations, whether newly or currently eligible, are exempt from benchmark and must receive the state’s standard Medicaid package of benefits. The “benchmark-exempt” populations include parents below the states’ 1996 welfare level; aged, blind and disabled populations; some pregnant women; and the medically frail.

There is an unprecedented opportunity for millions of individuals with behavioral health needs to gain insurance coverage and benefits for crucial services through Medicaid expansion, such as psychosocial counseling and prescription drugs, to treat their illnesses. However, for many individuals, particularly those with serious illnesses, the scope of services available under new coverage options will likely not meet all of their service needs.

...rather than stipulating a very broad benefits package for all individuals, policy makers can leverage the scope of services currently available under state Medicaid programs to meet the needs of individuals with behavioral health disorders.

Under the changing healthcare landscape, rather than stipulating a very broad benefits package for all individuals, policy-makers should leverage the scope of services currently available under state Medicaid programs to meet the needs of individuals with behavioral health disorders. For example, future initiatives should specify that current exemptions to mandatory enrollment in benchmark coverage are continued, allowing individuals with disabling

behavioral health problems, but with incomes above the limit for traditional Medicaid benefits, to receive the full range of Medicaid services.

Policy-makers have several options for addressing this challenge in four key ways:

- First, regulations should clarify the scope of the essential health benefits package to include services that are important to improving the health of the general population with behavioral health conditions. For example, essential health benefits should include additional preventive services (e.g., screening and counseling for substance use disorders) to help identify those with behavioral health problems. In addition, essential health benefits should include case management for people with chronic diseases, including behavioral health disorders, to help those living with lifelong disorders manage their illnesses.

Policy-makers also can draw on the experience of Medicare Part D to clarify essential health benefits. Given the importance of prescription drugs to behavioral health treatment, federal guidelines for drug formularies in qualified plans will have important implications for individuals with behavioral health disorders. Medicare formulary guidelines require plans to list “all or substantially all” antidepressants, antipsychotics and anticonvulsants on their formularies (plans may assign drugs in these classes to high cost-sharing tiers, impose prior authorization or step therapy, or both). This process guards against adverse selection and inhibits health plans from limiting coverage for drugs used by people with high total expected drug costs. Experience to date suggests that Medicare formulary guidelines have led to better coverage of psychiatric medications in Medicare than in private plans.

- Second, policy-makers may take steps to prevent erosion of Medicaid benefits and ensure that other payment sources (such as State funds or Mental Health Block Grant funds) finance the services excluded from private or benchmark plans through waivers and the rehabilitation option. Policy-makers could consider a requirement that states not restrict Medicaid services beyond current levels to correspond to the requirement for eligibility.
- Third, policy-makers should also be required to maintain their non-Medicaid behavioral health spending at some proportion under the changing healthcare landscape. Maintenance of these funding sources will be particularly important for individuals with behavioral health disorders who remain uninsured.
- Fourth, policy-makers should consider whether special coverage provisions should be developed for individuals with serious illnesses. In contrast to traditional Medicaid coverage, private or benchmark coverage is not designed to provide the full range of acute and long-term medical and social support services needed by individuals with disabling conditions. Differences in the



Policy makers should consider whether special coverage provisions should be developed for individuals with serious illnesses.

scope of coverage of behavioral health services across sources of insurance are likely to persist.

The changing healthcare landscape exempts certain populations from mandatory enrollment in benchmark coverage rather than traditional Medicaid coverage. Individuals falling into these groups must be provided the option of receiving traditional, full Medicaid benefits. These groups include (among others) those with “special health needs,” including individuals with disabling mental health disorders and individuals with mental illnesses that significantly impair their ability to perform one or more activities of daily living.

The Changing Healthcare Landscape that Addresses Scope of Requirement and Benefit Issues

As highlighted in Role 3, the 1915(i) authority provides individual states an opportunity to offer services and supports *before* individuals need institutional care, and also provides a

The 1915(i) authority provides individual states an opportunity to offer services and supports *before* individuals need institutional care, and also provides a mechanism to provide State Plan HCBS to individuals with behavioral health disorders.

mechanism to provide State Plan HCBS to individuals with behavioral health disorders.

Unlike other State Plan services, under 1915(i), states may design service packages without regard to comparability. States may offer HCBS

to specific, targeted populations and offer services that differ in amount, duration, and scope to specific population groups, including eligibility groups as authorized under 1915(i)(6)(c), either through one or multiple 1915(i) service packages. Services must be available statewide.

The 1915(k) provision to the Social Security Act, effective October 2011, allows states to provide “Community-based Attendant Services and Supports”-- called the Community First Choice Option. Under 1915(k), states that provide HCBS attendant services and supports through their State Plans under this option will receive a six percentage points higher Federal match. This is unprecedented to have this high a federal match since the inception of the Medicaid program. Individuals must be eligible for Medicaid under the State Plan and have an income that does not exceed 150 percent of the Federal Poverty Level, or, if their income is greater, they must meet institutional level-of-care criteria.

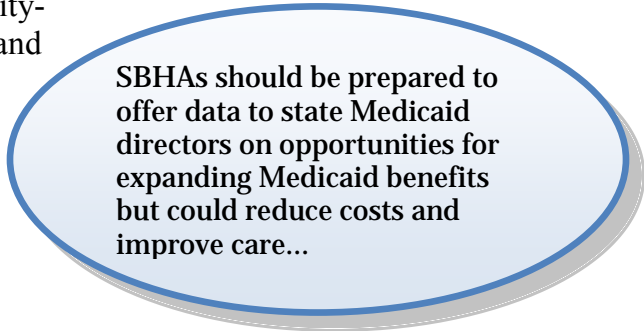
When Medicaid was enacted, states were given the option of covering a wide range of services, several of which can be provided in home and/or community settings. They include rehabilitation services, private duty nursing, physical and occupational therapy, and transportation services.

The Rehabilitation option, in particular, offers states the means to provide a range of supportive services to people in home and community settings. Medicaid defines

rehabilitation services as any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability, and restoration of a recipient to his or her best possible functional level. Rehabilitation services can be provided to people with either physical or mental disabilities.

The Rehabilitation option is a very flexible benefit, because services may be furnished either in the person's residence or elsewhere in the community. Many states cover psychosocial rehabilitation services, which – when combined with personal care and targeted case management services – can meet a wide range of service and support needs for persons who have a serious mental illness.

These changes in the HCBS waiver have great potential to assist Medicaid enrollees with behavioral health needs for whom home and community-based services and supports would enhance recovery and prevent institutional care. SBHAs could encourage their states to make use of the 1915(i) waiver to provide HCBS to Medicaid enrollees with behavioral health conditions.



SBHAs should be prepared to offer data to state Medicaid directors on opportunities for expanding Medicaid benefits but could reduce costs and improve care...

Develop and Implement Innovative Payment Systems – A Case Study

One of the many roles for SBHAs is to develop innovative payment systems that recognize and reward performance. Like many SBHAs, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has been seeking creative solutions to improve provider performance in the face of state budget cuts. Through a collaborative process with the Community Mental Health Center (CMHC) provider community, the Oklahoma Health Care Authority (OHCA), and the state's Medicaid agency, ODMHSAS was able to accomplish something that many cash-strapped state agencies are seeking to do; that is, improve quality of care, increase provider payments, and serve more people in need.

The partnership, called the Oklahoma Enhanced Tier Payment System, provides very important lessons for SBHAs, Medicaid agencies, providers, clients, and stakeholders. Even for those states for which an Upper Payment Limit (UPL) incentive system is not an option, this approach still provides lessons applicable for all states. It demonstrates that states and providers can engage in a mutually beneficial process to improve quality and that it is the partnership between the state and provider community that helps reach that goal.

It challenges the common assertion that provider rates already include payment for quality or that providers should have been performing in a certain way all along; therefore, additional payment is not needed. By shining a spotlight on what was most important to the state – enhancing outcomes – the state improved how its system performed. Additionally, Oklahoma was able to demonstrate that agencies provided something extra for that money – and those extras were the key to important changes in their system.

Finally, the Oklahoma Enhanced Tier Payment System provides a template for how mental health authorities, substance use authorities, and Medicaid agencies can address mutual goals. Promoting health improvement and aligning financial incentives to pay for outcomes, not simply volume of service provision is essential. The expertise of the mental health and substance use authorities to shape system performance in this area is essential to a state Medicaid program.

Medicaid authorities are acutely aware that persons with untreated mental health and substance use issues lead to increased Medicaid costs; and therefore could benefit greatly in partnering with their sister agencies to implement mental health and substance use specific performance benchmarks that improve the system.³²

Goals for Role 9

Action. SBHAs should be prepared to offer data to state Medicaid directors on how the following opportunities for expanding Medicaid benefits could reduce costs and improve care:

The key benefit provisions that apply to behavioral health issues include:

- Requiring the inclusion of behavioral health services in Medicaid benchmark benefit packages that are provided to the new Medicaid expansion group of parents and childless adults with incomes below 133 percent of the FPL.
- This expanded coverage will be especially beneficial to adults with serious illnesses. Frequently, this group has difficulty obtaining Supplemental Security Income (SSI) benefits that would qualify them for Medicaid. In addition, under the changing healthcare landscape, certain Medicaid plans (i.e., benchmark plans) that were designed to mimic private insurance and have fewer benefits than traditional Medicaid to comply with the requirements of the mental health and addictions parity law.

... SBHAs should comment on HHS regulations defining benchmark coverage, especially on the definition of “mental health services.” These comments could include discussion about how and why this definition might differ from the provision of behavioral health treatment under the essential health benefit package.

- Requiring Medicaid to cover smoking cessation, medications, barbiturates and benzodiazepines, all of which are drugs that are frequently used to treat individuals with behavioral health disorders.

Action. As states work to expand their Medicaid program to newly eligible populations, SBHAs should consider providing guidance to state Medicaid directors on how best to ensure that the Medicaid program serves persons with behavioral health needs.

Action. New Medicaid enrollees who qualify for Medicaid are entitled to “benchmark” or “benchmark-equivalent” coverage. Benchmark coverage will be defined by the HHS Secretary, but this coverage *must* include all essential health benefits (as defined for the state Exchange), including prescription drug coverage and “mental health services.” NASMHPD and SBHAs should comment on HHS regulations defining benchmark coverage, especially on the definition of “mental health services.” These comments could include discussion about how and why this definition might differ from the provision of behavioral health treatment under the essential health benefit package.³³

Action. There are 18 categories of optional Medicaid benefits, including diagnostic, screening, preventive and rehabilitative services (“preventive services”). SBHAs could begin educating state Medicaid decision-makers about the benefits of preventive depression and alcohol screening (S-BIRT) to encourage state uptake of this important benefit.

Action. SBHAs could advocate for states to offer HCBS services both to disabled individuals experiencing behavioral health service needs, and individuals who are disabled by a mental illness.

Action. SBHAs could work in partnership with consumer advocacy organizations to develop a statewide plan for outreach and education for individuals with behavioral health disorders under the changing healthcare landscape that may benefit them.

Action. The changing healthcare landscape requires that all benchmark and benchmark equivalent state Medicaid plans must comply with federal parity law. SBHAs have a role in advocating that Medicaid plans comply with the Mental Health Parity and Addictions Equity Act (MHPAEA), and may wish to monitor benchmark plans for compliance.

Action. NASMHPD and SBHAs should work to exempt certain populations (those with “special health needs,” including individuals with disabling mental health disorders and individuals with mental illnesses that significantly impair their ability to perform one or more activities of daily living) from mandatory enrollment in benchmark coverage rather than traditional Medicaid coverage. Individuals falling into these groups must be provided the option of receiving traditional, full Medicaid benefits.

ROLE 10: Provide content expertise on benefits and scope and requirements for behavioral health services -- in partnership with state insurance authorities – that are offered in public and private health insurance plans operating in the state.

Background

Under the changing healthcare landscape, in addition to Medicaid expansion, expansion of health insurance coverage to 16-18 million more people is projected through the creation of state health insurance pools (not to be confused with “high-risk pools”).

One group of Americans that stands to significantly benefit are those individuals who have behavioral health disorders. It is estimated that 26.2 percent of adults in America suffer from a mental health disorder in a given year, with about six percent suffering from a serious mental illness. One in five children aged 0 to 18 years have a diagnosable mental health disorder. Even with this high prevalence of behavioral health disorders, the ability to access behavioral health services has been mixed.³⁴

It is estimated that 26.2 percent of adults in America suffer from a mental disorder in a given year, with about six percent suffering from a serious mental illness...

Under the changing healthcare landscape, insurance pools are designed to serve as a place where individuals and businesses can shop for coverage with the help of easy-to-understand information on all their options. Plans sold through health insurance pools will have to meet certain standards so that consumers get good value for their money.

The insurance pools will serve an important purpose for people who are in middle- or lower-income categories. They will be the place where people can purchase insurance with refundable tax credits in order to increase the availability of affordable health insurance coverage.

SBHAs and behavioral health leaders need to pay particular attention to how the implementation of insurance pools may affect any existing behavioral health treatment mandates and other consumer

In addition, when individuals who are eligible for Medicaid or other public coverage programs enter the insurance pool it is anticipated that they could be quickly be directed to the correct program. However, all of this is possible only if implementation of the insurance pools is successful in each state.

States will develop and run their own insurance pools. If any state declines or fails to do that, a federally-operated insurance pool will serve residents of those states.

There are many provisions intended to make sure that state implementation goes smoothly and that the insurance pools work for consumers. Although these provisions establish a critical baseline of protections to help insurance pools work well, states still have many tasks to complete and choices to make regarding the development and operation of insurance

pools. With the right choices, states can make sure that insurance pools function as intended: as marketplaces for comprehensive coverage that are user-friendly, transparent, and stable.

SBHAs and behavioral health leaders need to pay particular attention to how insurance pools' implementation may affect any existing behavioral health treatment mandates and other consumer protections. States will also need to make key decisions, such as whether to allow national plans to operate and whether to have distinct insurance programs for small businesses. SBHAs will have to become familiar with the mechanics of the insurance pools, such as the roles in eligibility determination, benefit design and public education; and the quality measures used for behavioral benefits offered by qualified plans.

State agencies will have to track ongoing insurance pool-related developments to be well positioned to provide input, make prudent decisions and seize opportunities as they arise.

Behavioral healthcare services are an integral component of the healthcare service packages to be offered within insurance pools. Although the coverage expansion will not begin until 2014, the expansion should ensure coverage of behavioral services by:

- Requiring the inclusion of behavioral health services in the essential benefit package to be offered by qualified health plans, including plans in the health insurance pools and those in the individual and small group markets outside the insurance pool (with the exception of grandfathered individual and employer-sponsored plans).
- The scope of this essential benefit package must be similar to that provided under a typical employee plan (we recognize that at this stage that those benefits do not comply with parity). In addition, the behavioral health parity requirements as set forth in the 2008 parity law are applied to the qualified health plans (QHPs). This means that behavioral health benefits must be provided in the same way as all other covered medical and surgical benefits.

... a range of insurance reforms are intended to make health insurance coverage fairer and more accessible to individuals with heightened health needs ...

A range of health insurance reforms are intended to make health insurance coverage fairer and more accessible to individuals with heightened health needs such as individuals with serious mental illness and substance abuse disorders. Among other things, the changing healthcare landscape will:

- Prohibit discrimination in coverage based on health status—that is, prohibit plans from denying coverage to individuals, and from utilizing varying health insurance premiums, based on factors other than family size, region, age or whether the

individual participates in wellness programs;

- Bar the use of preexisting condition exclusions; guarantee the renewability of coverage;
- Bar lifetime and annual limits on coverage;
- Establish medical-loss ratio standards;
- Prohibit cost-sharing for certain preventive services; and
- Require coverage of routine patient costs associated with certain clinical trials.

These changes alone will not ensure the adequacy of coverage in relation to healthcare need. Nor will they prevent insurers from designing coverage – including benefits, cost-sharing and provider networks – in ways that attract and better serve healthier individuals with lower financial risks.

The Changing Healthcare Landscape that Addresses Scope of Requirement and Benefit Issues

Health plans can offer health insurance coverage in the individual and small group markets to ensure that such coverage includes the essential health benefit package.

Essential health benefits must include as a general category “*mental health and substance use disorder services, including behavioral health treatment.*”

Lower-income persons will receive health insurance coverage either through the state pools, Medicaid expansion program or traditional Medicaid. This coverage will result in one of three benefit packages:

- (1) Persons enrolled in a qualified health plan in the state pools (above 133 percent of the FPL) and not otherwise enrolled in private insurance) are entitled to the essential health benefit package;
- (2) Persons who qualify for coverage under the Medicaid expansion (below 133% of the FPL) are enrolled in benchmark plans that include the essential benefit package, including prescription drug coverage and mental health services; and
- (3) Persons who qualify for traditional Medicaid (whose income is below the state’s current Medicaid limit) are entitled to certain mandatory Medicaid benefits and any additional optional benefits states have elected to cover through state plan amendments.

If states do not plan well, there may be inconsistencies between what benefits are offered under the state insurance pools, the Medicaid expansion, and traditional Medicaid. This

If states do not plan well, there may be inconsistencies between what benefits are offered under the state Exchange, the Medicaid expansion, and traditional Medicaid.

inconsistent coverage will be problematic when individuals inevitably oscillate between the pool, the Medicaid expansion and traditional Medicaid qualifying levels.

To qualify for insurance pools, health plans must include within their networks certain “essential community providers” (ECPs) that

serve predominantly lower-income, medically underserved individuals. HHS has yet to define the scope of this requirement, including which types of providers will qualify as an ECP, and the number of ECPs that qualified health plans must contract with for network adequacy. The scope of this requirement will be extremely important in ensuring that underserved populations are able to access the benefits in the essential health benefit package.

Institute of Medicine (IOM) on Essential Health Benefits (Exhibit 4)

An evolution in the policy development of the essential health benefits (EHB) has occurred in late 2011 beginning with the release of the IOM report. The IOM report has been followed by a new document called the “HHS Bulletin on Essential Health Benefits”.

In a comprehensive policy report, the IOM recommended that the initial Essential Health Benefits (EHB) package offered by health plans and insurers participating in insurance pools be equivalent in scope to what could be purchased by the average premium a **small business** would pay on behalf of an employee.

Exhibit 4

IOM Report on Essential Benefits

The following recommendations were adopted by the IOM Committee in its 320-page final report – “*Essential Health Benefits: Balancing Coverage and Cost*”:

1. The Secretary of Health and Human Services (HHS) should establish an essential health benefits (EHB) package including the 10 categories contained in new Federal legislation and as guided by a national average premium target. **Once developed, the package should be adjusted so that the expected national average premium for a “silver plan” (second-lowest-price arrangement that health plans are allowed to offer) is actuarially equivalent to the average premium small employers will likely pay in 2014 (the initial year when coverage expansions are scheduled to kick-in) for a typical benefit plan.**
2. By January 2013, HHS should establish a framework for monitoring EHB implementation and updating that accounts for changes in provider payment rates, financial incentives, practice organizations, and other relevant matters. HHS should implement this framework and coordinate federal efforts to produce and make the data accessible for public use.
3. Beginning in 2015, the HHS Secretary should update the EHB package to make it more fully evidence-based, specific, and value-promoting – explicitly incorporating costs. A public deliberative process should be used to inform choices about what to include in or exclude from the updated package.
4. HHS should permit states administering their own exchanges to adopt variants of the federal EHB package, provided that modifications are consistent with the federal package, not significantly more or less generous.
5. The HHS Secretary should establish a National Benefits Advisory Council, with members appointed through a nonpartisan process, which should make recommendations annually stemming from its oversight of the EHB package.
6. To ensure that the EHB-defined packages remain affordable and sustainable, the HHS Secretary should develop a strategy, in collaboration with others, for aligning the growth rate of healthcare spending in all sectors with that of the economy.

Although behavioral health benefits are included in the benefit categories that health plans must offer to individuals and small businesses who seek coverage through an insurance pool, pegging small employer plans as the typical health plan that HHS should consider in

Although behavioral health benefits are included in the benefit categories that health plans must offer...pegging small employer plans as the typical health plan that HHS should consider in determining the minimal benefit package, will likely serve to lessen the overall scope of behavioral health benefits in the exchanges.

determining the minimal benefit package, would likely serve to lessen the overall scope of behavioral health benefits offered in the exchanges. It is critical for NASMHPD to continue to advocate for the strongest possible inclusion of comprehensive behavioral health benefits throughout EHB policy process.

The IOM report identified key challenges that HHS will face as it strives to equate the defined EHBs with the typical small-business package. For one, a recent U.S. Labor Department survey of 3200 employer-sponsored insurance plans found it difficult to describe with much precision the health benefits of a “typical” employer package. In addition, some benefits mandated under the changing healthcare landscape – such as mental health services, habilitative services, wellness programs, and pediatric oral and vision care – are generally not included in standard small-employer health insurance contracts.

A common theme throughout the IOM report is affordability. The committee decided to peg its budgeting target to the estimated average premium for a “silver” package — the second-lowest-priced plan available through an exchange and the level to which the ACA's premium subsidies are linked. The report suggests that HHS's selection of benefits be guided by an estimate such as that prepared recently by the Congressional Budget Office (CBO) and converted to 2014 dollars by the IOM committee – \$6,933 for an individual policy – or a RAND study and estimate of \$5,474 for a silver plan when individual and small-group risk pools are combined.³⁵

Criteria to Guide Content of the Aggregate EHB Package

The IOM Committee recommended that in the aggregate, the EHB must:

- **Be affordable** for healthcare purchasers;
- **Maximize the number of people with health insurance coverage;**
- **Protect the most vulnerable** by addressing the particular needs of those patients and populations;
- **Encourage better care practices** by promoting the right care to the right patient in the right setting the first time;
- **Advance stewardship of resources** by focusing on high value services and reducing use of low value services.;
- **Address the medical concerns of greatest importance** to enrollees in EHB-related plans; and

- **Protect against the greatest financial risks** due to catastrophic events or illnesses.

Criteria to Guide EHB Content on Specific Benefit Components

The IOM report recommends that HHS officials should gauge potential services and products against a set of criteria including medical effectiveness, good evidence base, safety, improved outcomes, and cost-effectiveness. Benefits that have been mandated for insurance coverage by individual states should be subject to the same review and criteria. Products and services that do not meet the criteria should not be included, according to the report. The report also described specific criteria to guide methods for updating the EHB.

The committee decided not to recommend a single national definition of medical necessity but added that the criteria used for medically necessary services – or services that conform to medical necessity – are medical services that are:

- (1) Clinically appropriate for the individual patient;
- (2) Based on the best scientific evidence, taking into account the available hierarchy of medical evidence; and
- (3) Likely to produce incremental health benefits relative to the next best alternative that justify any added cost.



The IOM panel agreed unanimously that if the long-standing problem of rising healthcare costs is not addressed more aggressively, then offering meaningful benefits could be undermined.

Recognizing the controversy the EHB process could provoke, the committee recommended that HHS create a “structured interactive process” to advise the department on reconciling “the tensions between comprehensiveness and affordability.”

The IOM panel agreed unanimously that if the long-standing problem of rising healthcare costs is not addressed more aggressively, then offering meaningful benefits could be undermined.

HHS Bulletin on Essential Health Benefits

As a follow to the IOM recommendations, HHS released a bulletin on defining Essential Health Benefits on December 16, 2011. The bulletin sought comment before the formal rulemaking process on the intended approach for defining Essential Health Benefits by a benchmark plan selected by each state. HHS states that this benchmark plan is intended to balance affordability and State flexibility while maintaining comprehensive coverage for ten required categories of service.

HHS released the intended approach to give consumers, states, employers and health plans timely information as they work toward establishing insurance pools and making decisions for the implementation of the coverage expansions beginning in 2014.

The proposed overall regulatory approach that HHS is considering is summarized below:

- States will define Essential Health Benefits by identifying a specific benchmark plan, which will serve as a reference plan for Qualified Health Plans (QHPs) that offer policies within insurance pools. This benchmark or reference plan will reflect the scope of services and service limitations offered by a “typical employer plan” within the state.
- QHPs would offer policies that are “substantially equal” to the state-identified benchmark plan. HHS is considering whether variation would be permitted only within each category of essential health benefits, or whether broader variation would be permitted. HHS is also considering whether substituted benefits should be actuarially equivalent to the original benchmark.
- States may identify their benchmark plan from among the following choices:
 - The largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;
 - Any of the largest three state employee health benefit plans, as determined by enrollment;
 - Any of the largest three FEHBP plans available to all Federal employees, as determined by enrollment; or
 - The largest commercial Health Maintenance Organization operating in the state.

States would select a benchmark in the third quarter, two years prior to the coverage year in question, using enrollment data from the first quarter of that year. For example, for coverage year 2014, states would select a benchmark in the third quarter of 2012, using enrollment data from the first quarter of 2012. If a state does not select a benchmark health plan, the default benchmark will be the small group market plan with the largest enrollment in the state.

Under the HHS Bulletin, mental health and substance use disorder services would be required essential health benefits, with benefit designs that comply with mental health parity requirements, regardless of whether these services are included or treated at parity in the benchmark plan.

HHS particularly notes that mental health, habilitative services, pediatric oral services and pediatric vision services – all services that are essential health benefits – are less likely to be covered by benchmark plans. HHS lays out options for how plans should cover these services.

If a state were to choose as its benchmark a plan that includes all state-mandated benefits – for example, a plan sold in the small-employer market – these state-mandated benefits would be included in the benchmark. If the state chose a benchmark that does not include all of these benefits – such as an FEHBP plan – the state would be required to cover costs related to these requirements.

HHS will re-examine the entire EHB issue in 2016 as it evaluates the benchmark approach over the initial two years of implementation. For more information on the HHS Bulletin on the EHB package please click on this link.
http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

NOTE: NASMHPD has prepared comments to the HHS bulletin that are embodied in Appendix 4.

Goals for Role 10

Action. NASMHPD supports behavioral health benefits as delineated in Appendix 4 which provides detailed recommendations on essential health benefits. These benefits are based in part on a review of existing employer plans, because the changing healthcare landscape requires the essential health package to reflect those covered in a “typical employer plan.”

Action. At the same time, however, because final MHPAEA (parity) regulations have not been issued, and enforcement of existing regulations has been limited, the parity-based services and payment required under the changing healthcare landscape are not yet reflected in the current insurance market.

SBHAs could recommend an array of services to meet the needs of plan participants at all stages of the continuum of their behavioral health conditions, from mild to severe impairment. Clearly, some services will be necessary for individuals with severe mental illnesses and substance abuse disorders, while other services will meet the needs of those with mild to moderate behavioral health conditions.

... SBHAs could promote an overall benefit to include a universal definition of medical necessity that includes rehabilitation, habilitation, prevention, recovery programs and long term care services...

Under the changing healthcare landscape, behavioral health treatment must be sufficient to provide medically necessary care. Plans must be required to provide transparent definitions of medical necessity for mental health, substance use disorder and other medical conditions so that parity compliance can be measured.

Action. NASMHPD and SBHAs should consider commenting on the HHS proposed regulations on essential health benefits during the formal notice and comment period

beginning in March 2012, to ensure that the behavioral health benefit category is adequately defined.

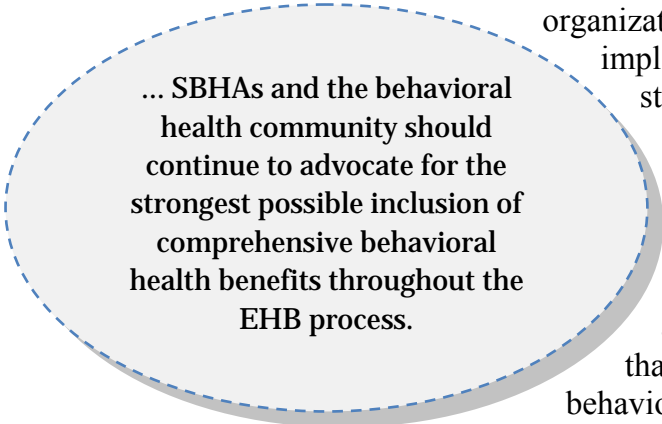
Action. States have the option of mandating additional benefits that qualified health plans participating in the state pools must cover. SBHAs could consider making recommendations to expand benefit requirements if the essential benefit package is not sufficient to meet the behavioral health needs of state residents.

Action. NASMHPD and SBHAs could promote an overall benefit to include a universal definition of medical necessity that includes rehabilitation, habilitation, prevention, recovery programs and long term care services in order to ensure an appropriate continuum of services in benchmark plans offered by health plans in the health insurance pools. This will provide clear guidance to providers that would promote consistency in the supports and services provided for mental health and substance use, utilization management and quality assurance.

SBHAs could highlight that the definition of medical necessity must balance the need for consistency with the need to apply the medical necessity definition to each individual, given the totality of that person's health condition.

Action. SBHAs could encourage their state to coordinate planning of the insurance pool and Medicaid expansion behavioral health benefit to be consistent with one another and with traditional Medicaid. Consistency in benefits offered means a more dependable benefit for persons in treatment. This is especially important for behavioral health clients, as interruptions in treatment may disrupt recovery efforts.

Action. Health Insurance pools will be administered by a governmental agency or non-profit organization and the entities responsible for implementing the insurance pool(s) will vary by state, and will likely include, representatives of the Governor, state insurance commissioners, representatives of state Medicaid offices, legislators and other state health leaders. Many states are establishing advisory boards for their insurance pools. SBHAs should join advisory board or special task forces or advocate that the board include one or more members with behavioral healthcare expertise.³⁶



... SBHAs and the behavioral health community should continue to advocate for the strongest possible inclusion of comprehensive behavioral health benefits throughout the EHB process.

This representation will help ensure that decision-makers remain cognizant of behavioral health concerns throughout the entire process, both during insurance pool establishment and once pools are operational. SBHAs could also encourage state advisory boards to hold public meetings, or at minimum make meeting minutes available for public comment.

Action. It is critical for NASMHPD, SBHAs and the behavioral health community to continue to advocate for the strongest possible inclusion of comprehensive behavioral health benefits throughout EHB process.

Action. SBHAs should be more strategic in their efforts to purchase services. The availability of new evidence-based approaches and funding will require SBHAs to rethink what services they purchase as well as how those services are purchased. Although access to Medicaid and private insurance will increase over the next few years, gaps in coverage will remain for specific populations and services (see Role 5 for more actions). SBHAs need to begin to identify those gaps by first mapping out which populations will be covered by various health insurance coverage options available under the changing healthcare landscape.

Within the different insurance packages, SBHAs should consider the extent to which specific behavioral health services will remain uncovered. In order to identify gaps in the continuum of services, SBHAs will need to determine what specific behavioral health services they should cover in addition or over and above to what is being covered by health insurers and other payers.

Action. The new healthcare environment may create new ways to purchase services. Reimbursement for episodes of care and pay-for-outcomes are just two strategies that payers may use in the future. These strategies have not been widely deployed by public behavioral health purchasers. SBHAs should consider using their block grant funds and develop reimbursement strategies, under the changing healthcare landscape, to reimburse for better services, not just more services.

ROLE 11: Actively ensure the outreach and enrollment of individuals with behavioral health disorders so they may receive health coverage based on their eligibility and are able to easily access care.

Background

U.S. citizens and legal residents will be required to have health insurance beginning in 2014, and under the changing healthcare landscape, a state-based system of insurance pools and expansion of Medicaid, coverage will readily be available to millions of uninsured people who need it.

It is estimated that 34-35 million people between the 2014-2021 time-frame will obtain coverage who would have otherwise been uninsured through state insurance pools and Medicaid. An

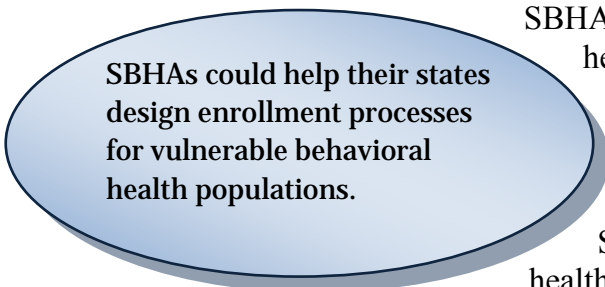
estimated six to ten million people with behavioral health conditions who are currently uninsured will be eligible for health insurance coverage.³⁷

It is estimated that 34-35 million people between the 2014-2021 time-frame will obtain coverage that would have otherwise been uninsured through state insurance pools and Medicaid.

State enrollment policies and procedures and supporting technology systems will help individuals and families enroll and stay covered, and also foster efficient administration. Despite intensive outreach and streamlined application procedures, the Children's Health Insurance Program (CHIP), for example, enrolled only 60 percent of eligible, uninsured children five years after the program began in 1998.³⁸

"If you build it, they will come," cannot be the motto of state health agencies. Simply offering health coverage subsidies, even coupled with vigorous outreach and simple application forms, is no guarantee that uninsured persons with mental illnesses and substance abuse disorders, and who are eligible for subsidies, will receive insurance. Without careful attention to enrollment mechanisms, take-up can be slow, endangering a new program's reputation and even survival before it has a chance to prove itself.

As states move forward, the experience of SBHAs in managing public insurance programs can help in the design of an integrated, consumer-friendly enrollment structure that incorporates Medicaid, CHIP, the HIE, and any other available state or local public health programs.



SBHAs could help their states design enrollment processes for vulnerable behavioral health populations.

SBHAs can play a facilitative and leadership role by helping behavioral health consumers identify and compare their coverage options and assess their eligibility for health insurance subsidy programs.

Statewide insurance pools under the changing healthcare landscape have the opportunity to tailor their enrollment process to address additional considerations for vulnerable individuals with special needs.

SBHAs could help their states design enrollment processes for vulnerable behavioral health populations. For example, homeless people with behavioral health conditions and active substance users can be particularly disenfranchised populations; proxy enrollment procedures may be necessary for these populations.

The Changing Healthcare Landscape that Addresses Health Insurance Outreach and Enrollment Issues

With millions of Americans people enrolling in health insurance pools by 2019, a strong navigation system will be needed to inform people about their new insurance options and help them enroll. A Navigator function has been created to help people who will obtain health coverage through their state's insurance pools, such as small businesses, self-employed or people who do not have access to insurance through their employers. The Navigator's job is to provide individuals and families with the information necessary to determine which health insurance option best fits their needs and then help them enroll in their plan of choice. All states will need to fund the Navigator process.

Under the changing healthcare landscape, private health insurers will be barred from denying coverage on the basis of pre-existing conditions or limiting coverage when people most need it will help people with behavioral health conditions obtain and keep health insurance coverage.

The ability of nonelderly adults with incomes up to 133 percent of the federal poverty level to enroll in Medicaid, and financial assistance to help individuals and families with incomes between 133 percent and 400 percent of the FPL to purchase coverage on insurance pools, will particularly benefit people with a behavioral health condition, many of whom live in poverty.

State insurance pools have the opportunity to tailor their enrollment process to address additional considerations for vulnerable individuals with special needs.

There will be a reduction in the cost of prescription medicines for people with a behavioral health disorder. Medicare Part D enrollees will benefit considerably from actions that will

close the prescription drug “doughnut hole” by 2010. Provisions remove smoking cessation drugs, barbiturates and benzodiazepines from Medicaid’s excludable drug list, effective January 1, 2014. This will make these prescription medicines, used to treat behavioral health disorders and smoking, available and affordable to all Medicaid beneficiaries.

Goals for Role 11

Action. SBHAs should consider whether it would be appropriate to apply for funding from the state pools to become Navigators. Behavioral health provider agencies can also provide enrollment education resources and serve as potential Navigator sites.

SBHAs should consider whether it would be appropriate to apply for funding from the pools to become Navigators. Behavioral health provider agencies can also provide enrollment education resources and serve as potential Navigator sites.

If SBHAs themselves do not become Navigators, they should provide information and assistance to Navigators to reach vulnerable persons with behavioral health needs, including homeless populations and persons released from prison.

Action. SBHAs could ensure that coverage is easily accessible for those eligible to receive coverage through insurance pools, and that the Navigator programs are sufficiently funded and staffed to facilitate the enrollment process for those

individuals for whom the process may be more burdensome and those transferring between Medicaid enrollment and the insurance pools.

Action. SBHAs should support efforts that explicitly identify community mental health and substance use disorder organizations licensed or certified by the state as essential community providers.

Action. SBHAs should support initiatives that explicitly recognize and enforce the essential health benefits requirements of the insurance pools, including the requirement that comprehensive behavioral health benefits, at parity with medical/surgical benefits, be covered by Qualified Health Plans (QHPs).

Action. SBHAs should be part of efforts that develop and help enforce network adequacy standards that ensure access to all essential health benefits, including behavioral health benefits.

Action. SBHAs could support efforts that enforce strong consumer protections for QHP enrollees to ensure that individuals can easily obtain access to the type, level and duration of healthcare and behavioral healthcare they need, and that confidentiality is protected.

Action. SBHAs could work closely with other stakeholders to ensure that the pools conduct strong outreach and education activities, targeted to the public, eligible employers, behavioral health consumers and service providers to ensure sufficient access to coverage and benefits.

Action. SBHAs could ensure that governing boards and other advisory bodies tasked with developing and administering the insurance pools include individuals with expertise regarding the unique needs of individuals with behavioral health disorders. SBHAs should be included in the development and management of the insurance pools.

SBHAs could advocate for the enrollment needs of individuals moving from institutions...to community-based settings in order to prevent discontinuity of care.

Action. SBHAs could advocate for the enrollment needs of individuals moving from institutions, such as IMDs or prisons, to community-based settings in order to prevent discontinuity of care. SBHAs also should engage with the state insurance pools and Medicaid programs to determine how best to address enrollment for individuals whose income levels fluctuate between Medicaid and insurance pools eligibility to ensure that these individuals have consistent access to behavioral healthcare services.

Action. As states begin designing and constructing their health information pools and their enrollment Web-sites, SBHAs could work to encourage their colleagues to think of these pieces as an integrated eligibility and enrollment system that includes Medicaid and CHIP, as well as the insurance pools (**Appendix 5**).

Action. SBHAs could identify the individuals who are designing and managing the consumer assistance program in their state and work with them to ensure appropriate outreach and support to individuals with mental health conditions.

Action. The experience of persons with behavioral health conditions in insurance markets similar to the insurance pools, such as the Massachusetts Connector and the Federal Employees Health Benefit Program, show that competition among health plans for enrollees who are “good risks” can undermine coverage and efficiency. SBHAs could promote approaches for contending with selection-related incentives, such as carving out all or part of behavioral health benefits, providing reinsurance for some behavioral healthcare costs, or running the insurance pool in the same way that an employer runs its employee benefits and addressing selection and cost control issues by choice of contractor.

Even with recent actions, millions of uninsured Americans could still be left without health insurance coverage including those with behavioral health conditions, unless effective mechanisms for enrolling eligible individuals are in place.

NASMHPD has provided comments on the **Establishment of Insurance Pools (exchanges) and Qualified Health Plans: Proposed Rule CMS-9989-P.** -- regarding the establishment

of the health insurance pools and qualified health plan (QHP) requirements. NASMHPD recommended the inclusion of the following items in the proposed rule:

- Explicit recognition that requires pools to consult with certain groups of stakeholders as they establish their programs and throughout ongoing operations, and the specific requirement that the insurance pools regularly consult with advocates for individuals with behavioral health service needs, both as the pools are developed and on an ongoing basis.
- The encouraging of the insurance pools to conduct outreach and education activities to promote participation, including outreach and education targeted at hard to reach populations and populations that experience health disparities, including individuals with behavioral health disorders.
- The requirement that the insurance pools must establish standards for termination of coverage that requires issuers of QHPs to provide reasonable accommodations to individuals with mental or cognitive conditions, including individuals with behavioral health disorders.

To further ensure that the insurance pools adequately address the needs of people with behavioral health disorders, processes should be established that:

1. Explicitly identify community mental health and substance use disorder organizations licensed or certified by the state as essential community providers;
2. Explicitly recognize and enforce the essential health benefits requirements of the pools including the requirement that comprehensive behavioral health benefits, at parity with medical/surgical benefits, be covered by all QHPs;
3. Develop and enforce network adequacy standards that ensure access to all essential health benefits, including behavioral health benefits;
4. Enforce strong consumer protections for QHP enrollees to ensure that individuals can easily obtain access to the type, level, and duration of care they need, and that confidentiality is protected;
5. Ensure that coverage is easily accessible for those eligible to receive coverage through the insurance pool, and that the Navigator programs are sufficiently funded and staffed to facilitate the enrollment process for those individuals for whom the process may be more burdensome and those transferring between Medicaid enrollment and the insurance pools;

6. Require insurance pools to conduct strong outreach and education activities, targeted to the public, eligible employers, consumers and service providers to ensure sufficient access to coverage and benefits; and

7. Ensure that governing boards and other advisory bodies tasked with developing and administering the insurance pools include individuals with expertise regarding the unique needs of individuals with behavioral health disorders. In particular, administrators of State and federal substance use disorder and mental health programs should be included in the development and management of the pools.

ROLE 12: Educate providers, insurance carriers, federal and state policymakers and officials, healthcare providers, consumer organizations and the general public on behavioral health parity within public and private insurance and monitor its implementation.

Background

In addition to the expansion of coverage under the changing healthcare landscape, expectations are rising about access to care as a result of *The Mental Health Parity and Addiction Equity Act* (MHPAEA). MHPAEA requires most health plans to increase coverage and eliminate discriminatory rules and payments, making benefits for behavioral health treatment comparable to the coverage provided for all other health conditions.³⁹ While the implementation of parity presents challenges, the parity law improves access to healthcare services for many individuals living with behavioral health conditions.

Both new coverage expansions and MHPAEA create an unprecedented opportunity to implement comprehensive health insurance coverage, including coverage for behavioral health conditions, for nearly all Americans.

The Mental Health Parity Act of 1996, revised and expanded by *The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, broadly addresses the problem of discrimination against behavioral health disorders in both private health insurance benefit design and plan administration. The original legislation addressed parity only in relation to annual and lifetime dollar limits on coverage; the 2008 amendments extend the concept of parity to reach a broad range of coverage limitations and exclusions and addresses substance abuse.

In addition to the expansion of coverage, expectations are rising about access to care as a result of the Mental Health Parity and Addiction Equity Act (MHPAEA).

These amendments were further refined in implementing regulations released in 2010 by the Departments of Labor, Treasury and HHS, which define parity in terms of quantitative treatment limits (i.e., the number of visits permitted) as well as “non-quantitative” treatment limits that “otherwise limit the scope or duration of benefits for treatment.”

These types of limits lie at the heart of modern benefit design and medical management systems; in particular, non-quantitative design and management techniques, which in some cases are expressly designed to constrain coverage to individuals with disabilities.

The 2010 parity regulations affect many of the health benefit design and management practices described above. For example, the regulations specify that discrimination may be present under the parity law when behavioral health disorders are singled out by guidelines that restrict coverage to certain treatments, regardless of the medical evidence, even when no similar absolute limits apply to other conditions.

The rules also clarified that parity can be violated through discriminatory medical necessity criteria that utilize more restrictive tests of necessity in the case of behavioral health disorders and through other design techniques such as tiered cost-sharing, tiered network arrangements and utilization management procedures that are applied in a discriminatory fashion.

The parity provisions thus offer an important precedent in approaching the essential benefits provisions under the changing healthcare landscape. In the case of behavioral health parity, the federal agencies not only have directly addressed the range of plan design and administration practices, but have identified many types of practices that must be held to nondiscrimination standards, including specific benefit definitions, broad definitional terms such as medical necessity, the use of practice guidelines and the use of provider network and cost sharing tiers.

The Changing Healthcare Landscape that Addresses Mental Health Parity

Qualified health plans operating in the state insurance pool are subject to the 2008 MHPAEA. Generally, MHPAEA requires that the financial requirements and treatment limitations imposed on behavioral health disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits.

SBHAs have an opportunity under the changing healthcare landscape and on-going discussions... to inform stakeholders on the key MHPAEA provisions and their linkage to 2014 coverage expansions.

Goals for Role 12

Action. SBHAs have an opportunity to use on-going discussions with health plans and healthcare purchasers, to develop user-friendly MHPAEA information to inform key stakeholders on the key provisions MHPAEA and their linkage to 2014 coverage expansions.

Action. For parity to achieve its intended goals, it is important for SBHAs to work closely with their state insurance divisions. Together, SBHAs can promote education of, and compliance with, parity requirements, monitor results, facilitate handling of consumer complaints, enhance transparency and accountability, and expand needed consumer protections.

Action. SBHAs could develop special websites to allow consumers to offer information about the implementation of the mental health parity, and SBHAs should strongly encourage individuals and families to share their personal experiences with parity implementation - both positive and negative.

Action. SBHAs should monitor parity implementation by assessing health plan performance related to access, quality, coverage and costs; examining the breadth of diagnoses covered by health plans; and mounting a campaign to educate consumers about their insurance benefits.



This report is a living document and will be updated to identify the appropriate roles of SBHAs in this quickly changing healthcare and behavioral healthcare environment, and in the rapidly changing budget, fiscal, and delivery system environment at the state and federal level.

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About NASMHPD

The National Association of State Mental Health Program Directors (NASMHPD) is home to the only member organization representing state executives responsible for the \$37 billion public behavioral health service delivery system serving nearly 7 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association.

NASMHPD serves as the national representative and advocate for state behavioral health agencies and their directors and supports effective stewardship of state mental health systems.

NASMHPD informs its members on current and emerging public policy issues, educates on research findings and best practices, provides consultation and technical assistance, collaborates with key stakeholders, and facilitates state to state sharing.

About the Author

Joel E. Miller, M.S. Ed., is Senior Director of Policy and Healthcare Reform for the National Association of State Mental Health Program Directors (NASMHPD). In this capacity, he leads the development and implementation of NASMHPD's policy agenda and regulatory strategies designed to support State Behavioral Health Agencies and the state public behavioral health systems.

Mr. Miller served as Senior Vice President at the National Coalition on Health Care (NCHC), where he oversaw the evaluation, preparation and dissemination of innovative research and policy analysis about the nation's healthcare system. At the National Alliance on Mental Illness (NAMI), Mr. Miller led NAMI's State Policy team, which is dedicated to improving the financing and delivery of mental health services at the state level, and addressing mental illness issues across the lifespan.

He has published over 50 articles and reports on behavioral health and healthcare delivery and financing issues, the healthcare workforce, medical practice assessment issues, quality improvement, insurance exchanges, public/private health insurance programs, and state healthcare programs.

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APPENDICES

Appendix 1

Measures in the Development of EHRs and Health Information Technology Systems

The following is a set of specific issues and populations of high priority, such as co-occurring health conditions, the health of children and adolescents, and the behavioral health recovery movement. SBHAs could support the inclusion of these measures in the development of EHRs and health information technology systems:

- 1. Appropriate monitoring of metabolic/cardiovascular side effects for individuals receiving antipsychotic medication*
- 2. Meaningful use of disease registries and evidence-based decision support for (at least two) behavioral health conditions*
- 3a. Depression screening and follow-up Process Depression screening based on recommendation of the US Preventive Services Task Force and HHS*
- 3b. Use of standardized assessment tools (for example, PHQ-9) for depression*
- 3c. Depression remission at 6 months Outcome*
- 3d. Depression remission at 12 months Outcome*
- 4. Screening, brief intervention, and referral for alcohol abuse Process Based on recommendation of US Preventive Services Task Force and Physician Consortium for Performance Improvement*
- 5. Appropriate number of visits after initiating ADHD treatment Process NQF-endorsed measure stewarded by NCQA Patient-centeredness*
- 6. Experience of care/satisfaction with care/recovery consumer survey items*
- 7. Initiation and enrollment in alcohol and drug dependence treatment within 14 days, 30 days*
- 8. 30-day re-hospitalization for individuals hospitalized for a mental health or substance use condition*
- 9a. Items 1, 3–8 analyzed for disparities with regard to race/ethnicity, sex and age (over age 65 and under age 18)*
- 9b. General medical quality indicators for chronic conditions such as diabetes,*

cardiovascular disease and preventive care analyzed for population denominators with mental illness co-morbidity

10. Availability and distribution materials for shared decision-making, self-management, and recovery that are culturally relevant to community populations.

Appendix 2

Expanded Use of Health Information Technology to Increase Access to Behavioral Health Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded up to 29 new grants, totaling up to \$25 million over three years, to expand use of health information technology to increase access to behavioral health services.

This program will leverage technology to improve access and coordination of the treatment of mental and substance use disorders especially for Americans in remote areas or in underserved populations. Web-based services, smart phones, and behavioral health electronic applications (e-apps) will enhance communication between patients and healthcare providers to improve discussions about treatment options and decisions, and better manage health.

Each grantee may receive up to \$280,000 annually over three-years. The actual amounts may vary, depending on availability of funds and progress achieved by the awardees.

Below is a list of awardees and their projected yearly award amounts:

Grantees	City	State	Yearly Award
Aliviane, Inc.	El Paso	Texas	\$280,000
Centerstone of Indiana	Columbus	Indiana	\$280,000
Clinical and Support Options, Inc.	Greenfield	Massachusetts	\$280,000
Kentucky River Community Care, Inc.	Jackson	Kentucky	\$280,000
Human Services Center	Peoria	Illinois	\$279,087
Tarzana Treatment Centers	Tarzana	California	\$280,000
Wright State University	Dayton	Ohio	\$279,990
Preferred Family Healthcare Inc.	Kirksville	Montana	\$273,738
Odyssey House Louisiana Inc.	New Orleans	Louisiana	\$280,000
Volunteer Behavioral Health Care System	Chattanooga	Tennessee	\$280,000
Health Services Center, Inc.	Anniston	Alabama	\$280,000
CETPA	Norcross	Georgia	\$280,000
Street Works	Nashville	Tennessee	\$280,000

Northern Ohio Recovery Association	Cleveland	Ohio	\$280,000
The University of Tennessee	Knoxville	Tennessee	\$279,659
University of KS Medical Ctr Research Institute	Kansas City	Kansas	\$280,000
Arapahoe House, Inc.	Thorton	Colorado	\$280,000
Loyola Recovery Foundation, Inc.	Pittsford	New York	\$273,681
River Edge Behavioral Health Center	Macon	Georgia	\$280,000
Aspire Indiana, Inc.	Nobelsville	Indiana	\$262,792
Richmond Behavioral Health Authority	Richmond	Virginia	\$280,000
WestCare Nevada, Inc.	Las Vegas	Nevada	\$280,000
Turning Point	Paterson	New Jersey	\$279,581
Spectrum Programs, Inc.	Miami	Florida	\$280,000
Advocates, Inc.	Framingham	Massachusetts	\$279,970
Nicasa, NFP	Round Lake	Illinois	\$267,882
TASC, Inc.	Chicago	Illinois	\$267,881
Central Oklahoma Family Medical Center, Inc.	Konowa	Oklahoma	\$262,579
First Call Alco/Drug Prevention & Recovery	Kansas City	Missouri	\$265,927

Appendix 3

SAMHSA Working Definition of Recovery from Mental Disorders and Substance Use Disorders (Released December 2011)

The Substance Abuse and Mental Health Services (SAMHSA) recognizes there are many different pathways to recovery and each individual determines his or her own way. SAMHSA engaged in a dialogue with consumers, persons in recovery, family members, advocates, policy-makers, administrators, providers, and others to develop the following definition and guiding principles for recovery. The changing healthcare landscape compels SAMHSA to define recovery and to promote the availability, quality, and financing of vital services and supports that facilitate recovery for individuals. In addition, the integration mandate in title II of the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) provide legal requirements that are consistent with SAMHSA's mission to promote a high-quality and satisfying life in the community for all Americans.

Recovery from Mental Disorders and Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- **Health:** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
- **Home:** a stable and safe place to live;
- **Purpose:** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community:** relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent

possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence is the safest approach for those with substance use disorders. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups,

community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, and employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

SAMHSA has developed this working definition of recovery to help policy makers, providers, funders, peers/consumers, and others design, measure, and reimburse for integrated and holistic services and supports to more effectively meet the individualized needs of those served.

Many advances have been made to promote recovery concepts and practices. There are a variety of effective models and practices that States, communities, providers, and others can use to promote recovery. However, much work remains to ensure that recovery-oriented behavioral health services and systems are adopted and implemented in every state and community. Drawing on research, practice, and personal experience of recovering

individuals, within the context of health reform, SAMHSA will lead efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them.

Appendix 4

Recommendations on Coverage of Mental Health and Substance Use Disorder Services in the Essential Health Benefit Package

The following specific recommendations are part of NASMHPD's and the "Coalition for Whole Health Recommendations on Coverage of Mental Health and Substance Use Disorder Services in the Essential Health Benefit Package," and recommendations of the Bazelon Center for Mental Health Law regarding "HHS Definition of Essential Benefits With Respect to Mental Health Services" where NASMHPD was a multi-stakeholder signee.

Assessment. Standardized assessment tools should include:

- Assessment of health including a comprehensive bio-psychosocial assessment of related mental health and substance use issues, and of needs and strengths that can be used to help individuals attain their treatment, other service and support goals;
- Ongoing mental health and substance use disorder assessments using evidence-based assessment tools;
- Specialized evaluations including psychological and neurological testing; and
- Diagnostic assessments of behavioral health disorders in general medical settings, including education and counseling for mild behavioral health conditions.

Patient Placement Criteria. Evidence-based patient placement criteria can help to effectively place individuals into the optimal level of behavioral healthcare for the amount of time that is deemed medically necessary.

- For example, the *Patient Placement Criteria for the Treatment of Substance-Related Disorders-- Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is a widely used tool by which practical and clinical determination of substance use levels of care can be measured.⁴⁰
- ASAM criteria are currently used in some form in 30 states and have been adopted by a wide range of commercial payers and providers.
- *Level of Care Utilization System for Psychiatric and Addiction Services* (LOCUS) developed by the American Association of Community Psychiatrists (AACP), provides quantifiable measures to guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes that are becoming increasingly important. This single instrument provides a single instrument that can be used for these functions in a wide variety of settings, including both mental

health and addictions. It provides a common language and set of standards with which to make such judgments and recommendations.

LOCUS has three main objectives. The first is to provide a system for assessment of service needs for adult clients, based on six evaluation parameters. The second is to describe a continuum of service arrays which vary according to the amount and scope of resources available at each “level” of care in each of four categories of service. The third is to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum.⁴¹

Outpatient Treatment. Outpatient treatment services should include evidence-based:

- Individual, group, and family therapies;
- Devices and technology interventions for mental health and addictive disorders;
- General and specialized outpatient medical services;
- Consultation to caregivers and other involved collateral contacts, such as school teachers, in accordance with confidentiality requirements; and
- Evidence-based complementary medicine services, comparable to complementary medicine services covered for other health conditions.

Intensive Outpatient Services. Intensive outpatient covered benefits should include:

- Substance use intensive outpatient treatment;
- Mental health intensive outpatient treatment;
- Partial hospitalization;
- Dual-diagnosis partial hospitalization and intensive outpatient services for persons with co-occurring behavioral health conditions; and
- Intensive case management for behavioral health disorders.

Residential Treatment. These services include:

- Residential crisis stabilization;
- Detoxification in clinically-managed non-hospital residential treatment facilities for substance abuse care, including the use of medication-assisted withdrawal management services;
- Mental health residential for adults and youth;
- Substance use disorder residential, including the use of medication-assisted

- treatment, for adults and youth;⁴²
- Dual-diagnosis residential services for adults and youth with co-occurring mental health and substance use conditions;
- Clinically managed medium intensity care;
- Inpatient psychiatric hospital;
- Inpatient behavioral health disorder care; and
- Inpatient hospital dual-diagnosis care for youth and adults with co-occurring mental health and substance abuse conditions.

Laboratory Services

- While the use of laboratory tests at all levels of care is clearly indicated to identify potentially co-occurring general medical conditions, or general medical complications of treatments for behavioral health conditions, evidence-based medical care for persons with behavioral health conditions requires the ability to offer integrated general medical and behavioral healthcare.
- The Essential Health Benefit should include coverage for laboratory tests whether offered by behavioral health specialists, general medical professionals such as primary care providers, or persons in non-behavioral, non-primary care medical/surgical specialties.
- Laboratory services should include drug testing.

Emergency Services. These services should include:

- Crisis services in both behavioral health and medical settings, including 24 hour crisis stabilization and mobile crisis services, including those provided by peers;
- 24/7 crisis warm and hotline services; and
- Hospital-based detoxification services.

Prescription Drugs.

- Medication management;
- Medication administration;
- Pharmacotherapy (including medication-assisted treatment);
- Home-based, mobile device or internet-based medication adherence services;
- Assessment for medication side effects; and

- Appropriate wellness regimens for consumers who are experiencing metabolic effects as a result of their medication.

Rehabilitative Services. The following rehabilitative services should be covered:

- Psychiatric rehabilitation services;
- Behavioral management;
- Comprehensive case management in physical health or behavioral health settings which should include individualized service planning with periodic review to address changing needs, treatment matching, navigation between all needed services, communication between all service providers, enrollment in Medicaid/insurance, and support to maintain continued eligibility;
- Assertive Community Treatment (ACT) Teams;
- Peer provided telephonic and internet based recovery support services, including those delivered by recovery community centers;
- Recovery supports, including those delivered by peer run mental health organizations; and
- Skills development including supported employment services;

Recovery supports. These services include:

- Peer provided recovery support services for addiction and mental health conditions;
- Recovery and wellness coaching;
- Recovery community support center services;
- Support services for self-directed care; and
- Community Support Programs and other continuing care for mental health and substance use disorders.

Habilitative Services. These services should include:

- Personal care services;
- Respite care services for caregivers;
- Transportation to health services; and
- Education and counseling on the use of interactive communication technology devices.

Prevention and Health Promotion.

Health promotion is a significant part of comprehensive prevention and wellness plans and should be included in the preventive and wellness services and chronic disease management Essential Health Benefit. Services identified in the Preventive, Wellness and Chronic Disease Management Essential Health Benefits category should include:

- Screening (including screening for depression, alcohol, drugs, and tobacco), brief interventions (including motivational interviewing) and facilitated referrals to treatment;
- General health screenings, tests and immunizations;
- Appropriate behavioral health related educational programs for consumers, families and caretakers including programs related to tobacco cessation, the impact of alcohol and drug problems, depression and anxiety symptoms and management, and stress management and reduction and referral for counseling or support as needed;
- Caretaker education and support services, including non-clinical peer-based services, that engage and offer support to individuals, their family members, and caregivers to gain access to needed services and navigate the system;
- Health coaching, including peer specialist services, provided in person or through telehealth, e-mail, telephonic or other appropriate communication methods;
- Health promotion, including substance use prevention and services that impact well-being and health-related quality of life;
- Services for children, including therapeutic foster care;
- Interventions aimed at facilitating compliance with treatment and improving management of physical health conditions;
- Care coordination (including linkages to other systems, recovery check-ups, linkages to peer specialists, recovery coaches, or support services based on self-directed care); and
- Relapse prevention, including non-clinical peer-based services, to prevent future symptoms of and promote recovery strategies for mental and substance use disorders.

Coverage for Youth.

While most services mentioned above apply to youth, there are additional behavioral health services that are only appropriate for youth and families. These services are listed below in the appropriate corresponding Essential Health Benefits categories. The Medicaid Early and

Periodic Screening, Diagnostic and Treatment (EPSDT) benefit should serve as a model for coverage for children and youth up to age 21 who are insured through the state Exchanges and Medicaid expansion plans.⁴³

These comprehensive benefits are essential to ensure the early identification, treatment and recovery of youth diagnosed with a mental illness or substance use disorder.

Specific attention should also be paid to ensure that the needs of transition age youth are well met.

Maternal and Newborn Services. These services include:

- Pre-natal and peri-natal screening and brief interventions for maternal depression and substance use disorders and referral to treatment;
- Health education;
- Targeted case management; and
- Maternal, infant, and early childhood home visiting programs.

Pediatric Services. These services include:

- Screening for substance use, suicide, and other mental health problems using tools such as the CAGE questions, the Alcohol Use Disorders Identification Test (AUDIT) instrument and other rapid identification tools;⁴⁴
- Early intervention services;
- Caretaker coaching on children’s social/emotional development and support;
- Intensive home-based treatment; and
- Targeted case management.

The following are suggestions regarding how plans should address scope of covered services, chronic care management and the ACA requirement for non-discrimination with respect to disability.

Scope of Covered Services.

- Services covered should be those designed to meet a healthcare objective in an effective, cost-efficient and consumer-friendly manner. Healthcare objectives are intended to “continuously reduce the impact and burden of illness, injury and disability and to improve the health and functioning” of the individual.

- Each health plan’s benefit should ensure coverage of services for:
 - Acute/transient conditions;
 - Chronic conditions;
 - Conditions requiring rehabilitation to achieve or maintain a designated level of functioning; and
 - Prevention.

- Non-medical services, especially for those with chronic conditions, should be covered when they are part of an evidence-based practice that bundles together medical and non-medical services (examples would be supportive housing and supported employment) in order to ensure a sustainable, successful outcome (stability or remission) of a serious or chronic condition.

- Covered services should be those that meet certain criteria (and services that do not meet these criteria are not required to be covered but may be covered at plan option):
 - Services with credible evidence to demonstrate the efficacy and safety of a treatment (peer-reviewed medical literature);
 - Services for which there are practice guidelines from credible sources;
 - Services for which there are national consensus evidence-based treatment protocols;
 - Services that are found more efficacious in comparison to existing treatments based on evidence of efficacy and safety (the existing treatment is therefore not, or is no longer, covered);
 - Emerging technologies which have some evidence of efficacy, application of population specificity, relative safety and measurable outcomes. (CMS has instituted such a process through the National Coverage Determination policies);
 - Treatments that are widely practiced but do not have historical evidence strong enough to meet the criteria of “proven” (but not based on single case studies or only the personal clinical opinion of the provider); and
 - Services that do not meet these standards but which are critical due to the potential for adverse outcomes if not included – these treatments may preserve life or avoid disability, be furnished to subpopulations who have

demonstrated no response to traditional treatment and who are at risk of significant disability or death.

- All services in the plan's benefit package should be covered in sufficient amount, duration and scope to reasonably achieve their purpose, unless limits are permitted in the HHS definition of Essential Benefits.
- All covered services for persons with mental or physical disabilities must be furnished in the least restrictive setting appropriate to the person's needs.

Chronic Disease Management.

- Covered services should be individualized and furnished to enrolled individuals when needed to treat the individual's condition. Plan care management systems must ensure coverage at a minimum when the following conditions are met:
 - A licensed professional practicing within the scope of his/her training, exercising prudent clinical judgment provides evaluation, diagnostic, treatment or rehabilitative services for an illness, injury, disease or its symptoms;
 - Services are furnished in accordance with generally accepted standards of medical practice;
 - Services are clinically appropriate for the individual, in terms of type, frequency, extent, site and duration of treatment and considered effective for the patient's condition; and
 - Services are at least as likely to produce equivalent therapeutic or diagnostic results as any alternative service, regardless of cost.

Non-Discrimination.

- Health plans may not discriminate with respect to people with mental and physical disabilities in the design of their service package. This includes:
- Coverage of services for the restoration or recovery from a mental or physical condition;
- Coverage of services that maintain functioning and prevent deterioration of a mental or physical condition;

- Payments to providers that take account of the additional time needed to manage care for a person with one or more chronic mental or physical conditions as well as payments to providers that are risk-adjusted to reflect patient mix;
- No exclusions from care based on failure to complete a course of treatment, to come to appointments or to comply with specific treatment options; and
- Medical management standards that are equally applied and are not used to limit or exclude benefits for persons with disabilities based upon the person's diagnosis.

In addition to the federal minimum requirements in the HHS-defined Essential Benefits, the federal government should provide guidance to insurance pools regarding the most effective approaches for meeting the needs of individuals with serious mental illness. These individuals have traditionally been served primarily in public systems and as a result health plans have less experience in the best approach.

SBHAs should help to require or encourage health plans to cover the following mental health **chronic care or case management services** in the benefit:

- Intensive case management may include Assertive Community Treatment, an evidence-based practice in mental health;
- Family education may include Family Psychoeducation, an evidence-based practice in mental health; and
- Illness/Disability Self-Care (which may include Illness Self Management, an evidence-based practice)

Individuals with mental illness frequently have **co-occurring substance use disorders or chronic medical conditions such as diabetes, heart disease and cancer**. Coordinated care for these individuals is essential for a cost-effective system. SBHAs should encourage health plans to cover:

- Integrated treatment individuals with co-occurring mental illness and substance use disorders (which may include Integrated Dual Disorder Treatment -- (an evidence-based practice);
- Consultation and collaboration time for providers serving individuals with mental illness who have significant co-occurring disorders; and
- Consider encouraging the co-location of primary care and mental health providers through reimbursement policies that allow billing for two separate services on the same day and through pay for performance or other payment incentives.

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Appendix 5

Outreach and Enrollment Strategies Definitions of Studied Outreach/Enrollment Strategies⁴⁵

Term	Definition
Media Campaign	An outreach strategy that uses the media (e.g. internet, radio, newspaper/magazines, television, and billboards) as a way to disseminate a central message regarding a public health insurance program, changes in policy and program rules and guidelines, and/or health messages to promote awareness of the health insurance program.
Community Health Workers	Individuals from the target communities who are linguistically and culturally compatible with the target population and are trained in or knowledgeable about outreach and enrollment procedures. Community Health Workers (CHWs) are also known as “promotoras de salud,” “health aids,” “health advocates,” “community workers,” “peer leader,” and “lay health adviser.” Promotoras may also be Certified Application Assistants (CAAs) but are not required to be CAAs for purposes of this study.
Health-E-App	An interactive internet-based application used to simplify and expedite the enrollment process for Healthy Families and Medi-Cal coverage for children and pregnant women. The web-design allows the application, signature, and supporting documents to be transferred electronically from the local enrollment site through Single Point of Entry to the appropriate agency for final processing and eligibility determination.

One-E-App	Similar to the Health-e-App and provides online enrollment for a broader, more comprehensive range of health insurance and public health programs. The system is used in conjunction with community-based organizations and assisters who work with the family to complete the application. It is designed to eliminate the need for families to complete numerous applications for programs that require the provision of duplicate information to determine eligibility.
Provider In-Reach	Any effort to approach clients who are already known by the agency or program; for example, patients in a clinic.
School Based Strategies	A collection of strategies that use school resources to identify and enroll children and families into health programs. They may include unique approaches such as express lane enrollment, or may deploy other strategies (such as promotoras) in a school setting. They may be school-organized (such as using school counselors or teachers), or be based on partnerships with community based organizations.
County Developed Data System	A system used by administrators and application assistors that is designed to track and document issues and/or activities pertaining to outreach, enrollment, retention and/or utilization.
Matching Public Programs	Analyzes, matches, or cross-references data sources with similar eligibility requirements to identify children that may be eligible for a particular public health insurance program. For example, emergency or limited scope Medi-Cal enrollment is cross-referenced with Health Kids enrollment to send Health Kids eligibility notifications to EMC children, not already enrolled in Healthy Kids.

<p>Pre-Populated Redetermination or Renewal Forms</p>	<p>A form generated by the public health insurance program, county or state department, or outreach and enrollment agencies that contains patient demographic information and is designed to ease and minimize the administrative paperwork associated with renewing in a program.</p>
<p>Waiting List</p>	<p>A database/list of pre-screened, eligible clients that have expressed interest or willingness to apply to a program for which enrollment is currently closed or is no longer accepting applications. The list is intended to be a future reference to target enrollment.</p>

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ENDNOTES

¹ 2010. Owens P.L., Mutter R., Stocks C. *Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007*. HCUP Statistical Brief #92. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf>; and 2011. <http://www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf>.

² 2007. Robinson P., and Reiter J. *Behavioral Consultation and Primary Care: A Guide to Integrating Services*. New York: *Springer*. Available at <http://www.amazon.com/Behavioral-Consultation-Primary-Care-Integrating/dp/0387329714>.

³ 2006. *National Association of State Mental Health Program Directors*. “Morbidity and Mortality in People with Serious Mental Illness.” Alexandria, VA. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf2006; and Freeman, E., Yoe, J.T. *The Poor Health Status of Consumers of Mental Healthcare: Behavioral Disorders and Chronic Disease*, Presentation.

⁴ 2000. Lasser K, Boyd J.W., et al., Smoking and Mental Illness: A Population-Based Prevalence Study, *JAMA*; 284(20):2606-2610.

⁵ 2005 Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*; 62(6):617-27.

⁶ 2005. Kessler R. C., Berglund P., Demler O., Jin R., Merikangas K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593–602.

⁷ 2006. *National Association of State Mental Health Program Directors*. “Morbidity and Mortality in People with Serious Mental Illness.” Alexandria, VA. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf

⁸ 2009. Miller T., Hendrie D.. *Substance abuse prevention dollars and cents: A cost-benefit analysis*. (HHS Pub. No. (SMA) 07-4298). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

⁹2007. Ray K., Hall, B.S., Keith G. Meador, M.D., M.P.H., *Psychiatric Services* 58(10), pp. 1317-1323.

¹⁰ 2009. *Integration of Mental Health/Substance Abuse and Primary Care*. Evidence Report/Technology Assessment, Number 173, Agency for Healthcare Research and Quality, Rockville, MD.

¹¹ 2008. Parks J., et al., *Measurement of Health Status for People with Serious Mental Illnesses.* NASMHPD, Alexandria, VA.

¹² 2011. Description of a Good and Modern Addictions and Mental Health Service System, *SAMHSA*, Rockville, MD.

¹³ 2003. *Achieving the Promise: Transforming Mental Health Care in America*. The President's New Freedom Commission on Mental Health. Rockville, MD. Available at: www.mentalhealthcommission.gov/reports/finalreport/fullreport-02.htm

¹⁴ 2010. Employment and Income Supports. *National Alliance on Mental Illness*. Arlington, VA.

¹⁵ 2011. Barrett, N., et al. *State Behavioral Health Agencies and the Affordable Care Act*, George Washington University Department of Public Health, May 2011.

¹⁶ 2010. Draper D.A., McHugh M.C., Achman L., Kuo S. *Medicaid Financing of State and County Psychiatric Hospitals*. DHHS Pub. No. (SMA) 03-3830 Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA).

¹⁷ 2010. NRI projections.

¹⁸ 2011. Barrett, N., et al.

¹⁹ 2009. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ5/pdf/PLAW-111publ5.pdf>.

²⁰ 2011. <http://www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf>.
<http://store.samhsa.gov/shin/content//SMA11-PDELANY081611/SMA11-PDELANY081611.pdf>

²¹ 2011. National Council for Community Behavioral Healthcare Project called the Association Executives Affordable Care Act Learning Community. *Mental Health Weekly*, August 29, 2011.

²² 2011. Barrett, N., et al.

²³ <http://www.hrsa.gov/advisorycommittees/rural/2009secreport.pdf>.

²⁴ 2003. *Achieving the Promise: Transforming Mental Health Care in America*. Available at: www.mentalhealthcommission.gov/reports/finalreport/fullreport-02.htm

²⁵ 2001. National Research Council. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press.

²⁶ 2011. *SAMHSA, Funding and Characteristics of State Mental Health Agencies, 2009*. HHS Publication No. (SMA) 11-4655. Rockville, MD: SAMHSA.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Ibid.

³¹ 2010. Lutterman T. et al. Mental Health Agencies, in Edited by Bruce Lubotsky Levin, Kevin D. Hennessy and John Petriola Mental Health Services: A Public Health Perspective. *Oxford University Press*.

³² 2011. *The Oklahoma Enhanced Tier Payment System: Leveraging Medicaid to Improve Mental Health Provider Performance and Outcomes*, National Association of State Mental Health Program Directors, Alexandria Virginia.

³³ 2011. Barrett, N., et al.

³⁴ Results from the 2010 National Survey on Drug Use and Health (NSDUH): Mental Health Findings, SAMHSA; CMHS/SAMHSA Uniform Reporting System, 2009 and NASMHPD and NASADAD estimates.

³⁵ 2011. See *Congressional Budget Office*, “Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the HealthCare and Education Reconciliation Act of 2010 (P.L. 111-152)” .

³⁶ 2011. Barrett, N., et al.

³⁷ http://www.samhsa.gov/samhsnewsletter/Volume_18_Number_5/HealthReform.aspx

³⁸ 2004. Selden T.M., Hudson J.L., Banthin J.S.. “Tracking Changes in Eligibility and Coverage among Children, 1996-2002,” *Health Affairs*, September/October 2004, 23(5): 39-50.

³⁹ https://www.cms.gov/healthinsreformforconsume/04_the_mental_health_parity_act.asp.

⁴⁰ 2009. Gastfriend D.R.: Addiction Treatment Matching: Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria. Binghamton NY: *Haworth Medical Press*, 2004, pp. 170. Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Griffith JH, eds. ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, 2nd edition, revised. Chevy Chase, MD: American Society of Addiction Medicine; 2001. Mee-Lee D, Shulman G.D. The ASAM Placement Criteria and Matching Patients to Treatment. In: Ries R.K., Fiellin D.A., eds. Principles of Addiction Medicine, 4th edition. Chevy Chase, MD: American Society of Addiction Medicine; 2009:387-399.

⁴¹ http://www.communitypsychistry.org/publications/clinical_and_administrative_tools_guidelines/LOCUS2010.pdf

⁴² 2004. Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁴³ Section 1905 of the Social Security Act provides that coverage for youth up to age 21 shall include regularly scheduled, comprehensive preventive health screenings sufficient to “determine the existence of certain physical or mental illnesses or conditions” and “such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” Section 1905(a) also states that “no service (including counseling) shall be excluded from the definition of ‘medical assistance’ solely because it is provided as a treatment service for alcoholism or drug dependency.” The benefits provided for under Section 1905(a) are comprehensive and include services such as “other diagnostic, screening, preventive and rehabilitative services, including any medical or remedial services (provided in a facility, a home or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”

⁴⁴ 2006. AUDIT: *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care*, second edition, by Babor, T.F., Higgins-Biddle J.C., Saunders J.B., Monteiro M.G..

⁴⁵ 2009. *Use of Outreach and Enrollment Strategies in California*. Cousineau, M.R., G. D. Stevens, Ph.D.; A. Farias, MPH, State Health Access Reform Evaluation, A National Program of the Robert Wood Johnson Foundation® Center for Community Health Studies • University of Southern California.