BEHAVIORAL HEALTH SERVICES AND COVERAGE

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One group of Americans that stands to benefit from the New Patient Protection and Affordable Care Act (Act) are those individuals who have behavioral health disorders (i.e., mental health and/or substance abuse disorders). 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, and that one in five children aged 0 to 18 years have a diagnosable mental disorder.[1] A recent health survey conducted in Arizona found that in comparison to national prevalence rates for adults, Arizona had a higher rate of bi-polar or manic depressive disorder and a much higher rate of anxiety disorder.[2]

KEY REFORM CHANGES

- **Enhances coverage of behavioral health (mental health and substance abuse) services by including them as part of the basic benefit plan for Medicaid and individual and small group markets.**
- **Requires application of mental health parity and mandated Medicaid coverage of certain drugs important for people with behavioral health disorders.**
- **Implements multi-faceted strategies to address capacity issues and gaps in behavioral health workforce.**
- **Includes behavioral health as a component of initiatives promoting medical homes and integrated and coordinated care delivery.**
- **Provides funding for Medicaid emergency psychiatric demonstration projects and research and services related to treatment of depression.**

Even with this high prevalence of behavioral health disorders, the ability to access behavioral health services in Arizona has been mixed. Over the past decade, Arizona has continued to work on improving its public behavioral health system, which is funded primarily through Medicaid/Children's Health Insurance Program (CHIP) monies. This public system of care offers a comprehensive behavioral health benefit package to Medicaid/CHIP eligible individuals.[3] However, access to behavioral health services in Arizona continues to be very limited for those individuals who either have no insurance or have individual or small group private insurance. Such insurance often does not include behavioral health coverage.

With the recent downturn in the economy, access to behavioral health services in Arizona has become even more of a problem. Factors contributing to this include: more restrictive eligibility and coverage for certain individuals in the public behavioral health program, an overall increase in the percentage of uninsured in the state, and an unstable behavioral health provider network that is struggling to maintain program operations in the face of recent reductions in provider fee schedules and overall reduction in program funds.

As the Act is implemented over the next four years, behavioral health services will become more financially accessible for Arizonans with behavioral health disorders. In addition to benefiting from the general insurance and Medicaid/CHIP healthcare reform provisions (such as establishment of high-risk pools, Medicaid coverage expansion, and elimination of preexisting condition requirements), the new law includes a number of provisions which specifically address the needs of and provision of care to individuals with behavioral health disorders. These include adding behavioral health as a basic benefit for Medicaid and individual and small group insurance markets, application of mental health parity requirements, and development of medical homes for those with behavioral health disorders.

These provisions, along with other behavioral health provisions (such as demonstration programs), are specifically aimed at improving coverage and access to prevention, treatment and recovery services for individuals with behavioral health disorders. The law affords Arizona the opportunity to further develop and enhance both its behavioral health provider network (such as through workforce development initiatives and the establishment of centers for excellence in treatment of depression) and the manner in which services are provided to individuals (e.g., medical homes, co-location of providers). Two of the central challenges for Arizona will be to make sure that 1) the behavioral health network will be able to adequately address the needs of Arizonans by 2014 when public and private coverage is expanded, and 2) the consumer population understands how to access these services.

EXPANDING COVERAGE OF BEHAVIORAL HEALTH SERVICES

The Act clearly acknowledges that behavioral health services are an integral component of the healthcare service packages to be offered under the new healthcare reform system. Although the coverage expansion provisions will not begin until 2014, these provisions 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 exchange and those in the individual and small group markets outside the exchange (with the exception of grandfathered individual and employer-sponsored plans).[4] The scope of this essential benefit package must be similar to that provided under a typical employee plan. Additionally, the mental health parity requirements as set forth in the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 are applied to the qualified health plans. This means that behavioral health benefits must be provided in the same way as all other covered medical and surgical benefits.
- 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 Federal Poverty Level (FPL). This expanded coverage will be especially beneficial to adults with serious mental illness. Frequently, this group has difficulty obtaining Supplemental Security Income benefits that would qualify them for Medicaid. Additionally, the Act requires 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 mental health parity law.
- Requiring Medicaid to cover smoking cessation agents, barbiturates and benzodiazepines, all of which are drugs that are frequently used by individuals with behavioral health disorders.

Benefits and Services in Arizona

The impact of these new coverage requirements on Arizona will vary. For example, under its current Medicaid/CHIP program (AHCCCS), Arizona already covers smoking cessation agents, barbiturates and benzodiazepines. On the other hand, Arizona's individual or small group insurance market is currently not required to offer behavioral health services as a covered benefit. The recent application of the mental health parity requirements in January 2010 only applies to employers that have more than 50 employees. Furthermore, while AHCCCS offers a comprehensive array of behavioral health services to eligible Medicaid and CHIP enrollees, Medicaid eligibility for parents and childless adults is limited to those with incomes below 100 percent of FPL as opposed to 133 percent of FPL under healthcare reform Medicaid expansion.

With these new coverage expansions, Arizona will need to determine the scope of behavioral health services that will be covered under the Medicaid basic benefit package offered to childless adults and parents; provide outreach and education for Arizonans with behavioral health disorders about the availability of these new public and private benefits; and enhance its current behavioral health provider network so that it is able to meet the increased demand for behavioral health services.

KEY TAKEAWAYS:

- Arizona will need to determine the scope of behavioral health services offered under the Medicaid benefit package for the expanded coverage group and decide whether the services available will be the same as those that are currently provided to Medicaid eligibles.
- Arizona should work in partnership with consumer advocacy organizations to develop a statewide plan for outreach and education for individuals with behavioral health disorders about all the healthcare reform provisions that may benefit them. This should include the coverage expansions as well as more recent changes such as establishment of a high risk pool, insurance coverage for young adults and elimination of preexisting condition restrictions.
- Arizona needs to work in partnership with behavioral health providers and health plans to assess the adequacy of the current provider network 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 with the implementation of the expanded coverage in 2014.

DEVELOPING A QUALITY BEHAVIORAL HEALTHCARE WORKFORCE

In order to improve access to and the delivery of high-quality healthcare services to all Americans, a major component of the Act is increasing the supply of qualified healthcare professionals/workers and enhancing healthcare workforce education and training. This is being accomplished through a variety of broad-based strategies: the availability to states of planning and implementation workforce development grants, establishment of a federal National Health Care Workforce Commission to evaluate and make recommendations to Congress and the Administration on development of a healthcare workforce, and establishment of the Center for Health Care Workforce to analyze healthcare workforce-related issues and evaluate workforce-related programs.

The Act's healthcare workforce provisions specifically target behavioral health professionals (psychologists, substance abuse prevention and treatment providers, social workers, etc.), direct care workers (psychiatric aides, health aides, etc.) and para-professional child and adolescent mental health workers. The Act also identifies behavioral healthcare workforce capacity at all levels as one of the high-priority workforce development areas and allows behavioral health providers (such as community mental health centers) to serve in the capacity of a teaching health center or training provider.

In addition to the broader-based workforce development strategies, the Act includes a limited number of provisions that focus more specifically on improving the healthcare workforce in relation to treating individuals with behavioral health disorders. Beginning in 2010 this includes:

- A new five-year pediatric specialty loan repayment program that includes child and adolescent mental and behavioral health care as one of the subspecialty focus areas. Each selected qualified health professional must agree to provide care in an area with a shortage of the specified pediatric subspecialty.
- Grants to higher education institutions to support the recruitment and training of students and make available clinical experience in the field of social work and psychology. The grants can also be used to establish or expand internship programs or pay behavioral health services for pre-service or in-service training of paraprofessional child and adolescent mental health workers. Funding for this program has been authorized through 2013.
- A new United States Public Health Services Track that grants advanced degrees in specific fields. The law specifically states that not less than 100 behavioral and mental health professional students must graduate annually. The Track will be located across the United States at accredited health professions education training programs at academic health centers that are selected by the Secretary of the U.S. Department of Health and Human Services (HHS).

Recent Progress, New Opportunities

A shortage of qualified behavioral health workers has been an ongoing issue in Arizona. Over the last 10 years, the Arizona Department of Health Services' Division of Behavioral Health Services – in partnership with behavioral health providers, advocacy groups and higher education institutions – has worked on expanding the behavioral health workforce, especially in the area of community-based services (peer support specialists, support and rehabilitation providers, case managers, child psychologists and mental health specialists).[5] These efforts have also focused on enhancing the quality and expertise of the workforce through the provision of focused training programs on topics such as recovery, provision of support and rehabilitation services and the role of family and child teams.

Recent state budget cuts and subsequent provider staff reductions have undermined some of this progress. Nonetheless, Arizona may be able to continue to move forward through healthcare reform. The state, in partnership with providers and educational institutions, may be able to take advantage of some of these healthcare workforce development initiatives under the Act to further enhance the behavioral health workforce. This will be particularly critical as the state prepares for the coverage expansion in 2014.

KEY TAKEAWAYS:

- Arizona should explore the feasibility of applying for any relevant workforce development grants.
- Arizona should actively educate individuals about available educational and training opportunities such as the pediatric specialty loan repayment program or the US. Public Health Services Track.

BEHAVIORAL HEALTH AS A COMPONENT IN MEDICAL HOMES

Person-centered medical 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 medical homes can enhance efficiency and quality while improving access to needed health care and support services, including appropriate referral and linkage with specialty services such as community behavioral health care.

As a result of federal legislation in 2006, the Centers for Medicare and Medicaid Services (CMS) is in the process of implementing a Medicare medical home demonstration program. In the Act, provisions were included to support and further expand the development of the medical home model as a component of the service delivery system afforded to individuals through both the private and public health insurance market.

A key component of this effort is the availability, beginning 2011, of a new Medicaid state plan option for the provision of medical homes for Medicaid enrollees with chronic conditions including mental health disorders. States must use medical homes that meet certain defined standards, consult with the federal Substance Abuse and Mental Health Services Administration (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 medical home services. To further incentivize states to select this option, HHS will award planning grants to states for the purposes of developing a Medicaid state plan amendment and will provide a 90 percent federal match for the first two years the Medicaid state plan amendment is in effect.

In addition to promoting the use of medical homes for Medicaid individuals with behavioral health disorders, the healthcare reform law also supports and promotes the community behavioral health provider's role in establishing medical homes that promote coordination of care for individuals with serious behavioral health disorders. Under the Act, HHS is required to establish:

- A program to support person-centered medical homes (either through contracts or grants) through the establishment of community-based interdisciplinary teams that would include behavioral health providers along with other healthcare professionals. A state or state-designated entity or Indian tribe or tribal organization would be eligible to receive a grant or contract under this provision.

- Beginning in 2010, a demonstration project in which the Center for Mental Health Services under SAMHSA will provide funding to qualified community mental health programs for provision of on-site primary care services to adults with mental illness who have co-occurring primary care conditions and chronic diseases, making medically necessary referrals to specialty care professionals, development of necessary information technology and facility modifications.

Medical Homes in Arizona

As in many states, the establishment of highly functioning medical homes in Arizona is still in its infancy. As part of the most recent AHCCCS health plan bid in 2008, AHCCCS initiated a process to develop, implement and expand the medical home concept. The current AHCCCS health plan contract[6] requires AHCCCS health plans that provide services to children with special healthcare needs to have a method for identifying providers who are willing to provide medical home services as defined by the American Academy of Pediatrics. Last year, UnitedHealthcare announced a three-year, person-centered medical home initiative in Arizona that will involve 17,000 patients, including individuals enrolled in their Medicaid health plan. Additionally, the state, along with the AHCCCS health plans/healthcare providers and/or Regional Behavioral Health Authorities (RBHAs)/behavioral health providers, has been exploring the feasibility of establishing programs in which medical and behavioral health services are co-located.

The Act's provisions, especially the medical home Medicaid State Plan option and planning grant, provide the State with the opportunity to receive financial support as they move forward in trying to further develop the medical home model in Arizona and develop effective strategies for the integration and coordination of care for individuals with complex medical and behavioral health needs. While there is support for the development of medical homes in Arizona, some health providers have noted the challenge of paying for high-functioning medical homes in the current environment in which provider rates continue to be cut.

KEY TAKEAWAYS:

- AHCCCS should explore the feasibility of submitting a state Medicaid Plan for the medical home option along with submitting a medical home planning grant.
- AHCCCS and the Arizona Department of Health Services should work together along with community providers and health plans/RBHAs to explore the feasibility of submitting a grant for either of the demonstration programs described above.

OTHER POTENTIAL BEHAVIORAL HEALTH FUNDING OPPORTUNITIES

The Act supports and provides funding to HHS for initiatives targeted at addressing two specific areas related to delivery of behavioral health services. Beginning in 2011, these include:

- A three-year Medicaid emergency psychiatric demonstration project in which up to eight state Medicaid programs would be able to reimburse non-governmental freestanding psychiatric hospitals for emergency psychiatric treatment provided to eligible Medicaid recipients between 21 and 65 years of age. Currently, these hospitals are required to provide services under EMTALA, but are not able to receive Medicaid payments for services provided to Medicaid eligible adults between 21 and 65 years of age due to the Medicaid coverage preclusion for Institutions for Mental Disease (IMDs).
- Establishment of national centers of excellence for depression. Five-year grants will be competitively awarded to institutions of higher education or public/private nonprofit research institutions for the establishment of between 20 to 30 centers for excellence for treating depression. Activities carried out by these centers would include development and dissemination of evidence-based interventions, training and technical assistance to mental health professionals, public outreach and education, collaboration with other centers to improve treatment standards, clinical guidelines, diagnostic protocols and care coordination practices and translational research.

While the first demonstration project affords the opportunity of obtaining additional federal dollars for a service currently not being covered under Medicaid, additional cost-benefit analysis needs to be conducted prior to deciding if this is a demonstration that Arizona should pursue. At one time Arizona had a waiver from the federal government to pay for IMD services, but that waiver

was rescinded several years ago. Arizona's philosophy is to keep individuals in the community, avoiding unnecessary psychiatric care and supporting crisis intervention through the use of community-based alternatives such as mobile crisis teams, urgent care centers and rapid response teams. Arizona may be better served by continuing to develop these systems of care as opposed to pursuing this demonstration.

The 2008 Arizona Health Survey found that 8.4 percent of adults have been told that they have clinical depression.[7] Depression is also frequently found with individuals who suffer from other chronic conditions such as diabetes or chronic heart failure. While Arizona does not currently have any nationally recognized center for depression, Arizona does have a center for excellence in postpartum depression. The establishment of a center for excellence for depression in Arizona would serve to complement this already established center for excellence in postpartum depression and would also provide a vehicle for further enhancing the behavioral health network in the state.

KEY TAKEAWAYS:

- AHCCCS, in partnership with the Arizona Department of Health Services and the provider community, should evaluate and look at the cost-benefit of submitting an application for the emergency psychiatric demonstration program.
- The state should encourage and work with the universities and/or other nonprofit research institutions to establish a center for excellence for depression in Arizona through the submittal of the grant application to HHS.

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Linda Huff Redman, PhD is an independent healthcare consultant with 14 years of experience advising organizations that serve low income populations on a broad range of healthcare related issues. Her expertise includes Medicaid program and provider organization restructuring, redesign of programs serving special need populations, federal fund maximization, managed care Medicaid RFP submittals, performance reviews, and federal waiver and strategic plan development. Previously, Dr. Redman spent eight years with Arizona's Medicaid agency (AHCCCS) as the Deputy Director.

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2 Marsiglia, F., & Wolfersteig, W. (2010, April). Adults: Mental health issues and disparities in Arizona. Phoenix, AZ: St. Luke's Health Initiatives. Retrieved July 30, 2010 from http://www.arizonahealthsurvey.org/wp-content/uploads/2010/04/AHS-AdultsMentalHealthDisparities.pdf

3 In May AHCCCS reported at the Arizona Behavioral Health Planning Council that of the total number of AHCCCS enrollees (1,259,000), 175,000 were behavioral health recipients resulting in a 9.3 percent penetration rate.

4 A "qualified health plan" (QHP) will be a health plan that is certified as meeting a specified list of requirements related to marketing, choice of providers, plan networks, and other features, or is recognized by each exchange through which such plan is offered; and provides the essential health benefits package.

5 To ensure the availability of certain providers in specific areas of the state, the ADHS Bureau of Health Systems Development has established a loan repayment program and stipend program as incentives for child psychologists and mental health specialists, speech/language pathologists and occupational and physical therapists who will address the needs of children age birth to five. The program is part of the First Things First Early Childhood Therapists Incentives Program. http://www.azdhs.gov/hsd/ftf_therapist_incentive.htm

6 The medical home concept is not addressed in the AHCCCS contracts for the other Medicaid programs - ALTCS, ADHS - Children Rehabilitative Services or ADHS-DBHS.

7 Marsiglia, F., & Wolfersteig, W. et al. (2010, April). Adults: Mental health issues and disparities in Arizona. Phoenix, AZ: St. Luke's Health Initiatives. Retrieved July 30, 2010 from http://www.arizonahealthsurvey.org/wp-content/uploads/2010/04/AHS-AdultsMentalHealthDisparities.pdf

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