MOVING THE FIELD FORWARD

POLICY, ADVOCACY AND EDUCATION TOOLKIT

HEALTH CARE REFORM AND PARITY

2011 - 2012

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CHAPTER ONE

HEALTH CARE REFORM IMPLEMENTATION

- 10 Priorities for Health Reform Implementation Soon after the passage of Health Reform legislation, the National Academy for State Health Policy (NASHP) identified 10 aspects of federal health reform that states must get right if they are to be successful in implementation. States that adopt a coordinated, strategic approach to implementing federal health reform will find that the new law contains many provisions that support significant improvements in their health care systems. Simultaneously, states will face significant challenges implementing the new law—due to the many tasks they must complete, and due to extremely constrained financial and staff resources. The 10 areas are: *(May 2010)*

  1. Be Strategic with Insurance Exchange
  2. Regulate the Commercial Health Insurance Market Effectively
  3. Simplify and Integrate Eligibility Systems
  4. Expand Provider and Health System Capacity
  5. Attend to Benefit Design
  6. Focus on the Dually Eligible
  7. Use Your Data
  8. Pursue Population Health Goals
  9. Engage the Public in Policy Development and Implementation
  10. Demand Quality and Efficiency from the Health Care System

- This issue brief from NASADAD focuses on health reform priority recommendations and provisions in the ACA that directly and indirectly impact the substance use disorder community. It highlights and explains what federal and state policymakers, state associations, providers, consumers and other stakeholders need to pay attention to as the implementation of health reform continues to march on. *(February 2011)*

- The Kaiser Family Foundation launched an online gateway providing easy access to new and comprehensive resources on the health reform law. Recognizing the transition from the debate about passage to the realities of implementing a law, the Health Reform Source has many new features that provide explanations of the basics of the law, in-depth analysis of policy issues in implementation, and quick and easy access to relevant data, studies and developments. *(May 2011)*

- Preventing Chronic Disease: The New Public Health
  A number of provisions in the health reform law are aimed directly at improving population health by addressing conditions where Americans live, learn, work, and play – at their schools, worksites, restaurants and more.

  How can prevention and public health be leveraged to improve health and reduce health care costs, particularly within Medicare, Medicaid, and CHIP? What are the threats to the "new public health" in light of budget constraints on the federal, state and local levels? How does the Patient Protection and Affordable Care Act (ACA) relate to public health and prevention activities? How are the resources in the $15 billion Public Health and Prevention Fund, set up under the ACA, being deployed? How might budget cuts affect public health programs and population health? This Alliance for Health Reform briefing addresses these questions and others. *(July 2011)*

- [Explaining Health Reform: Uses of Express Lane Strategies to Promote Participation in Coverage](#)
  Under the ACA, millions of uninsured adults and children will gain eligibility for health coverage through new health insurance Exchanges beginning in 2014. The law calls upon states to develop simple and streamlined processes for establishing, verifying and updating eligibility for Medicaid, CHIP and federal subsidies. This Kaiser Family Foundation issue brief examines how states can employ "express lane" principles in designing systems to help identify individuals who may be eligible for Medicaid, CHIP or premium subsidies. *(July 2011)*

- [Managing Costs and Improving Care: Team-based Care of the Chronically Ill](#)
  It may be possible to improve the quality of care for the chronically ill while altering the trajectory of spending for their care. Savings have been shown in some private and public sector approaches using teams that span multiple sites of care, reduce fragmentation and improve health outcomes. In addition, the ACA establishes new pilots and innovations that could change the way we deliver and pay for care to the chronically ill. The [Alliance for Health Reform](#) and the [Commonwealth Fund](#) co-sponsored this briefing to discuss partnerships among Medicare, Medicaid, private plans and providers to develop new approaches and achieve public health goals. Could these programs address the different needs of populations in institutional care versus community-based care? How do these new models differ from former approaches? What infrastructure and training enhancements are needed? What have we learned from states that have tried Medicaid case management for the chronically ill? *(August 2011)*

- [Preventive Services Covered by Private Health Plans under the Affordable Care Act](#)
  A new Kaiser Family Foundation fact sheet outlines new private insurer prevention requirements created by the ACA and discusses their possible impact. Private health plans – other than "grandfathered plans" (in existence prior to March 23, 2010) – must provide coverage for these preventive services without charging copayments, deductibles, or co-insurance to patients. These rules apply so long as the preventive service is performed by an in-network provider, is not billed separately from the office visit, and is the main reason for the office visit. Among the no-cost-sharing services are screening for depression, alcohol screening and counseling for anyone age 11 and older, counseling for drug and tobacco use and other common health concerns.

  Insurers must provide coverage for evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the [United States Preventive Services Task Force](#) (USPSTF), an independent panel of clinicians and scientists that includes behavioral health specialists.

  The majority of the preventive care requirements went into effect for non-grandfathered plans beginning on September 23, 2010. The fact sheet examines which types of preventive services must be offered to individuals in general and which preventive services must be offered to special populations such as children, youth and women. *(September 2011)*

CHAPTER TWO

PARITY

- The Parity Implementation Coalition provides a comprehensive Parity Toolkit to aid individuals in and seeking recovery from addiction and mental illness. It is also useful for their families, providers and advocates to help them understand their new rights and benefits under the parity law. The toolkit is designed to be a resource in how to better communicate with plans, how to prepare and document information should disputes arise with a health plan over coverage or reimbursement and better understand your basic appeals rights and procedures. Because each plan has its own appeals policies and procedures, participants must become informed about the appeal process in their own plan.

  As health care costs have increased, public and private health plans have imposed stricter cost containment techniques on health benefits. Many plans have subjected addiction and mental health benefits, often called "behavioral health" benefits, to an even stricter form of cost containment, often in the form of higher co-pays and deductibles, shorter day and visit limits, pre-approval or "prior-authorization" for these services and other forms of "medically managing" these benefits that are more stringent than how other medical benefits are managed.

- In the 2011 legislation session, Illinois HB 1530 overwhelmingly passed in both chambers and is now waiting for the Governor's signature which is expected shortly. This bill
  - Requires mental health insurance parity that matches the federal requirements under the Wellstone-Domenici Parity Act.
  - Adds substance use treatment to the list of parity required health insurance benefits to existing state law.
  - Gives the state, through the Department of Insurance, the power to more aggressively enforce federal standards.
  - Extends the parity requirement to employers with just two or more employees, going beyond Wellstone-Domenici.
  - Includes a medical necessity determination for substance use disorders using criteria established by the American Society of Addiction Medicine. (*August 18, 2011* Public Act . 97-0437)

CHAPTER THREE

ESSENTIAL BENEFITS PACKAGE

- **Comments to the IOM Essential Benefits' Panel**
  The Coalition for Whole Health, co-chaired by the Legal Action Center, is a broad coalition of national organizations representing the mental health and addiction prevention, treatment and recovery communities. Last December, the Coalition drafted and presented comments to a panel of Institute of Medicine experts looking into an essential benefit package. Some of the issues addressed by the comments include the definition of medical necessity, criteria and methods currently used by insurers to determine coverage and how to best take into account the needs of diverse segments of the population, including persons with disabilities. *(December 2010)*

- **National Health Council White Paper on Essential Benefits**
  This paper considers the approach the Secretary of HHS may take in defining the federal essential health benefits package. The paper: provides a background on insurance mandates; describes the essential health benefits package created in ACA; explores the potential challenges in defining "essential"; considers the Medicare program and the Blue Cross Blue Shield Standard Option available to federal employees as potential frameworks for the federal standard; and evaluates benefits mandated at the state level, including those established under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program for children. *(September 2010)*

- **Description of a Good and Modern Addictions and Mental Health Service System**
  This SAMHSA document describes the basic services required for a delivery system of mental health and addiction services that offers a continuum of effective treatment and support services spanning healthcare, employment, housing and educational sectors, where integration of primary care and behavioral health is an essential component.

  The document is designed to foster discussion among the Department of Health and Human Service Operating Divisions and other federal agencies on how best to integrate mental and substance use disorders into the health reform implementation agenda. This document can provide clarity to federal agencies that regulate or purchase services for individuals with mental and substance use disorders; offer guidance to agencies that are presently making decisions about expanding services to these populations; and assist in planning possible changes to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Mental Health Services Block Grant. *(April 2011)*

- The Coalition for Whole Health has developed recommendations to fully include mental health and substance use disorders within the Essential Health Benefits framework of the Affordable Care Act. This paper details the mental health and substance use disorder benefits that the Coalition believes must be included by the Essential Health Benefits package covered by "new" small employer and individual plans, qualified health plans operating in state Exchanges, and Medicaid expansion plans. Over 150 national, state, and local organizations have endorsed the Coalition's Essential Health Benefits recommendations. To sign on to the Coalition's recommendations, please email Sherie Boyd. *(August 2011)*

- **Essential Health Benefits Package – the Next Big Thing**
  An actuarial analysis of a model insurance policy under the health care law estimated annual premiums of $5,000 for an individual and $12,500 for a family. Its actuarial value would be near the "platinum" level established in the law – one of the most generous plans. The analysis released by Avalere Health and the National Health Council, an advocate for the chronically ill, estimated premiums and out-of-pocket charges for a model plan similar to what BC/BS offers to federal employees. Annual out-of-pocket spending for people with chronic illnesses often can run into the thousands. People with chronic conditions and limited incomes and resources may have a tough time affording insurance even with government subsidies.*(August 2011)*

CHAPTER FOUR

MEDICAID EXPANSION

- **Defending Medicaid in Hard Times: A Guide for State Advocates**
Community Catalyst reports that 46 states faced budget shortfalls in fiscal year 2011. Because of Medicaid's prominence in state budgets (17% of spending), the program becomes a popular target for cuts. Thirty-eight states and the District of Columbia cut Medicaid in fiscal year 2011 by reducing eligibility, benefits or provider payments and increasing patient co-payments. The outlook is equally grim for fiscal year 2012. To prevent harm from these types of Medicaid cuts and to preserve the Medicaid program for its 2014 expansion, defenders must persuade policymakers that:
  - Cutting eligibility, benefits or rates, or creating barriers to enrollment are bad ideas.
  - Better alternatives to Medicaid cuts

  This Community Catalyst guide distills lessons from Medicaid defense work in a number of states and provides tools to fight cuts and introduce the most promising alternatives. *(November 2010)*

- The Kaiser Family Foundation's Commission on Medicaid and the Uninsured explores key aspects of mental health care financing and access. Mental Health Financing in the United States: A Primer provides an overview of behavioral health care, reviews the sources of financing for such care, assesses the interaction between different payers and highlights recent policy debates in mental health. It also discusses the role of Medicaid, currently the largest source of financing for behavioral health services in the nation, covering a quarter of all expenditures. *(April 2011)*

- This issue brief from the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, Medicaid Policy Options for Meeting the Needs of Adults with Mental Illness under the Affordable Care Act, examines the salient issues raised in a recent roundtable discussion of national and state experts to discuss Medicaid policy options available under health reform to help meet the needs of adults with mental illness. *(April 2011)*

- The Kaiser Commission on Medicaid and the Uninsured recently released a report on dual eligibles, Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS. In July 2011, CMS released a "State Medicaid Director" letter containing preliminary guidance on opportunities to align Medicare and Medicaid financing. CMS is interested in testing capitated integration and a fee-for-service integration models. The capitated model would receive a prospective blended rate for all primary, acute, behavioral health, and long-term services and supports. The initial proposal submissions are expected to evolve based on stakeholder input and further design work. The proposed designs will describe how states would "structure, implement and evaluate an intervention aimed at improving the quality, coordination and cost-effectiveness of care" for duals, with implementation targeted for 2012.

  This policy brief summarizes significant characteristics of the preliminary proposals including the type of entity to deliver benefits, target population and enrollment, benefits package, financing, beneficiary protections, stakeholder involvement and proposed timeframe. The 15 states are -California -Colorado -Connecticut -Massachusetts -Michigan -Minnesota -New York -North Carolina -Oklahoma -Oregon -South Carolina -Tennessee -Vermont -Washington –Wisconsin. *(August 2011)*

- **Louisiana to overhaul and expand mental health and addiction services**
Louisiana's state health agency taps Magellan to streamline and coordinate services among multiple providers with a goal to improve health outcomes for the state's Medicaid and uninsured populations. The new program is set to launch March 1, 2012. *(September 2011)*

- [Nebraska Struggling With Rural Mental Health Services](#)
  The state Medicaid director testified before a legislative panel that Nebraska is still struggling to provide rural, community-based mental health and substance abuse services to children. The state will have to rely more on such providers as it tries to come into compliance with federal rules for mental health and substance abuse treatment. At stake are millions in federal matching dollars given to Nebraska to administer the services. *(August 2011)*

CHAPTER FIVE

INTEGRATION OF SUD SERVICES AND PRIMARY CARE

- Evolving Models of Behavioral Health Integration in Primary Care
  The U.S. mental health system fails to reach and/or adequately treat the millions of Americans suffering from mental illness and substance abuse. This Milbank Memorial Fund report offers an approach to meeting these unmet needs: the integration of primary care and behavioral health care. The report summarizes the available evidence and states' experiences around integration as a means for delivering quality, effective physical and mental health care. For those interested in integrating care, it provides eight models that represent qualitatively different ways of integrating/coordinating care across a continuum—from minimal collaboration to partial integration to full integration—according to stakeholder needs, resources, and practice patterns.

  The Fund commissioned this report to provide policymakers with a primer on integrated care that includes both a description of the various models along the continuum and a useful planning guide for those seeking to successfully implement an integrated care model in their jurisdiction. *(May 2010)*

- A Unique Opportunity to Integrate Behavioral Health Into the Person-Centered Medical Home
  The Patient Protection & Affordable Care Act (PPACA) established a new medical home pilot program which allows states to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness and substance use disorders, into medical homes beginning in 2011. Health homes will be composed of a team of health professionals that will provide a comprehensive set of medical services, including care coordination. This National Council for Community Behavioral Health fact sheet explains what this means for states, emphasizes the importance of insuring the careful consideration necessary to assure access for and engagement of persons living with behavioral health conditions, and provides examples of patient centered medical homes initiatives.

- Delivering Substance Use Care Within Health Reform: Opportunities and Challenges to Integrated Care
  This power point presentation reviews CMS guidance for establishing health homes, presents the AECOM service delivery system as a model for a behavioral health home with a substance use focus and presents guiding principles for states in developing the standards for health homes targeting substance users. *(May 2011)*

- Collaborative Care in Primary Care and Behavioral Health: Are We at the Tipping Point?
  This power point presentation addresses major issues in creating collaborative systems of care in primary care and behavioral health settings. Among the issues the presentation examines are: why integration matters for the treatment of behavioral health patients, what are the key ingredients of collaborative care, does integrated care mean the same as collaborative care and whether the formation of health homes and accountable care organizations equate to arriving at the promised land. Also examined are the concepts of quality outcomes and measurement tools *(May 2011)*

- Key Considerations in Designing the Medicaid Health Home State Plan Amendment
  This power point presentation examines key discussion points as policymakers and policy analysts think through their state's interest to use health homes in coordinating care for individuals with chronic conditions. The discussion points include a definition of health homes, expectations of CMS, outcome measures, reimbursement, planning and implementation considerations as well as some proposed approaches. *(May 2011)*

CHAPTER SIX

HEALTH INFORMATION TECHNOLOGY AND MEASUREMENT

- **Paving an Enrollment Superhighway: Bridging State Gaps Between 2014 and Today**
The ACA's transformative vision for eligibility and enrollment in publicly subsidized health coverage is an enrollment superhighway that is streamlined, modern, seamless, integrated, easy for consumers to use, and connects Medicaid, CHIP and Exchange coverage. This vision contrasts sharply with most states' welfare-era, paper-based systems that rely on complex eligibility rules and outdated technologies. This National Academy for State Health Policy paper frames ACA's vision and discusses gaps between 2014 and today and opportunities to close these gaps in four key areas: 1) Consumer Experience; 2) Eligibility and Enrollment Policy; 3) Technology and Systems Infrastructure; and 4) Governance and Administration. *(March 2011)*

- **A Framework for Tracking the Impacts of the Affordable Care Act in California** The goal of this State Health Access Data Assistance Center's project was to recommend how California (and the California HealthCare Foundation) can measure and monitor the impacts of health care reform in three areas: health insurance coverage, affordability and comprehensiveness of health insurance coverage and access to health care services. The study also addresses the best data source for each measure, gaps in existing data and issues for data presentation. It identified a total of 51 measures that California can use to monitor the impacts of health care reform over time: 19 related to insurance coverage, 15 related to affordability and comprehensiveness of coverage, and 17 related to access to care. *(June 2011)*

- **The Federal Government Has Put Billions into Promoting Electronic Health Record Use: How Is It Going**? This Commonwealth Fund article reports that despite the huge government investment to incentivize hospitals and providers to adopt electronic health records (EHR) systems, the progress made to that end has been slow and obstacles remain. The article also highlights the rewards for adopting EHR, field support available through Regional Extension Centers, workforce training and related issues. *(June/July 2011)*

- **Strengthening Medicaid with Health Information Technology: Are Providers & States Up to the Challenge?** Under the American Recovery and Reinvestment Act of 2009, providers can receive Medicare and Medicaid payment incentives when they adopt electronic health records and demonstrate their "meaningful use." Additionally, the ACA requires states to establish a website for Medicaid beneficiaries to electronically enroll and renew coverage. Yet many challenges remain for health information technology to help Medicaid operate more effectively.

  The Alliance for Health Reform sponsored this briefing to discuss HIT's impact on Medicaid's care delivery and administration. Some of the questions that were addressed: How are states preparing to integrate their HIT systems with the exchanges? What role are state Medicaid agencies playing? How can Medicaid health plans and providers use HIT to provide better care delivery, improve outcomes and reduce costs? What have HIT initiatives such as the Beacon Communities learned about deploying HIT resources? How does meaningful use strike the right balance between encouraging progress and achievability? *(August 2011)*

CHAPTER SEVEN

HEALTH INSURANCE EXCHANGES

- State Legislation on Insurance Exchanges - This Center on Budget Policies and Priorities report provides a summary of proposed or enacted state exchange legislation introduced in the 2011 legislative sessions, focusing on governance and conflict of interest provisions. *(July 2011)*

- This Kaiser Family Foundation issue brief, Establishing Health Insurance Exchanges: An Update on State Efforts examines states' progress in creating health insurance exchanges. As most states' 2011 legislative sessions have concluded this brief examines the trends in states' initiatives to establish or study exchanges.

  Legislatures in 13 states passed laws to establish exchanges. In Utah and Massachusetts additional legislation may be required to comply with ACA's specifications. Other states enacted legislation that allowed the state to continue investigating whether or how to establish an exchange. North Dakota and Virginia both passed laws stating their intent to create an exchange and delegated responsibility for planning to the state insurance and health and human services agencies. Mississippi and Wyoming decided to study the feasibility of creating an exchange. By January 2013, the HHS will evaluate states to identify those that have not made sufficient progress toward establishing a "fully operational" state-based exchange. *(July 2011)*

- On August 12th, the Obama Administration allotted $185 million to 13 states and the District of Columbia to help build new insurance exchanges. It also issued rules on how the new marketplaces will enroll individuals, provide subsidies and interact with state Medicaid programs. As the next big step to help states establish the exchanges, the guidelines stipulate that states need to provide a "one-stop shop" system to determine eligibility for insurance and tax credits. The proposed rules highlight the expectation of a smooth connection between state-run exchanges and federal systems to make sure they connect and share information.

  Last year, HHS awarded $1 million planning grants to 49 states and the District of Columbia, although some states gave the money back. States awarded exchange grants Friday are Maryland, Connecticut, Missouri, Mississippi, California, Illinois, Kentucky, Minnesota, Nevada, New York, North Carolina, Oregon and West Virginia. Indiana, Rhode Island and Washington received exchange grants in May. *(August 2011)*

- Wellmark of Iowa Undecided On Insurance Exchange
  Iowa's dominant health insurer is considering staying out of the state's planned insurance exchange, which could hamstring the initiative. Insurance exchanges are expected to be a key part of the national health reform program. Wellmark Blue Cross/Blue Shield provides three-quarters of policies to Iowa individual consumers and small businesses. *(August 2011)*

CHAPTER EIGHT

WORKFORCE

CHAPTER NINE

THIRD PARTY PAYERS

POLITICAL AND POLICY STRATEGIES

- **Medicaid, the Budget, and Deficit Reduction: The Threat Continues** This Families USA paper provides an analysis of the provisions of the recently signed-into-law Budget Control Act of 2011 and its potential impact on Medicaid, Medicare and other entitlements. The deficit reduction legislation includes nearly $1 trillion in spending cuts over the next decade, including cuts to vital programs.

  Although Medicaid was spared in those initial cuts the program is still at risk. The new law establishes a "super committee" of 6 Democrats and 6 Republicans, whose charge is to come up with a specific plan by the end of November—policy and funding changes that would reduce the deficit by another $1.5 trillion over the next 10 years. To reduce the deficit the committee can consider cutting or restructuring Medicaid, Medicare or Social Security, as well as raising revenue. If the committee can't decide on a plan approved by Congress and signed by the President, automatic spending cuts ensue. *(August 2011)*

- 11th Circuit Rules that Americans Can't Be Forced to Buy Insurance
  In mid-August, the 11th Circuit Court of Appeals in Atlanta ruled that the federal government cannot force individuals to purchase health insurance under President Obama's landmark health care overhaul.

  The federal court ruling against a key provision of the health care reform law makes it almost certain the Supreme Court will decide the law's constitutionality in the 2012 term. The court has two very strong reasons to take the case now. First, there are two circuit courts that have ruled in opposite directions on the constitutionality of the law's individual mandate. And second, because the Obama administration lost in the latest ruling, it is going to be the one filing the appeal. The Supreme Court rarely turns down such requests from the federal government. As court action continues, some policy experts expect that efforts to find an alternative to the individual mandate will intensify. *(August 2011)*

- Republican Governors Announce Proposals To Overhaul Medicaid
  The nation's Republican governors released a detailed list of policies in late August that would give them greater control over their Medicaid programs by limiting spending and allowing them to design programs without federal interference. The 31 recommendations include longtime Republican priorities such as repealing the health care reform law's "maintenance of effort" requirement that forbids states from cutting their Medicaid rolls. *(August 2011)*

CHAPTER ELEVEN

MOBILIZING AND ORGANIZING THE GRASSROOTS

- [Building Partnerships: State Officials and Advocates Working on Health Reform](#) In March 2011, state officials and consumer advocates from nine southern states came together to discuss health reform implementation and ways to work together. The meeting was convened by the [National Academy for State Health Policy](#) (NASHP) in collaboration with Community Catalyst, and funded by the Public Welfare Foundation. This paper highlights themes from this meeting, such as lessons learned in building stronger or more effective relationships between these groups and ways to work together as health care reform implementation proceeds at the state level. *(June 2011)*

CHAPTER TWELVE

MODEL LEGISLATION

- In the 2011 legislation session, Illinois HB 1530 overwhelmingly passed in both chambers and is now waiting for the Governor's signature which is expected shortly. This bill
  - Requires mental health insurance parity that matches the federal requirements under the Wellstone-Domenici Parity Act.
  - Adds substance use treatment to the list of parity required health insurance benefits to existing state law.
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CHAPTER THIRTEEN

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