



CMHDA-CADPAAC HEALTH CARE REFORM PRINCIPLES Jointly Adopted 12-13-12

On March 23, 2010, President Obama signed into law the comprehensive health care reform legislation promising to extend coverage to 33 million Americans – the Patient Protection and Affordable Care Act (ACA). Of note to the behavioral health community, the ACA explicitly includes mental health and substance use disorder services, including behavioral health treatment, as one of ten categories of service that must be covered as essential health benefits. Furthermore, the ACA also mandates that mental health and substance use disorder benchmark coverage must be provided at parity, compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008). Individuals with mental illness and substance use disorders have the opportunity to significantly benefit from the health care law, as insufficient insurance health care coverage for these conditions has traditionally prevented countless people from obtaining needed treatment. If applied correctly, the health care reform law has the opportunity to ensure that clients, families and communities struggling with mental illness and substance use disorders have access to culturally competent prevention and treatment opportunities. Research suggests that without addressing the treatment needs of persons with serious mental health and substance use disorders, it may be very difficult to achieve the three critical healthcare reform objectives articulated by the Institute for Healthcare Improvement's Triple Aim:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of total healthcare

The following are some of the opportunities for this population under the ACA:

- Given the low rate of service utilization among uninsured adults with mental health and substance use disorder needs, the expansion of health insurance coverage through health care reform could increase access to and utilization of mental health and substance use disorder services for many uninsured adults in California.
- Half a million uninsured California adults with mental health needs will become eligible for health insurance coverage in 2014.¹
- Qualified adults will for the first time have access to mental health and substance use disorder services through the Medi-Cal program or subsidized insurance without having a disability.

Given the tremendous opportunities that the ACA affords this population, CMHDA and CADPAAC believe that California's implementation of the ACA should be grounded in the

¹ UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, "Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions."

following principles to ensure access to the highest quality mental health and substance use disorder services for these populations and achieve health care reform objectives:

- 1) **Health equity must be integrated into all aspects of ACA implementation.** This includes addressing systematic disparities in health status related to race, ethnicity, gender, sexual orientation, income and geography. People of color and people living in rural areas are more likely to be low-income, uninsured, and without access to employer-based health insurance², and therefore have the most to gain from the ACA.
- 2) **Mental health and substance use disorder systems must be equity partners with physical health care systems.** Parity between mental health and substance use disorder and other medical systems and services must be realized at every level.
- 3) **Recovery and resiliency-driven services that are culturally and linguistically appropriate must be the standard for covered mental health and substance use benefits available to California's Medicaid Expansion population.** This includes coverage of consumer/client- and family-directed case management and behavioral health rehabilitation services in the community that reflect the cultural, ethnic and racial diversity of mental health and substance use consumers/clients, and that address each consumer/client's individual needs.
- 4) **Access to mental health and substance use disorder services for both the Medicaid Expansion population and the Covered California population should be based upon established medical/clinical necessity criteria for specialty mental health services and substance use services – e.g. Medi-Cal criteria and evidence-based American Society of Addiction Medicine (ASAM) placement criteria.** This is essential to ensure seamless continuity of care and consistent access to services regardless of change in economic status or type of health care coverage. There is also a strong business case supported by research that demonstrates that efficiencies in care and improved outcomes occur when patient needs are well matched with the most appropriate, medically necessary and least restrictive/costly level of care.
- 5) **Education, prevention and early intervention for mental health and substance use disorders must be fully integrated as part of the spectrum of reimbursable services in any benefit package provided to the Medicaid Expansion population, or individuals insured through Covered California.** The prevention of disease is a central tenet of the ACA; this should apply no less to mental health and substance use disorder services as it does for physical health. Research and experience have proven that education, prevention and early intervention for mental health and substance use disorders play an essential role in population health, client outcomes and cost containment. Such services may include screening in primary care, media and public awareness campaigns, suicide prevention and peer-delivered services.
- 6) **Specialty mental health and substance use disorder services provided in field, home and community-based settings must be available and reimbursable under all coverage programs and opportunities.** Effectively addressing the rehabilitative needs of children, youth, adults and older adults with serious mental illness and

² National Health Law Program (August 21, 2012), 10 Reasons the Medicaid Expansion Helps to Address Health Disparities.

substance use disorders requires assertive, proactive, culturally and linguistically appropriate outreach in a variety of settings by specialty and community providers who have the expertise in engaging individuals at the earliest possible point in an episode of mental illness and/or substance use.

- 7) **Mental health and substance use benefit packages must promote high quality, patient-centered and cost-effective care, and continue to support the existing safety net.** This includes, but is not limited to, services not traditionally provided in the medical arena and/or covered by Medicaid, such as many homeless outreach services, mobile response programs, services to children and youth in specialized foster care, supports for housing stability, recovery maintenance homes, field-based services, etc. These services are critical in addressing social determinants of health and are an integral component of California's specialty mental health and substance use disorder systems.
- 8) **Safety net funding for residually uninsured populations must be preserved.** As healthcare reforms take hold and insurance coverage gradually expands, we must ensure that a shifting or reduction in safety net funding does not diminish access to mental health and substance use disorder services for residually uninsured populations. In particular, approximately 11% (58,600) of today's uninsured Californians with mental health needs will not be eligible under the ACA due to immigration status³. This means increasing the efficiency of federal funds reimbursement, preserving realignment revenue and federal block grant funding for County mental health and substance use disorder services and ensuring that the State does not reduce Medi-Cal eligibility or benefits. The size and impact of the residual population, including those ineligible for programs due to placement in an Institute for Mental Disease (IMD), will likely be realized only over time once the ACA policies and programs are fully implemented. Any diversion of funds from these health care delivery systems before a full assessment of the near-term and longer-term impacts of the ACA are determined and analyzed would offer a recipe for undermining the very systems the State will need to rely on to service the expanded Medi-Cal and other publicly sponsored populations. Financing systems may need to be reformed to better align payment policies with care coordination and quality improvement goals and objectives.
- 9) **Support for policies that address the workforce composition, development and expansion to address the needs of the Medicaid expansion and Covered California populations is critical, including pathways to employment, competencies for peer support, etc.** This includes the utilization of non-licensed providers and peer support to most effectively and efficiently meet the needs of consumers/clients with mental health and substance use disorders.
- 10) **Coordination of mental health, substance use and primary care is essential to ensuring quality care and realizing cost savings.** The aim of the ACA is to ultimately reduce the cost of healthcare delivery to the entire population. In order to more effectively care for the whole person, there must be more seamless coordination between system partners. This includes reducing barriers to the exchange of information necessary to appropriately coordinate care, improve quality, and address confidentiality.

³ UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, "Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions."