



**National Association of State Mental Health Program Directors**

**INSTALLING THE BUILDING BLOCKS FOR A  
MORE EFFECTIVE MENTAL HEALTH SYSTEM:  
EARLY EVIDENCE UNDER HEALTHCARE REFORM AND  
ROLES FOR STATE BEHAVIORAL HEALTH AGENCIES**

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## INTRODUCTION

Healthcare accounts for a remarkably large portion of the United States' economy. In 2013, the United States spent \$2.7 trillion on healthcare, an average of more than \$8,400 per person (up from \$1,110 in 1980). For more information, please go to:

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf> .

During this time, healthcare expenditures per person have grown an average of 2.5 percentage points faster than the Gross Domestic Product (GDP).

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf> .

The increases in healthcare costs impact the ability of employers to offer health insurance and of individuals to afford insurance premiums and cost-sharing. Rising healthcare costs also impact government programs such as Medicaid and Medicare, which are major parts of federal and state budgets. Increasing healthcare costs contribute to our federal deficit and reduce our ability to spend in other areas such as education, transportation, and economic development.

In 2010, Congress passed national health reform in two pieces of legislation<sup>1</sup> referred to in combination as the Affordable Care Act (ACA). The ACA was enacted to address certain fundamental problems with our current healthcare system, including the growing numbers of uninsured, poor overall population health, poor or uneven quality of care, and rapidly rising healthcare expenditures in both the public and private sectors.

The ACA expands coverage to millions of individuals through new public and private health insurance mechanisms, focuses on prevention to improve population health, and places an increased emphasis on quality measurement and reporting. The ACA also aims to increase the supply of health professionals – including mental health providers – and strengthen the healthcare safety net. The legislation also includes provisions aimed at slowing the rate of escalation in healthcare spending.

Through its expansions in coverage and access, the ACA also offers new opportunities to expand health insurance coverage to millions of people with behavioral health conditions, improve population mental health through prevention and health promotion, and improve the quality of behavioral health provided to consumers. At the same time, the legislation creates new policy, program and operational challenges for state agencies and programs, as well as behavioral health professionals and behavioral health organizations.

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<sup>1</sup> The Patient Protection and Affordable Care Act, Pub. L. 111-148, and the Healthcare and Reconciliation Act of 2010, Pub. L. 11-152.

## Assessing the Impact of the Affordable Care Act on Behavioral health: Rationale and Approach of the ACA Issue Papers

The objective of this Issue Paper series, as outlined in the Substance Abuse and Mental Health Administration's (SAMHSA's) *RFTO No. 13-233-SOL-00600*, is to identify gaps in knowledge related to the implementation of the ACA and behavioral health services for State Behavioral Health Agencies (SBHAs) and SAMHSA. SAMHSA's goal is to identify potential solutions and best practices, highlighting lessons learned from states successfully implementing the ACA while ensuring the behavioral health needs of the community are met. This was accomplished by developing a series of issue papers on a range of policy specific areas related to the delivery and financing of mental health services in the era of health reform. The issue papers and their findings have been widely disseminated and prominently posted on the website of the National Association of State Mental Health Program Directors (NASMHPD).

To address SAMHSA's needs and interests, NASMHPD's overarching goal was to evaluate the early evidence and experience of implementing the ACA at the state level through a comprehensive and integrated approach. Specifically, we examined three specific overarching areas – mental health coverage, mental health promotion, and mental health integration – through seven issue papers and the prism of ACA implementation:

1. Outreach and enrollment initiatives, with a focus on “hard-to-reach” populations such as homeless individuals with a mental health condition
2. Implementation of state health insurance Marketplaces (originally called Exchanges under the ACA), specifically looking at provider network adequacy issues
3. Reducing the burden of mental illness, with an eye toward the role of the prevention activities and public health strategies promoted within the ACA
4. A companion piece to the third issue paper on the need for early mental health screening and intervention across the life-span and diverse population groups
5. New models of care delivery and financing, focusing primarily on early results associated with the health homes and accountable care organizations (ACOs) authorized under the ACA
6. The role of health information technology (HIT) in improving care for people with mental illness
7. The impact of community-based services on behavioral health in the aftermath of the Olmstead Decision

These areas, in essence, serve as the key building blocks for the implementation of the ACA and healthcare reform going forward (see “Mental Health Infrastructure” diagram below). If one element of the overall structure is left uncompleted, it will be difficult for the ACA to address the needs of people with behavioral health conditions in a comprehensive and integrated fashion. While there are other key areas such as client engagement, the structure for a more effective and accountable mental health delivery system must be built on, first, addressing the needs of consumers and providers.

In these initial reports and overall series, we examined each of these areas in detail, through the prism of healthcare reform and impact on state behavioral health programs, and consumers with behavioral health conditions.

## Methodology for the Issue Papers

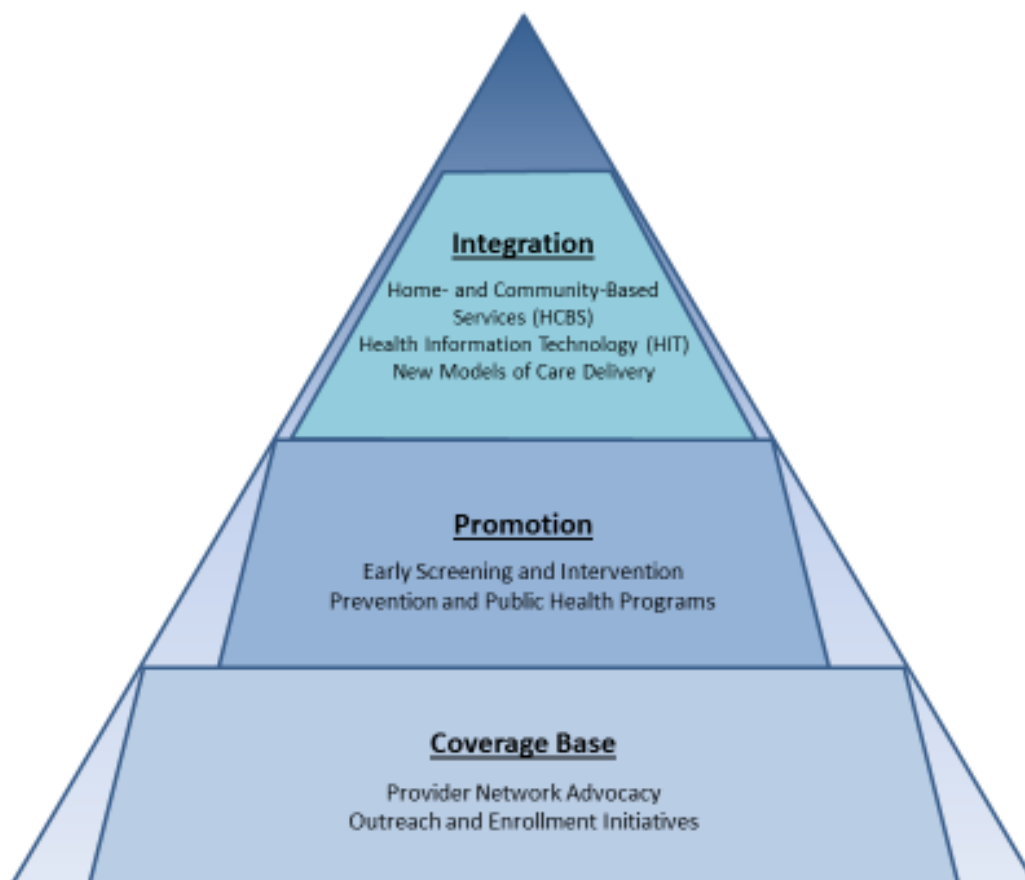
All of the issue papers were based on comprehensive environmental scans and detailed literature reviews using public and private sector data bases, with a specific focus on the implementation of healthcare reform under the ACA and the impact on behavioral health. Each issue paper encompassed findings from this research and our analysis.

Each issue paper contained information about ACA provision relationships to mental health, findings on best practices in implementing those provisions that address the behavioral health system, and lessons learned and recommendations for ongoing improvements.

This final summary report highlights key findings relative to several best practices adopted and key lessons learned in implementing healthcare reform.

To access the complete seven issue papers, please go to: [www.nasmhpd.org](http://www.nasmhpd.org).

## Mental Health Building Block Infrastructure



## **Outreach and Enrollment Initiatives**

Our research identified at a general level, whether Marketplaces and state Medicaid agencies have engaged in broad outreach efforts to inform the public, especially targeted populations, about the availability of new insurance coverage options, insurance subsidies, and how to enroll. It also assessed whether states created a standardized training curriculum along with a competency exam to certify individual navigators and in-person assisters under conflict of interest rules, as well as policies allowing properly trained and certified agents and brokers to sell qualified health plans (QHPs).

## **State Health Insurance Marketplaces and Essential Health Benefits**

The ACA required most people to have statutorily specified minimum essential health insurance coverage beginning January 2014 or pay a penalty.<sup>2</sup> To help individuals who do not have access to affordable employer-based coverage, the ACA requires that each state establish an online Marketplace, or partner with the federal government in operating a Federally Facilitated Marketplace.<sup>3</sup> The Marketplaces offer information to help individuals compare health plans based on cost, quality, and provider networks, and then enroll in coverage.

QHPs offered through Marketplaces must provide coverage of statutorily specified essential health benefits (EHBs), including mental health and substance use disorder services (and other behavioral health-related treatment), ambulatory patient services, emergency services, hospitalization, maternity and newborn care, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services.<sup>4</sup>

We specifically examined whether states are applying objective network adequacy standards as may be required by the ACA that apply to all health issuers operating inside and outside the Marketplaces, and whether health plans are contracting with statutorily specified “essential community providers (ECPs)” — Federally Qualified Health Centers (FQHCs) and FQHC “lookalikes”, Disproportionate Share Hospitals, hemophilia treatment centers, black lung clinics, children’s hospitals, critical access hospitals, rural referral centers, Ryan White AIDS treatment centers, Indian organizations and tribes, among others—in order to be certified for participation in Marketplace QHP networks.<sup>5</sup>

## **Adoption of Prevention, Health Promotion and Wellness Programs**

Ultimately, the goal of any broad-scale health system reform should be improving population health. The ACA includes new funding to invest in prevention, wellness, and public health infrastructure. This focus on improving population health is particularly important based on a composite of several different measures affecting health including individual behaviors,

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<sup>2</sup> Section 1501 of the ACA, § 5000A of the Internal Revenue Code, 26 U.S.C. § 500A.

<sup>3</sup> Section 1321 of the ACA, 42 U.S.C. § 18041.

<sup>4</sup> Section 1302(b) of the ACA, 42 U.S.C. § 18022(b).

<sup>5</sup> Section 1311(c) of the ACA, 42 U.S.C. § 18031(c).

community and environmental factors, public and health policies, clinical care, and health outcomes. The ACA includes new requirements and options to cover clinical preventive services in public and private health insurance plans. In addition, the ACA requires Marketplace plans, Medicare, and certain Medicaid plans to promote and cover employee prevention and wellness programs, prohibiting consumer cost-sharing for services, when assigned a grade of A or B by the U.S. Preventive Services Task Force.<sup>6</sup> The ACA also specifically requires state Medicaid agencies to provide coverage for tobacco-cessation drugs and to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use.<sup>7</sup> State Departments of Insurance are expected to monitor health plans to ensure compliance with the requirement that new employer-sponsored group health plans and private health insurance policies provide coverage, without cost sharing, for preventive services.

The ACA also provided new funding to expand prevention, wellness, and public health efforts through the creation of a Prevention and Public Health Fund<sup>8</sup> and an Education and Outreach Campaign,<sup>9</sup> as well as creating new initiatives to prevent or reduce obesity<sup>10</sup> and tobacco use,<sup>11</sup> improve maternal and infant health,<sup>12</sup> and otherwise strengthen the public health infrastructure. A number of states have received the authorized funding as grants to implement or strengthen programs at the local level.

The authors ascertained how the ACA prevention and wellness provisions embodied in the essential health benefits packages are provided through the QHPs and the new Medicaid expansion program. We also assessed if evidence-based screening for mental health and substance use conditions is being embedded in medical homes, health homes, safety net programs, and school based clinics in the states.

### **Early Assessment and Treatment Are Critical Across the Lifespan**

For consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience mental health problems.

Emerging research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability. New understanding of the brain science indicates that early identification and intervention can sharply improve outcomes and that longer periods of abnormal thoughts and behavior have cumulative effects and can limit

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<sup>6</sup> Sec. 2713(a)(1) of the ACA, 42 U.S.C. § 300gg-13(a)(1); § 4104(b)(1) of the ACA, 42 U.S.C. § 1395l(a)(1), § 1833(a)(1) of the Social Security Act; § 4105(a) of the ACA, 42 U.S.C. § 1395m(n), § 1834(n) of the Social Security Act; § 4106(a)(13) of the ACA, 42 U.S.C. § 1396d(a)(13), § 1905(a)(13) of the Social Security Act.

<sup>7</sup> Sec. 4107(a) of the ACA, 42 U.S.C. § 1396d(a)(4)(B), § 1905(a)(4)(B) of the Social Security Act.

<sup>8</sup> Sec. 4002 of the ACA.

<sup>9</sup> Sec. 4004 of the ACA.

<sup>10</sup> Secs. 4004(b)(2), (d), and (i), 4108(a)(3)(ii), and 4306 of the ACA.

<sup>11</sup> Secs. 4108(a)(3)(ii) and 4202(a)(3)(ii) of the ACA.

<sup>12</sup> Sec. 5313(a) of the ACA; § 42 U.S.C. 399v(b)(5).



capacity for recovery. Untreated childhood disorders can lead to a downward spiral. Early childhood is a critical period for the onset of emotional and behavioral impairments. Each year, young children are expelled from preschools and childcare facilities for severely disruptive behaviors and emotional disorders.

Because children develop rapidly, delivering mental health services and supports early and swiftly is necessary to limit the subsequent impact of disorders and ensure that children are ready for school. Emerging neuroscience highlights the ability of environmental factors to shape brain development and related behavior. Consequently, early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening.

### **New Models of Care Delivery and Financing, and the Cost Containment Imperative**

New models of care delivery are essential to improve the value delivered by the behavioral health system. The ACA includes provisions aimed at testing new models of delivering and paying for health services with the goals of reducing unnecessary utilization and healthcare expenditures, while improving individual health outcomes and overall population health.

The ACA gives the Centers for Medicare and Medicaid Services (CMS) authority to test new models of behavioral health that expand access to needed services, as well as incentivize providers to improve quality and individual and community health outcomes, involve patients more directly in their own care, and moderate rising healthcare costs by reducing redundant, ineffective, and inefficient utilization.

Some states have many different pilots or demonstrations under development, both in the public and private sector, including, but not limited to, multi-payer patient-centered medical homes, health homes, and accountable care organizations (also known as ACOs), new payment models, value-based insurance designs, and broader population health interventions. Our second issue paper catalogued the various successful initiatives implemented by states and the impact of those initiatives on behavioral health and consumers.

### **Improving Quality of Care and Adopting Health Information Technology**

The ACA includes new provisions aimed at improving the quality of care provided by different types of healthcare professionals and providers. For example, the ACA requires the Secretary of HHS to develop quality measures to assess healthcare outcomes, functional status, transitions of care, consumer decision-making, meaningful use of health information technology, patient experience, health disparities, and safety, efficiency, and equity in healthcare. Care professionals and providers will be required to report data on these new measures to CMS, which will ultimately make the data available to the public. In addition, the ACA changes the Medicare and Medicaid reimbursement structures to reward providers and healthcare professionals, in part, based on the quality of services provided.<sup>13</sup>

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<sup>13</sup> Title II, Subtitle I, Title III, and Title X, Subtitle C of the ACA

Our fourth issue paper examines how behavioral health providers need to be educated about these changes, so that they can understand and be prepared to meet the new reporting and quality standards. In addition, consumers will need to understand how to interpret the quality comparison data when they become available. 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 consumer and all providers associated with care of the individual.

Behavioral health providers should support and participate in the development of interoperable, integrated electronic health records that will be necessary to monitoring the quality of patient outcomes and indicators of mental health and substance use disorders.

### **Behavioral Health and Community-Based Services in the Aftermath of Olmstead**

The U.S. Supreme Court, in its 1999 *Olmstead v. L.C.* decision,<sup>14</sup> 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 1990 Americans with Disabilities Act (ADA) may require states to provide community-based services rather than institutional placements for consumers with disabilities. Since the 1973 passage of § 504 of the Rehabilitation Act,<sup>15</sup> federal agencies administering federally funded programs, such as Medicaid agencies and State Mental Health Agencies, have been mandated to eliminate segregation of individuals with disabilities. The ADA<sup>16</sup> and the implementing federal regulations that followed accelerated the movement to eliminate segregation for individuals with disabilities. In passing the ADA, Congress said it had found that “discrimination against individuals with disabilities persists in such critical areas as ... institutionalization.”

Title II of the ADA prohibited state and local government agencies, departments, special purpose districts, and other instrumentalities from discriminating against people with disabilities in their programs, services, and activities. Most importantly, the Title II ADA regulations required a public entity to administer services, programs, and activities ***in the most integrated setting appropriate*** to the needs of qualified individuals with disabilities. Our seventh issue paper looks at final regulations governing the implementation of home and community-based services (HCBS) and the impact on people with behavioral health conditions.

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<sup>14</sup> *Olmstead*, 527 U.S. 581 (1999).

<sup>15</sup> 29 U.S.C. § 794(a), Pub.L. 93-112 (September 26, 1972).

<sup>16</sup> 2 U.S.C. § 12101(a)(2), (3).

## **Summary of Issue Paper**

### **On**

## **Strategies to Enroll Uninsured People with Mental Health Conditions under the Affordable Care Act**

### **Key Take-Aways**

1. Raising awareness among providers of services to homeless individuals and discussing the benefit of having access to health insurance will be critical to ensuring that eligible individuals enroll.
2. It may take multiple contacts with a homeless person to develop sufficient trust before they are willing to engage in care.
3. To allow for more effective enrollment to address the needs of homeless individuals who have a mental illness, it is important for behavioral health centers to have the infrastructure to accommodate extra demand.
4. The first step in developing a health insurance enrollment program for individuals in local justice systems is to identify the optimal location for enrollment.
5. The time of transition from an institutional setting to the community is a critical time for juvenile justice-involved youth with mental health conditions.
6. A “no wrong door” policy” can increase veterans’ awareness of VA services, facilitating their enrollment.
7. Effective outreach must be community-based, where it is conducted through trusted messengers, and designed to reach minority populations.
8. The rollout of the State Children’s Health Insurance Program (CHIP) taught policy-makers that it takes considerable time to achieve broad participation among consumers eligible for coverage.
9. SBHAs need to work closely with other stakeholders to ensure that insurance marketplaces and pools conduct strong outreach and education activities, targeted to the public, eligible employers, behavioral health consumers, and service providers to ensure sufficient access to health coverage and benefits.

Under the ACA, states are responsible for conducting outreach and enrollment for vulnerable and underserved populations eligible for the new Medicaid Expansion, as well as for enrolling people in State Health Insurance Marketplaces.<sup>17</sup> Targeted outreach and enrollment is essential and necessary to reaching newly-eligible adults with mental illness and substance use disorders, and identifying specific barriers relevant to outreach and enrollment for persons with a mental illness.

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<sup>17</sup> Secs. 1411 and 1413 of the ACA; 42 U.S.C. § 18081 and 18083.

## Reaching Individuals with a Mental Illness Who Are Homeless

Raising awareness among providers of services to homeless individuals and discussing the benefit of having access to health insurance for people who are homeless or at risk of homelessness is critical to ensuring that those eligible individuals enroll. It may take multiple contacts with a homeless person with a mental illness in shelters, libraries, encampments, food kitchens, and other places where people congregate to develop sufficient trust before a homeless individual is willing to engage in the healthcare system.

Once trust is established, education and enrollment are next. Many homeless people are unaware of new programs or the new insurance coverage opportunities made available through health reform. To reach them quickly, those engaging people who are homeless should try discussing their immediate mental illness or medical problem and what services they want to access.

To allow for more effective outreach and enrollment to address the needs of people who are homeless and have a mental illness, it is important for behavioral health centers to have the infrastructure to accommodate the extra demand to utilize these strategies:

**Raising awareness among providers of services to homeless individuals and discussing the benefit of having access to health insurance for people who are homeless or at risk of homelessness will be critical to ensuring that eligible individuals enroll.**

- **Tailor pamphlets and other educational materials.** Ensure they include information on Medicaid and that they use culturally appropriate language consumers understand.
- **Hire in-person assisters and certified application counselors.** These positions can be used to conduct both “in-reach” with existing clients and outreach with new clients.
- **Leverage group sessions.** Add discussions and question and answer sessions about coverage opportunities under the ACA and Medicaid to group sessions already scheduled.
- **Set aside one-on-one time.** Give consumers a chance to talk about income eligibility, affordability concerns, and personal circumstances in a private setting.
- **Create electronic alerts.** Set up electronic medical records to automatically notify the provider when a client can apply for Medicaid.
- **Partner with shelters and other providers.** Staff an on-premises “enrollment table” that includes familiar and trusted shelter personnel.
- **Invest in a tablet computer.** Take it to the shelters, parks, soup kitchens and encampments to assist in enrollment.

Explore the possibility of a “Healthcare for the Homeless” grantee or other homeless outreach agency becoming an entity authorized to conduct Medicaid enrollment activities. People who are homeless with mental health conditions and substance use disorders may be particularly disenfranchised. SBHAs should offer to help states modify enrollment processes to ensure access by vulnerable populations.

## Reaching County Jail Populations

According to experts in the field, the first step in developing a healthcare enrollment program for individuals in local justice systems is to identify the optimal location for enrollment. A provision of the ACA prohibits treating an incarcerated individual as eligible for Marketplace coverage, other than under an incarceration pending disposition of charges. An incarcerated individual is permitted to enroll in the Medicaid program, but may not receive outpatient benefits while incarcerated. Given these restrictions, the best opportunities for enrollment of the population include:

- shortly after arrest for diverted individuals or individuals cited out;
- at the county jail, during initial intake;
- at the county jail, post-arraignment and pre-trial; or
- at the county jail, pre-release.

Marin County, California, has initiated an innovative reentry program whereby the sheriff takes custody of the prisoners who will be on Post-Release Community Supervision (PRCS) 60 days before their release. The prisoners spend the end of their term in the county jail, where the jail’s reentry coordinator and probation officers work closely with them to prepare for their reentry into the community, including enrolling them in health insurance coverage. To determine the best time and location for enrollment, county justice officials can collaborate with county health officials to understand each individual’s considerations and needs.<sup>18</sup>

SBHAs should advocate for the enrollment needs of individuals moving from jails and prisons to community-based settings in order to prevent discontinuity of care. State and county health officials should work with state justice system officials to explore ways to use technology to streamline enrollment. County jails that have already collected information needed to make eligibility determinations for a health plan can explore with the state or county health department the possibility of making that data available to automate eligibility determinations.

SBHAs also should engage with state Medicaid programs to determine how best to address enrollment for individuals who are transitioning between correctional systems to Medicaid to ensure these individuals have consistent access to mental health services.

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<sup>18</sup> Miller, J.E. and Glover, R.W., *Strategies to Enroll Uninsured People with Mental Health Conditions under the Affordable Care Act*, National Association of State Mental Health Program Directors, Alexandria, VA (January 2014).

## Reaching Medicaid-Eligible Youth in Correctional Systems

The time of transition from an institutional setting to the community or home is a critical time for juvenile justice-involved youth with mental health conditions. As youth move through the juvenile justice system – sometimes bouncing between settings multiple times before leaving the system completely – there are many opportunities for them to lose their Medicaid eligibility.

Presumptive eligibility is a Medicaid option that allows qualified entities to determine, based on a simplified calculation of family income, whether a child is likely to be eligible for Medicaid. States have the flexibility to deem agencies that provide services, such as juvenile justice programs, as qualified entities. Youth can receive temporary Medicaid eligibility pending a final eligibility determination by the Medicaid agency. This is important because the faster youth get enrolled into Medicaid, the more quickly they will be able to access services after they leave the system.

The New Hampshire Department of Children, Youth and Families (the agency in charge of determining Medicaid eligibility) fiscal staff are notified whenever a youth's placement changes to a group or residential placement. The fiscal staff immediately determines Medicaid eligibility.

**Regardless of the size, breadth, and depth of investments in outreach and application assistance, the State Children's Health Insurance Program (CHIP) taught policy-makers that it takes considerable time to achieve broad participation among eligible consumers in coverage.**

**Provisions such as the “no wrong door” policy, whereby applications to Medicaid, CHIP, or exchange coverage can be screened for a variety of health insurance programs; the individual mandate; and the use of trained navigators to assist individuals who are seeking health insurance coverage could increase veterans' awareness of and interest in VA services, facilitating their enrollment.**

Few juvenile justice agencies screen at intake to identify Medicaid-eligible youth. SBHAs should encourage juvenile justice agents, such as case managers or probation officers, to screen youth for Medicaid eligibility and assist with the application process, in order to help ensure continuity of care and allow juvenile-justice involved youth to access medical care once they leave an institution.

## Reaching Uninsured Veterans with a Mental Illness

Beyond Medicaid expansion, veterans' health insurance coverage and mental healthcare access will likely be affected by other policy changes in the coming years. Provisions such as the “no wrong door” policy, whereby applications to Medicaid, CHIP, or Marketplace coverage can be screened for eligibility for a variety of coverage programs, the individual mandate, and the use of trained navigators to assist individuals who are seeking health insurance coverage could increase veterans' awareness of and interest in Veterans



Administration (VA) services, facilitating their enrollment. Enrollment should also be facilitated by the recent passage of federal legislation allowing veterans with “Veterans Choice” cards to access care outside the VA system when VA care is more than 40 miles distant or otherwise inaccessible, or wait times for service exceed 30 days.<sup>19</sup>

Encouraging state enrollment agencies to add screening questions about veteran status on Medicaid/Marketplace applications and the use of data matches to identify and enroll eligible veterans would also help to increase uptake of coverage among veterans.

## Reaching Minority Populations

Outreach to minority populations should be conducted by trusted messengers, including healthcare providers, promoters and community health workers, and community members and leaders. Enrolling on-site in immigrant communities, farm worker communities, rural residents, and tribal areas where people live and work is essential. Locations for effective outreach can include community centers, day care centers, schools, grocery stores, pharmacies, libraries, senior centers, and healthcare providers.

Messaging and enrollment outreach needs to occur at flexible times, before and after standard work hours and on weekends, as well as during the weekday.

**Messaging and enrollment outreach needs to occur at flexible times, before and after standard work hours and on weekends, as well as during the weekday.**

## Reaching Men of Color

Men of color should be a critical target for states and new Medicaid coverage because this population has historically lower rates of healthcare coverage, poor health outcomes, and disproportionate rates of poverty and homelessness than the general population. Outreach to this population will take concerted and coordinated efforts on the part of multiple stakeholders working at multiple levels.

Outreach Programs are a critical component, but their efforts need to be supplemented and supported by many other organizations. With any difficult-to-reach population, community-based outreach and education efforts should be a critical complement to broader marketing campaigns. Community outreach and enrollment efforts need to be on-going and widespread and involve others beyond officially certified assisters. Community members need to be pro-active in their outreach efforts and target places where men of color are most likely to be present. These locations might include:

- Churches and faith-based organizations;
- Affinity/associational groups of all types: immigrant associations, college fraternities, sports leagues;
- Pharmacies, recreational centers, gyms, and barbershops;

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<sup>19</sup> [Veterans Access, Choice, and Accountability Act of 2014](#), Pub. L. 113-146 (August 7, 2014).

- Ethnic restaurants and grocery stores; and
- Soup kitchens, food pantries, and homeless shelters.

**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.**

Regardless of the size, breadth, and depth of investments in outreach and application assistance, the CHIP taught policy-makers that it takes considerable time to achieve broad participation among eligible consumers in coverage. Policy-makers appear to be heeding those lessons in designing outreach campaigns that combine both broad efforts to raise public awareness and community-based efforts to reach the outliers.

Furthermore, outreach campaigns are being supported by extensive application assistance programs, designed to provide consumers with direct, hands-on help in completing the application process.

### **SBHAs should:**

- Support efforts that explicitly identify community mental health and substance use disorder organizations licensed or certified by the state as ECPs.
- Support initiatives that explicitly recognize and enforce the EHB requirements of the ACA, including the requirement under the Mental Health Parity and Addiction Equity Act, §§ 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Public Law 110-343), that behavioral health benefits provided by QHPs be at parity with (no more restricted than) medical/surgical benefits.
- Take part in efforts that develop and help enforce network adequacy standards that ensure access to behavioral health providers.
- 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 health they need, and that confidentiality is protected.
- Advocate for the enrollment needs of individuals moving from institution to community-based settings in order to prevent discontinuity of care.
- Work closely with other stakeholders to ensure that the issuers of insurance plans conduct strong outreach and education activities, targeted to the public, eligible employers, and behavioral health consumers and service providers to ensure sufficient access to coverage and benefits.



- Ensure that governing boards and other advisory bodies tasked with maintaining and administering the Marketplaces include individuals with expertise regarding the unique needs of individuals with behavioral health disorders.
- Advocate for the enrollment needs of individuals moving from institutions, such as Institutions for Mental Disease (IMDs) or prisons, to community-based settings in order to prevent discontinuity of care. SBHAs also should engage with the Marketplaces and Medicaid programs to determine how best to address enrollment for individuals whose income levels fluctuate between Medicaid and Marketplace eligibility to ensure those “churning” individuals have consistent access to behavioral health services.
- Monitoring that Marketplace and Medicaid enrollment procedures are synchronized, as required under the ACA, so that there is "no wrong door" for enrollment. SBHAs have a role in influencing the design of streamlined enrollment procedures to ensure that enrollment adequately addresses the needs of specific behavioral health populations.
- Advocate for temporary or presumptive eligibility procedures for likely qualified patients in need of acute or emergency services such as crises intervention and detoxification.
- Work with the individuals who are managing the consumer assistance program in their state to ensure appropriate outreach to and support for individuals with behavioral health conditions.
- Help to design enrollment processes for vulnerable behavioral health populations, such as homeless people with behavioral health conditions and active substance users, who can be particularly disenfranchised
- 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.

## Summary of Issue Paper

### On

## Striking a Balance: Mental Health Provider Network Adequacy under Healthcare Reform

### Key Take-Aways

1. Because the EHB package requires a minimum level of benefits for all health plans, enforcing and strengthening the adequacy of provider networks is a critical step in ensuring the millions of people newly insured through the ACA can easily access their benefits.
2. Final rules require QHPs to have provider networks that are “sufficient” in number and types of providers, including those that specialize in mental health and substance use disorder services.
3. HHS has set a minimum expectation that all participating health plans include at least 30 percent of all ECPs available in their service areas in their provider networks.
4. HHS has left it to the states to assess health issuers’ network adequacy and monitor plans for compliance once they are operating in Marketplaces. It is critically important for SBHAs and other stakeholders at the state level to closely monitor the adequacy and appropriateness of provider networks.
5. For many services, conversations about provider adequacy in networks are being moved from an in-person discussion to the computer or other technologies. The site of care is being transferred from institutions to home- and community-based settings. In the new digital age, we must find new and promote existing information technologies to improve or supplement provider networks to accommodate the needs of consumers and providers.
6. SBHAs should ensure that network adequacy standards include standards related to: enrollee-to-provider and enrollee-to-staff ratios, including ensuring that a sufficient number of licensed or certified providers and specialty providers are available to ensure adequate choice.
7. SBHAs should ensure that network adequacy standards accommodate access to peer support services.

The ACA requires that health plans participating in Marketplaces meet network adequacy standards. Regulatory standards adopted by CMS require the QHP or issuer to provide enrollees with reasonable and timely access to a broad range and “sufficient number” of providers for low-income, medically underserved individuals in the QHP's service area, including ECPs and providers that specialize in mental health and substance abuse services. These criteria require that consumers have access to needed care without “unreasonable delay.”<sup>20</sup> Enforcing and

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<sup>20</sup> 45 C.F.R. 156.230 and 156.235.

strengthening the adequacy of provider networks is a critical step in ensuring that the millions of people who are newly insured through the ACA can easily access their covered benefits.

This issue paper provided an overview of network adequacy requirements outlined in the ACA for QHPs and other standards applied in private insurance markets, Medicaid, and Medicare. We recommended key issues for mental health stakeholders and advocates to consider when advocating for strong network adequacy standards for QHPs in the Marketplaces.

### **ACA Network Adequacy Requirements for QHPs**

The ACA directed HHS to develop criteria to certify health plans sold in Marketplaces. These criteria were required to ensure:

- a sufficient choice of providers;
- inclusion of essential community providers (ECPs) to serve predominately lower-income and medically underserved individuals; and
- availability of providers to new patients.<sup>21</sup>

HHS issued final rules in March 2012 elaborating on the ACA requirements and giving states considerable flexibility to establish their own standards. To ensure that all services can be accessed without “unreasonable delay,” the final rules require QHPs to have provider networks that are “sufficient” in number and types of providers, including those that specialize in mental health and substance use disorder services.<sup>22</sup> However, there has been no further clarification on what the terms “sufficient” or “unreasonable delay” mean, thereby leaving the implementation of specific standards either to issuers and QHPs, or to the states.

In terms of ECP inclusion requirements, regulators from states running their own Marketplaces are responsible for establishing minimum contracting standards based on states’ unique geographic and demographic factors. For Federally Facilitated Marketplaces, HHS initially set a minimum expectation, in a April 2013 letter to issuers, that all participating health plans include at least 10 percent of all ECPs available in their service areas in their provider networks. At the same time, HHS promised to consider “factors and circumstances” that prevented them from meeting the minimum standard when evaluating their compliance.<sup>23</sup>

**In addition to expanding health insurance coverage for millions of people, the ACA also requires that health plans participating in State Health Insurance Marketplaces must meet network adequacy standards. These criteria ensure that consumers have access to needed care without “unreasonable delay.”**

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<sup>21</sup> Sec. 1311 of the ACA, codified at 42 U.S.C. § 18031.

<sup>22</sup> 45 C.F.R 156.230 and 156.235.

<sup>23</sup> Center for Consumer Information and Insurance Oversight, “Affordable Exchanges Guidance: Letter to Issuers in Federally Facilitated and State Partnership Exchanges (April 5, 2013).

However, in a February 2014 letter to issuers participating in the Federally Facilitated Marketplace in 2015, CMS raised the ECP threshold to 30 percent and also warned that issuers must ensure the presence of at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.<sup>24</sup> However, CMS said it would permit issuers who could not meet the benchmark to submit on its application for participation a description of how the issuer's provider network(s) would provide access for low-income and medically underserved enrollees and how the issuer would increase ECP participation in the provider network(s) in future years. However, CMS also noted that it had only received one such explanation in applications for the 2014 coverage year.

QHPs also must make provider directories available to enrollees online, and in hard copy on request. These directories must clearly indicate if any providers are not available to new patients. However, HHS leaves it to the states to assess issuers' network adequacy and monitor plans for compliance once they are operating in Marketplaces.<sup>25</sup>

### **Network Adequacy Standards Applied in Private Insurance Market and Public Programs**

Most states have broad standards requiring health plans in the private insurance market to have a "robust" or "sufficient" network. To help states set network adequacy standards, the National Association of Insurance Commissioners (NAIC) in 1996 developed the Managed Care Plan Network Adequacy Model Act #74, recommending the following criteria:

- maximum number of enrollees per primary care and specialty provider;
- geographic accessibility;
- waiting times for appointments with participating providers;
- hours of operation; and
- volume of technological and specialty services available to serve the needs of covered persons requiring advanced technology or specialty care.<sup>26</sup>

Although the NAIC Model Act, which has not been updated since 1996, applies to all managed care organizations (MCOs), only seven states have formally adopted the Model Act into statute.<sup>27</sup>

In most states, the Department of Insurance oversees network adequacy. In some states, the Department of Health reviews a plan's network adequacy when an MCO applies for licensure or

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<sup>24</sup> Center for Consumer Information and Insurance Oversight, 2015 Letter to Issuers in the Federally-Facilitated Marketplace (FFM) (February 4, 2014), p. 20.

<sup>25</sup> Center for Consumer Information and Insurance Oversight, Letter to Issuers on Federally-Facilitated and State Partnership Marketplaces (April 4, 2013), pp. 7-8.

<sup>26</sup> *Managed Care Plan Network Adequacy Model Act*, Sec. 5, National Association of Insurance Commissioners (October 1996).

<sup>27</sup> NAIC Model Regulation Service, *NAIC Model Laws, Regulations and Guidelines 74-1*, State Adoption Document ST-74 (April 2014).

as part of an MCO quality assurance assessment. However, to the extent that state regulators provide oversight, it is most commonly in response to consumer complaints.

## **Key Issues for Providers and Consumer Advocates to Watch**

Because standards set by the ACA are broad and general, they give states the opportunity to become more prescriptive by, for example, limiting travel times, distances, and appointment waiting times. However, network adequacy should not only focus on issues of accessibility, such as how far consumers must travel to receive treatment. When setting network adequacy standards, states should encourage greater consumer protections by taking into account quality of care and affordability, including enrollees cost-sharing imposed when utilizing out-of-network providers.

SBHAs, providers, and consumer advocates should focus on the following areas when advocating for stronger network adequacy:

1. Adopt in-network cost-sharing that can be applied equally to unexpected and often prohibitively costly services provided by out-of-network providers working in network facilities.
2. Require strong standards for the inclusion of ECPs to ensure timely access to healthcare for vulnerable populations.
3. Implement nondiscrimination provisions to ensure consumers have access to healthcare that is culturally and linguistically appropriate.
4. Apply network adequacy standards inside and outside Marketplaces that align to eliminate adverse selection.
5. Develop data collection systems to evaluate provider networks and monitor the compliance of health plans with network adequacy standards.
6. Encourage regulators to consider quality of care in determining whether networks are “sufficient”.
7. Help to adopt emerging technologies, new models of care, and value-based provider payments that can serve to facilitate access to an enhanced quality of care.

Traditional network adequacy standards, which vary among different regulators, are usually tied to the fee-for-service, visit-based model of care. For example, “time and distance” standards that assess how far people must go to receive treatment — especially common in Medicaid and Medicare managed care programs — are based on the premise that care is delivered in a face-to-face office visit. For many services, that model is changing. Conversations are being moved from an in-person discussion to the computer or other technologies. The site of care is being transferred from the institution to a home- and community-based setting. In the new digital age, we must find new ways to improve the provider networks to accommodate the changing healthcare environment and the needs of consumers and providers.

## **SBHAs should ...**

Ensure that plan networks are sufficient in number, mix, and geographic distribution of providers to ensure access to all covered mental health and substance use disorder services in a timely manner not detrimental to the health or well-being of the enrollee.

At a minimum, SBHAs should ensure that QHPs meet network adequacy standards related to:

- Enrollee-to-provider and enrollee-to-staff (including health professionals, administrative, and other support staff) ratios, ensuring that a sufficient number of mental health and substance use treatment providers licensed or certified by the state, and a sufficient number of specialty providers, are available to enrollees to ensure adequate choice;
- The ability of enrollees to access providers within 24 hours for urgent care and 10 to 14 calendar days for routine care, and more comprehensive, coordinated care that offers a full range of services;
- Travel time and distance to providers, which should take into consideration geographic and other barriers—such as a lack of accessibility by public transportation—that are not accounted for by simple mileage and travel-time criteria;
- Appointment waiting times, hours of operation, and provider acceptance of new patients;
- Appointment standards for transitional care, preventive care, non-urgent care, and emergency care;
- Reasonable proximity for at least 90 percent of plan enrollees to at least two network mental health and at least two network substance use treatment providers to the enrollee's business or personal residence, for each point along the care continuum, within specified urban, suburban, and rural distances; and
- Access to a non-network provider when no network provider is available, at no additional cost to the enrollee.

## Summary of Issue Paper

on

### Reducing the Burden of Mental Illness: The Role of Prevention Activities and Public Health Strategies

#### Key Take-Aways

1. Public health interventions and prevention programs can create major improvements in the mental health of our society.
2. To be effective, it is essential that the public health system clearly define population disparities, set goals for improvement, focus on community-based research, and educate the community about the effects of social determinants of health on mental health and mental illness.
3. A shift toward the efficient and effective implementation of a coordinated and comprehensive approach to mental health will involve many challenges, including a reallocation of resources, a retooling of the workforce, and a broader reconceptualization of mental health promotion.
4. Under the changing healthcare landscape and healthcare reform, SBHAs should work with 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.
5. SBHAs should partner with state Medicaid officials to define, develop, and implement universal and evidence-based standard screening protocols and tools for mental health and substance use conditions, working to embed the function in medical and health homes, safety net programs, and school based clinics.

Mental health and mental illness can be influenced by multiple determinants, including genetics and biology, but also by numerous social and environmental factors.<sup>28</sup> Social determinants of health—including income, stressful circumstances, trauma, early childhood experiences, social exclusion, occupation, education level, sanitation, social support, discrimination and stigma, and lack of access to health resources—can influence mental health and mental illness.

In turn, mental health and mental illness may influence physical health and biologic functioning. Positive mental health—positive emotions and evaluations of life—are associated with better endocrine function, and better immune response. Higher levels of purpose in life, personal growth, and positive personal relations have been linked with lower cardiovascular risk.

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<sup>28</sup> Centers for Disease Control and Prevention. *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention, 2011–2015* (2011).



**Mental health and mental illness can be influenced by multiple determinants, including genetics and biology, but also by numerous social and environmental factors.**

Social determinants may have positive or negative consequences. For example, an intact family provides a strong, protective social network. Other protective factors include religion and spirituality, social support, and social participation. On the other hand, a lack of infrastructure in poor urban neighborhoods often leads to communities that are disenfranchised and social networks that are frayed.

Public health interventions can create major improvements in the mental health of our society. To be effective, it is essential that the public health system clearly define population disparities, set goals for improvement, focus on community-based research, and educate the community about the effects of social determinants of health on mental health and illness. The interaction of the three elements—social determinants of health, health outcomes, and public health interventions—can yield central insights for maintaining positive mental health and fostering improvement for populations who have a mental illness.

The ACA includes four primary levers of change:

- coverage for previously uninsured persons which helps to reduce disparities in access to care, thereby improving overall well-being;
- mandated parity for mental health with other healthcare in QHPs and Medicaid benchmark benefit packages;
- funding for promotional and preventive programs and services that can have a positive impact on mental health; and
- integration of public health prevention and promotion programs.

**The interaction of the three elements—social determinants of health, health outcomes, and public health interventions—can yield central insights for maintaining positive mental health and fostering improvement for populations who have a mental illness.**

The case for a public health framework to address the persistent barriers to accessible and effective mental health services using this multi-tiered approach is compelling. A 1999 Surgeon General report on mental health identified relevant components of a public health framework and the positive impact that this approach can have on improving the mental health of the population. However, a shift towards the efficient and effective implementation of a coordinated and comprehensive approach to mental health will involve many challenges, including a reallocation of resources, a retooling of the workforce, and a broader reconceptualization of mental health promotion that includes healthy functioning (cognitive, social, and physical) across multiple domains and settings (home, school, and work).<sup>29</sup>

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<sup>29</sup> Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, Rockville, MD. (1999).



There are different ways to categorize preventive measures. A commonly-utilized framework within public health relates to the goals of a practice according to “stages of disease,” with a continuum across primary, secondary, and tertiary prevention. Primary prevention efforts may be further delineated by the level of risk of the targeted population, at the universal, selective, and indicated levels.<sup>30</sup> These are discussed in detail in our third issue paper, as are provisions of the ACA which states can leverage to implement or increase promotion and prevention-related activities to foster mental health, along with examples of models and activities that states might consider in their efforts to improve wellbeing and reduce the impact of mental illness.

### **SBHAs should:**

- Work with public and private sector stakeholders at the state level, including major health purchasers, to take advantage of public policy and private sector opportunities and the growing evidence-base behind prevention, with a focus on children and youth.
- Consider partnering with state Medicaid officials and other stakeholders to help design appropriate public awareness campaigns, consumer incentives, and programs for individuals with behavioral health conditions.
- Partner with state Medicaid officials to define, develop, and implement universal and evidence-based screening protocols and tools for mental health and substance use conditions, working to embed the function in medical and health homes, safety net programs, and school-based clinics.
- Communicate with pediatric and primary care professional organizations, as well as state medical boards and medical schools, to promote universal adoption of standardized protocols and tools for mental health and substance use conditions.
- Continue to work to prevent or reduce the consequences of: underage drinking and adult problem drinking; 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 prescription drug misuse and abuse.
- Continue to work to move state behavioral health systems toward a broader definition of health by recognizing the importance of wellness and prevention services in addressing behavioral health disorders.

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<sup>30</sup> Miller, J.E., Gordon, S.Y., Shea, P., National Association of State Mental Health Program Directors, *Reducing the Burden of Mental Illness: The Role of Preventive Activities and Public Health Strategies* (April 2014).

## Summary of the Issue Paper

### On

## The Need for Early Mental Health Screening and Intervention Across the Life Span

### Key Take-Aways

1. Mental illness has been viewed as a disease of early adulthood, but the onset of bipolar disorder or schizophrenia typically occurs in teens and young adults. In fact, about half of all lifetime cases of mental illnesses start by age 14 (16.5 years is the average). Symptoms in three-quarters of mental illness cases appear by age 24. Of children ages 9 to 17, 21 percent have a diagnosable mental or addictive disorder that causes at least minimal impairment.
2. Many people with psychosis fail to finish high school and struggle to maintain steady employment. Some become permanently disabled and unable to work; some live on the streets or wind up in jail. Most spend their lives dependent on family support or public assistance.
3. Young people who show early signs of emotional disorders often do not receive treatment because of stigma or because they lack information about available resources. Over 90 percent of children and adolescents who commit suicide have a mental health disorder.
4. Early intervention and linkage to treatment and supports can prevent the compounding of mental health problems, the accumulation of poor life outcomes, and may, in some cases, lessen long-term disability.
5. SAMHSA's Center for Mental Health Services' (CMHS's) "Now is the Time Project AWARE (Advancing Wellness and Resilience in Education) State Educational Agency Program (NITT-AWARE-SEA)" has cooperative agreements which build and expand the capacity of State Educational Agencies to increase awareness of mental health issues among youth, and provide training for school personnel and adults who interact with youth to detect and respond to mental health issues in children.
6. Public and private collaboration between public agencies at all levels and the community can create social and physical environments that enable good health through prevention for all age groups.
7. Collaborations across state and local mental health and human service agencies help to identify where investments can be made to prevent the social, emotional, and cognitive impairments that contribute to at-risk behaviors leading to disease, disability, social problems, and early morbidity.

According to the World Health Organization (WHO), between 35 percent and 50 percent of individuals with severe mental illness receive no treatment in high-income nations. WHO reports that mental health disorders account for 13 percent of the global burden of disease, defined as

premature death combined with years lived with disability.<sup>31</sup> Depression alone accounts for 4.3 percent of the global burden of disease and is among the largest single causes of disability worldwide [11 percent of all years lived with disability globally], particularly for women.<sup>32</sup>

About 4.1 percent of all adults (18 or older) in the United States—about 10 million adults—have a severe mental illness (SMI), defined as a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.<sup>33</sup>

The percentage of adults with SMI in the previous year among all those adults with any mental illness (AMI) in 2012 was highest among adults ages 26 to 49 (5.2 percent), followed by those ages 18 to 25 (4.1 percent). Those who were 50 or older constituted 3 percent of the population with AMI.<sup>34</sup>

Among children, data from the Centers for Disease Control and Prevention's (CDC's) 2011 National Health and Nutrition Examination Survey (NHANES) indicates that 11 percent of children ages 8 to 11 experienced serious emotional disturbance in the previous year and 12 percent of adolescents ages 12 to 15 experienced serious emotional disturbance in the previous year.<sup>35</sup>

**In addition to its enormous economic costs, serious mental illness has devastating effects on young people and their families.**

Mental illness has been viewed as a disease of early adulthood, but the onset of bipolar disorder or schizophrenia typically occurs in teens and young adults. In fact, about half of all lifetime cases of mental illnesses start by age 14 (16.5 years is the average). Symptoms in three-quarters of mental illness cases appear by age 24. Of children ages 9 to 17, 21 percent have a diagnosable mental or addictive disorder that

causes at least minimal impairment.<sup>36</sup>

<sup>31</sup> 65<sup>th</sup> World Health Assembly, 9<sup>th</sup> Plenary Meeting, Declaration 65.4 (May 25, 2012).

<sup>32</sup> World Economic Forum, the Harvard School of Public Health, The Global Economic Burden of Non-Communicable Diseases, Geneva, World Economic Forum (2011).

<sup>33</sup> Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805 (2013), last accessed at [http://www.samhsa.gov/data/NSDUH/2k12MH\\_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm](http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm).

<sup>34</sup> Ibid.

<sup>35</sup> Merikangas, K. R., et al. "Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A)," *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(10) (2010).

**Depression alone accounts for 4.3 percent of the global burden of disease and is among the largest single causes of disability worldwide [11 percent of all years lived with disability globally], particularly for women.**

In addition to its enormous economic costs, serious mental illness has devastating effects on young people and their families. Many people with psychoses don't finish high school and struggle to maintain steady employment. Some become permanently disabled and are unable to work; some live on the streets or wind up in jail. Most spend their lives dependent on family support or public assistance.

**Early intervention can have a significant impact on the lives of children and adults who experience mental health problems. Mental health screenings should be conducted not only in primary care settings, but in any setting where children, youths, adults, or older adults are at risk for mental illness.**

- **Employment prospects.**

Unemployment levels among those with serious mental illness are 9.1 percent. Compared with young adults without mental illness, young adults with AMI and SMI were more likely to be unemployed (12.3 vs. 14.6 and 16.2 percent) and less likely to have full-time employment (38.3 vs. 33.0 and 29.7 percent). When young adults with mental illness are able to gain employment, they can still have difficulty maintaining employment. Young adults with AMI or SMI are more likely than their peers without mental illness to have had more than three employers in the

past year (3.9 and 4.5 vs. 2.6 percent). Adults between the ages of 18 and 25 with co-occurring SMI and substance use disorders are less likely to have a high school diploma and 1.4 times more likely to be unemployed or have unstable jobs.<sup>37</sup>

- **Residential Stability.** Compared with young adults without mental illness, young adults with AMI or SMI were more likely to have moved three or more times in the past year (6.7 vs. 12.0 and 15.2 percent).<sup>38</sup>
- **Legal issues.** Young adults with AMI or SMI are more likely to have been on probation or parole in the past year than their peers without mental illness (6.8 and 7.1 vs. 4.7 percent). Over 70 percent of youth in the juvenile justice system suffer from mental health disorders; 27 percent of cases are so severe that functional ability is seriously impaired.<sup>39</sup>
- **Disability and Mortality.** Twenty-five percent of all years of life lost to disability and premature mortality are a result of mental illness.<sup>40</sup>

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<sup>36</sup> U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, *Mental Health: A Report of the Surgeon General* (1999).

<sup>37</sup> Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *CBHSQ Report: Serious Mental Health Challenges among Older Adolescents and Young Adults*, (May 6, 2014).

<sup>38</sup> Ibid.

<sup>39</sup> Shufelt J.L, Cocozza J.J., National Center for Mental Health and Juvenile Justice, *Youth With Mental Health Disorders in the Juvenile Justice System: Results for a Multi-State, Multi-System Prevalence Study* (2006).

<sup>40</sup> Centers for Disease Control and Prevention, 2010.

- **Physical Health.** In 1999, 34 percent of working-age adults receiving SSI, and 27 percent of SSDI recipients had a primary psychiatric impairment.<sup>41</sup> Nearly 25 percent of U.S. hospital admissions and disability payments are for people with SMI.<sup>42</sup>
- **Lifespan.** People with serious mental illness die *25 years earlier* than the general population, and an estimated 5 percent of people who suffer from severe mental illness commit suicide.<sup>43</sup>

Although delayed treatment is associated with incomplete and prolonged recovery, under the U.S. healthcare system young people with severe mental illness typically suffer serious consequences before they are treated. Young people who show early signs of mental health disorders often do not receive treatment because of stigma or because they lack information about available treatment resources. Over 90 percent of children and adolescents who commit suicide have a mental health disorder.<sup>44</sup>

### Early Assessment and Treatment Are Critical Across the Life Span and in Multiple Settings

Early intervention can have a significant impact on the lives of children and adults who experience mental health problems. Screening is a useful way of determining the likelihood that an individual has a particular disease or condition or is at increased risk of developing health or social problems. Screening assesses risk factors, which can be genetic, behavioral, or environmental. Screening also helps distinguish between those who could benefit from a minimal intervention and others who may require further diagnostic assessment or possible treatment. Mental health screenings should be conducted not only in primary care settings, but in any setting where children, youths, adults, or older adults are at risk for mental illness.

**Early interventions and educational efforts can help parents, the public, and providers learn about the importance of establishing a foundation for healthy social and emotional development during the first years of a child's life.**

New understandings of brain science indicate that longer periods of abnormal thoughts and

<sup>41</sup> McAlpine, D.D. Warner, L., Center for Research on the Organization and Financing of Care for the Severely Mentally Ill, Institute for Health, Healthcare Policy, and Aging Research, Rutgers University, *Barriers to Employment among Persons with Mental Illness: A Review of the Literature*, (2000).

<sup>42</sup> Wu, E.Q., Birnbaum, H.G., Shi, L., Ball, D.E., Kessler, R.C., Moulis, M., Aggarwal, J.. "The Economic Burden of Schizophrenia in the United States in 2002," *J Clin Psychiatry* Sep;66(9) (2005).

<sup>43</sup> Parks, Joe J., M.D. et al, National Association of State Mental Health Program Directors, Medical Directors Council, *Morbidity and Mortality in People with Serious Mental Illness*, (October 2006).

<sup>44</sup> Shaffer, D., and Craft, L. "Methods of Adolescent Suicide Prevention." *Journal of Clinical Psychiatry* 60 (Suppl. 2) (1999).

behavior have cumulative effects that can limit capacity for recovery. Early detection, assessment, and linkage with treatment and supports can prevent the compounding of mental health problems, the accumulation of poor life outcomes, and may, in some cases, lessen long-term disability. Early interventions and educational efforts can help parents, the public, and providers learn about the importance of establishing a foundation for healthy social and emotional development during the first years of a child's life.

As the mental health field becomes increasingly able to identify the early antecedents of mental illnesses at any age, interventions must be implemented, provided in multiple settings, and connected to treatment and supports. Quality screening and early intervention should occur in readily accessible settings, such as primary healthcare facilities and schools, and in settings where a high level of risk for mental health problems exists, such as in juvenile justice and child welfare systems.

### **Early Treatment of Childhood Mental Health Disorders Can Avert Subsequent Complications**

Because children develop rapidly, delivering mental health services and supports early and swiftly is necessary to avert subsequent mental and physical complications and ensure that children are ready for school and life in the community. The onset of emotional and behavioral impairments occurs even in very young children. Each year, young children are expelled from preschools and childcare facilities for severely disruptive behaviors and emotional disorders.

**Schools are in a key position to identify mental health problems early and to provide a link to appropriate services.**

Without intervention, child and adolescent disorders frequently continue into adulthood. For example, when children with co-existing depression and conduct disorders become adults, they tend to use more healthcare services and have higher healthcare costs than other adults. If the system does not appropriately screen and treat them early, these childhood disorders may persist and lead to subsequent problems in school, poor employment opportunities, and poverty in adulthood. No

other co-existing illnesses affect so many children as seriously.

One of the many factors that can affect the emotional health of young children is the mental health status of their parents. Depression among young mothers has been shown to influence the mental health of their young children. These findings are significant because mental health disorders that occur before the age of six can interfere with critical emotional, cognitive, and physical development, and can be predictive of a lifetime of problems in school, at home, and in the community.

### **Schools Can Help Address Children's Mental Health Problems**

Currently, no agency or system is clearly responsible or accountable for coordinating care for young people with serious emotional disturbances. Children are invariably involved with more than one specialized service system—including mental health, special education, child welfare,



juvenile justice, substance abuse, and health.

The mission of public schools is to educate all students. However, children with serious emotional disturbances have the highest dropout rates. Over 50 percent of these students drop out of high school, compared to 30 percent of all students with disabilities.<sup>45</sup>

Children spend most of each day at school. And while schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be partners in the mental healthcare of our children.

Schools are in a key position to identify mental health problems early and to provide a link to appropriate services. Every day more than 50 million students attend 135,000 schools in the United States.<sup>46</sup> When combined with the six million adults working at those schools, almost one-fifth of the population passes through the nation's schools on any given weekday. Clearly, strong school mental health programs that attend to the health and behavioral concerns of students can help ensure academic achievement.

The Center for Mental Health Services' "Now is the Time Project AWARE (Advancing Wellness and Resilience in Education) State Educational Agency Program (NITT-AWARE-SEA)" cooperative agreements build and expand the capacity of State Educational Agencies to increase awareness of mental health issues among school-aged youth, provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues in children and young adults, and connect with appropriate services children, youth, and families who may have behavioral health issues. The intent of NITT-AWARE-SEA is to develop a comprehensive, coordinated, and integrated program for advancing wellness and resilience in educational settings for school-aged youth.

The NITT-AWARE-SEA program supports the development and implementation of a comprehensive plan of activities, services, and strategies to reduce incidences of youth violence and promote the healthy development of children and youth. This program builds upon the successful strategies of the "Safe Schools/Healthy Students (SS/HS) Initiative" that, for over a decade, have proven to be successful in creating safe and secure schools and promoting the mental health of students in communities across the country.

Additional information is available at <http://beta.samhsa.gov/grants/grant-announcements/sm-14-018>.

These strategies include facilitating a closer relationship between state policy and local implementation of policies and programs and supporting the development and coordination of integrated systems that create safe and respectful environments for learning and promote the behavioral health of school-aged children and youth. This approach to early identification,

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<sup>45</sup> U.S. Department of Education, *Twenty-Third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act* (2001).

<sup>46</sup> U.S. Department of Education, Institution of Education Sciences, National Center for Education Statistics, *Fast Facts for 2013*, last accessed June 12, 2014 at <http://nces.ed.gov/fastfacts/display.asp?id=372>.

referral and systems development, both in the school and community, allows SEAs to make strides in significantly advancing the mental health of children.

### **Community Outreach Approaches**

When mental health problems are identified, children and youth, should be linked with appropriate services, supports, or diversion programs. Outreach should include:

- Targeting outreach efforts to parents, teachers, tutors, and social leaders—such as, for children and youth, coaches and scout leaders—most likely to come in contact with those in need of prevention or treatment services;
- Developing and disseminating consistent core messages that referrers need to know, such as how to identify a person at risk and then make a referral.
- Enhancing or assuring organizational capacity to deliver outreach activities with enough time to cover the core messages;
- Ensuring the credibility of educators and trainers involved in outreach; and
- Establishing benchmarks to monitor and promote progress.

### **Screening in Community Settings**

- Implementing systematic screening procedures to identify mental health and substance use problems and treatment needs in all settings in which children, youth, adults, or older adults are at high risk or in which a high occurrence of co-occurring mental and substance use disorders exists, including the juvenile or criminal justice systems, child welfare system, homeless shelters, hospitals, senior housing, long-term care facilities, and nursing homes.
- Screening for co-occurring disorders in those same sites.
- When mental health problems are identified, linking children, youth, adults, and older adults with appropriate services, supports, or diversion programs.
- Given the high incidence of substance use disorders among parents of children in the child welfare system, screening these parents, where indicated, for co-occurring disorders to link them with appropriate treatment and supports.
- Involving other healthcare and social service systems in addressing the needs of individuals with co-occurring disorders. For example, children in the juvenile justice system are at high risk for co-occurring mental and substance abuse disorders.



## **SBHAs should:**

- Promote public and private collaboration between public agencies at all levels and the community to create social and physical environments that promote good health through prevention for all age groups, but especially for youth. This includes placing an emphasis on the training of professionals in all settings to be able to identify and screen for mental health and substance use conditions.
- Support collaboration across state and local mental health and human service agencies to identify where investments should be made that can prevent the social, emotional, and cognitive impairments that, in turn, contribute to at-risk behaviors leading to disease, disability, social isolation, and early morbidity.
- Promote utilization of integrated service delivery options (e.g., health homes) that blend new payment methodologies like value-based purchasing with holistic care coordination for all populations with chronic conditions.
- Support public and private research to examine the systematic return on investment (ROI) from holistic preventive services as well as the ROI from more costly forms of care (e.g., increased utilization of emergency rooms for primary and behavioral health treatment).
- Support efforts to share information across agencies and programs serving the same individuals and families to more effectively coordinate care and achieve better outcomes.

## Summary of the Issue paper

### On

## The Role of Integrated Service Delivery Models in Addressing the Needs of Adults and Children with Behavioral Health Conditions

### Key Take-Aways

1. “Health homes” and “accountable care organizations” are new models for delivering care that have the potential to unleash powerful incentives for better coordinating and integrating behavioral health and primary care services, thereby improving quality of care for mental health consumers – especially those with chronic, comorbid medical conditions or co-occurring substance use issues.
2. Health homes developed and implemented for people with serious mental illnesses make it possible for providers to coordinate and manage the integration of services over the full range of the consumer’s needs, even when there are several caregivers and agencies involved in the patient’s care.
3. A state developing a health home program must treat certain statutorily defined populations, meet defined standards, consult with SAMHSA about addressing behavioral health issues, coordinate care and promote health, and monitor health outcomes. Health homes must also include patient-centered planning and family support, use health information technology to link services as appropriate and feasible, and provide comprehensive transition planning to access community-based and social support services.
4. 1 in 10 children in the United States has a serious emotional disorder, and mental health conditions are the most costly conditions among children and youth. These children often need a variety of services and supports, which makes care coordination imperative. A “wraparound” is a type of intensive, individualized care coordination involving a team process that wraps services, supports, and resources for a child or youth with a severe emotional or behavioral disorder, in order to meet team goals.

The CMS Innovation Center is implementing “health homes” under Medicaid, and “accountable care organizations (ACOs)” under Medicare, in order to improve quality of care and reduce healthcare costs. Behavioral health service providers and providers of supportive programs have expertise in care coordination and service delivery, and should play an important role in the implementation and delivery of these two new models of care and other emerging strategies as they play out both in the public and private sectors. These new models have the potential to unleash powerful incentives to better coordinate and integrate behavioral health and primary care services, and thereby improve care.

## Health Homes: Primary Care and Behavioral Health Team at a Single Site

One trending approach to addressing chronic disease in a holistic manner is the “patient-centered medical home (PCMH)” strategy. The PCMH construct is a service delivery model that has been tested for years by several public and private sector health insurance and provider organizations to better coordinate services and programs for people with chronic illnesses. PCMHs are collaborative care models that offer the opportunity to improve coordination and integration of behavioral health and primary care systems, while revitalizing and redefining the primary care system.<sup>47</sup>

**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 health.**

The concept of a single point of clinical responsibility – essential to the PCMH model – has long been a foundation of sound community behavioral health systems, although execution has historically often been challenging given the fragmentation in financing for care. Highly functioning and responsive medical 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-based behavioral health. Both NASMHPD and SAMHS have called for the creation of PCMHs for individuals with mental illness,<sup>48</sup> as these individuals so often have co-occurring substance use and co-morbid medical conditions.

Founded in 2006 by several large national employers and four primary care physician associations, the [Patient-Centered Primary Care Collaborative \(PCPCC\)](#) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). The PCPCC achieves its mission through the work of five Stakeholder Centers, dedicated to transforming the U.S. healthcare system through care integration and delivery reform, payment reform, patient and family engagement, advocacy and public policy, and employee benefit redesign. Today, PCPCC’s membership represents more than 1,000 medical home stakeholders and supporters throughout the U.S.

A Medicaid state plan option was created under the ACA under which the federal government provides a 90 percent funding match for the first two years of operation to states implementing PCMHs statutorily designated as “health homes” for individuals with multiple chronic conditions, one chronic condition and the risk of developing additional chronic conditions, or one serious and persistent mental health condition. Two of the chronic conditions that qualify a health home for the enhanced federal funding are a serious mental health condition and a

<sup>47</sup> Miller, J.E., Gordon, S.Y., National Association of State Mental Health Program Directors (NASMHPD), *The Role of Integrated Service Delivery Models in Addressing the Needs of Adults and Children with Behavioral Health Conditions* (April 2014).

<sup>48</sup> Parks, J, et al., National Association of State Mental Health Program Directors Medical Directors Council, *Measurement of Health Status for People with Serious Mental Illnesses* (2008).

substance use disorder. The state must meet certain defined standards, consult with SAMHSA about addressing behavioral health issues, and monitor and report on performance and outcomes using HIT where appropriate.<sup>49</sup>

Under the health home option, the state Medicaid agency reimburses a provider or team of providers who agree to manage care, make necessary referrals, provide support services as needed, and use electronic health records and health information technology, as appropriate and feasible to report on quality measures and outcomes.<sup>50</sup>

**NASMHPD and SAMHSA have long called for the creation of patient-centered medical homes for individuals who have a mental illness, as these individuals so often have comorbid substance use and other serious medical conditions.**

Health homes developed and implemented for people with serious mental illnesses make it possible for community behavioral health centers and agencies to coordinate and manage the integration of services over the full range of needs of consumers, even when there are several caregivers and agencies involved in the patient's care. To be able to effectively incorporate health homes into their Medicaid strategies, SBHAs should ensure that financing mechanisms align with, and promote, a single, integrated point of clinical responsibility, moving away from fragmented, fee-for-service reimbursement. SBHAs also should promote connections between behavioral health specialists and primary care physicians in order to encourage the development of successful health homes.

Once health home teams are established, SBHAs should begin to consider ways to foster integration of community-based behavioral health resources within disease prevention and disease management efforts.

### **Health Homes for Children with Serious Behavioral Health Conditions – A Wraparound Approach**

One in 10 children in the United States has a serious emotional disorder, and mental health conditions are the most costly conditions among children and youth. These children often need a variety of services and supports, which makes care coordination imperative.<sup>51</sup>

The ACA and CMS recognized that service utilization patterns and costs for children with serious emotional disorders render them an appropriate population for health homes. However, the medical home terminology of “chronicity” and “long-term care,” applied to adults with SMI does not resonate well with children and youth. While children with mental health conditions do not have the same high rate of co-occurring physical health conditions as adults

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<sup>49</sup> Sec. 2703 of the ACA; 42 U.S.C. § 1945.

<sup>50</sup> Ibid.

<sup>51</sup> Pires, S., Centers for Medicare & Medicaid Services, *Customizing Health Homes for Children with Serious Behavioral Health Challenges* (March 2013).

with SMI, it is important to note that these children use more physical healthcare than Medicaid-enrolled children in general.<sup>52</sup>

A “[wraparound](#)” is an intensive, individualized care planning, and team-based management process that wraps services, supports, and resources around a child or youth with a severe emotional or behavioral disorder to meet goals set by the team. A wraparound focuses on collaboratively serving children and youth with complicated issues who are involved with multiple service systems and often at risk of out-of-home placement. In the wraparound, the child and family are at the center of the team planning services and setting goals to build strengths, with a member of the team serving as a facilitator to engage the family. The team itself consists of licensed or registered healthcare providers, family, and community-based social supports who track progress toward the goals and update the plan as necessary. Wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and address a range of life areas.<sup>53</sup>

In Milwaukee, Wisconsin, intensive care coordination approaches using a high fidelity wraparound ensure that children have a designated primary care provider. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens and well-child visits are conducted, there is appropriate metabolic monitoring for children on psychiatric medications, and there is coordination between medical and behavioral health providers. Wraparound Milwaukee contracts with eight community agencies for the over 100 care coordinators who facilitate the delivery of services and other supports to families using a strength-based, highly individualized Wraparound approach. [Wraparound Milwaukee](#) has also organized an extensive provider network of over 200 agency and individual providers that offer an array of over 80 services to families.<sup>54</sup>

## **Accountable Care Organizations (ACOs): Coordination Across Providers and Practices**

ACOs are comprehensive, vertically, and horizontally integrated care systems designed to manage and coordinate care. With their focus on effective, coordinated care for the whole person, ACOs hold the potential for significantly improving the health of the clients they serve, including people with behavioral health conditions. Access to effective behavioral care services is as critical to the effectiveness of ACOs as it is to the success of health homes.

The focus of the ACO model is on arranging comprehensive, integrated, team-based care involving all caregivers along the delivery continuum and across multiple care sites. ACOs, like

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<sup>52</sup> Ibid.

<sup>53</sup> Minnesota Department of Human Services Website: Children’s Mental Health: Strategic Initiatives: Integrating Services: Wraparound, last accessed at [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_146306](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_146306); National Wraparound Initiative Website: Wraparound Basics, last accessed at <http://www.nwi.pdx.edu/wraparoundbasics.shtml>.

<sup>54</sup> Wraparound Milwaukee Website: Background and History, last accessed at <http://wraparoundmke.com>.

health homes, consolidate multiple levels of care for patients.<sup>55</sup> However, while health homes take the approach of having the primary physician lead the care delivery team in a single practice, an ACO consists of many coordinated practices. An ACO consists of many coordinated practices, while a health home is a single practice. That means ACOs should be more accessible to behavioral health providers currently in solo and small groups.

The ACO model has strong parallels to public mental health system constructs, with a single point of clinical and financial accountability and comprehensive home- and community-based services systems. The development of the ACO model is a response to criticisms of both fee-for-service payment arrangements and capitated payment models. Critics contend that fee-for-service offers incentives to provide excess services without devoting resources to managing chronic disease or coordinating care. Those critical of capitated payments argue that those payments offer healthcare providers perverse incentives to restrict necessary care and take on more financial risk than many can handle. In contrast, the ACO and its participating providers share savings and costs with the public program in which the ACO is a participant, providing both a positive incentive for those providers to achieve savings through positive health outcomes and negative incentives against building patient service volume as a means to increase provider income.

Federal law specifically authorizes federal payments only to ACOs serving Medicare fee-for-service beneficiaries,<sup>56</sup> although CMS has encouraged the use of similar structures in Medicaid as well through guidance issued to the states.<sup>57</sup> Medicare ACOs are eligible for enhanced payments from the federal government based on “shared savings” if they meet quality performance standards that include the adoption of electronic prescribing and health records.<sup>58</sup> The standards underscore the importance of behavioral health records integration to enable behavioral health providers and care networks to play as full partners in ACOs. NASMHPD and SAMHSA have urged participation by behavioral health providers in ACOs, as well as the integration of behavioral health records with records for physical health.

**Advocate that specialty behavioral health providers be included as ACO participants and encourage behavioral health providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related.**

Although there has been some skepticism by behavioral health providers about participating in ACOs, participation could provide new opportunities for behavioral health providers to integrate vertically with other components of the healthcare system, contributing to achieving cost and quality targets, and sharing in new payment models. SBHAs should advocate that specialty behavioral health providers be included as ACO participants and encourage behavioral health

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<sup>55</sup> Fisher, E. S. and Staiger, D. O., et al., “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” *Health Affairs* No.1: 26.1,44-57: (2007).

<sup>56</sup> § 3022 of the Accountable Care Act (ACA), adding 42 U.S.C. § 1395jjj (§ 1899 of the Social Security Act).

<sup>57</sup> Centers for Medicare and Medicaid Services: Letter to State Medicaid Directors SMDL #12-001, “Integrated Care Models” (July 10, 2012).

<sup>58</sup> 76 Federal Register 67802, 67872-67904; 42 C.F.R. Part 425 Subpart F.



providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related. Health homes and ACOs will likely be foundational elements of the future healthcare system, and behavioral health providers must immediately begin positioning themselves to be recognized as qualified partners.

In January 2014, CMS released data stating that ACOs had generated \$128 million in net savings for Medicare's trust fund in their first year of operations. At the same time, ACOs qualified for shared savings payments of \$445 million. The Congressional Budget Office had earlier projected that potential savings to Medicare from promoting ACOs could amount to \$5.3 billion over the first 10 years, with the savings realized as providers reduce the volume and intensity of services delivered to their patients.<sup>59</sup>

## Financing Strategies

Other delivery-related financing strategies include bundling payments for post-acute services with hospital payments and capitation of reimbursement. Bundling payment for services that patients receive across a single episode of care is intended to encourage healthcare providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Under capitation, physicians are paid a monthly fee for each patient under their care to cover a set of services, regardless of the amount of services provided. Capitation in behavioral health and primary care settings should motivate caregivers to provide preventive care to members and help them focus on keeping the member healthy in order to keep costs down and rely less heavily on costly specialists.

### **SBHAs should:**

- Assure that services provided in health homes are coordinated and include patient and family support, transition from the hospital, use of health information technology, and referrals to community and social services. The full inclusion of behavioral health prevention and treatment services must be an essential part of all health homes. SBHAs should promote connections between behavioral health specialists and primary care physicians who provide care within a health home.
- Advocate that specialty behavioral health providers be included as ACO participants. SBHAs may also want to encourage certain behavioral health providers to establish their own ACOs for patients whose primary diagnoses are behavioral health-related.
- SBHAs may want to help behavioral health providers consider merging with an ACO or health home provider, or partnering with them on a contract basis. A behavioral health provider may function as a specialty provider receiving referrals from the health home or ACO, with a business agreement that facilitates the referrals.

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<sup>59</sup> Department of Health and Human Services, "Fact Sheet: Medicare ACOs Continue to Succeed in Improving Care, Lowering Cost Growth" (September 16, 2014).

**Summary of Issue Paper**

**On**

**Crossing the Behavioral Health Digital Divide:  
The Role of Health Information Technology (HIT) in Improving Care for  
People with Serious Mental Illness in State Mental Health Systems**

**Key Take-Aways**

1. For behavioral health clients and providers, there are significant obstacles to achieving the levels of quality, coordination, and effectiveness derived by primary care providers and their patients from the use of HIT. Many behavioral health practices and clinicians lack interoperable (communication and linkages) information systems.
2. The availability of financial resources for behavioral health providers to invest in and maintain HIT systems is limited and most are ineligible for the financial incentives made available through the Medicare and Medicaid electronic health record (EHR) meaningful use incentive payment programs.
3. NASMHPD identified initially and has continually highlighted through major studies that persons with serious mental illness experience high levels of co-morbid health conditions and die up to 25 years sooner than individuals in the general population. Integrating personal behavioral health data with personal health data could be instrumental in addressing this disparity.
4. SBHAs could consider developing partnerships with Medicaid, private issuers, providers and other critical stakeholders to collaborate on developing a comprehensive quality strategy for their state that includes metrics to assess the quality of behavioral health services and improve them.
5. SBHAs should support and participate in the development of interoperable, integrated EHRs. As states braid current and future funding streams and methodologies, SBHAs should work with partners and stakeholder groups to incorporate behavioral health into the design, implementation, and use of EHRs and Health Information Exchanges (HIEs).

A substantial percentage of behavioral health is delivered in primary care settings. Nearly 34 percent of consumers with a primary mental health diagnosis are cared for by general and internal medicine physicians.<sup>60</sup> Given the burden of illness and the volume of behavioral health delivered in primary care settings, better integration between behavioral health and primary care

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<sup>60</sup>Centers for Disease Control and Prevention, 2008 National Ambulatory Medical Care Survey.



is needed. HIT—including EHRs, personal health records (PHRs), HIEs, and smartphone health applications—can be a key facilitator of this integration.

Behavioral health stakeholders are largely supportive of information-sharing to improve patient care. However, for behavioral health clients and providers, there are significant obstacles to achieving the levels of quality, coordination, and effectiveness derived by primary care providers and their patients from the use of HIT.

Many behavioral health practices and clinicians lack interoperable (communication and linkages) information systems. The availability of financial resources for them to invest in and maintain HIT systems is limited and most are ineligible for the financial incentives made available through the Medicare and Medicaid EHR meaningful use incentive payment programs.

**33 percent of behavioral health is delivered in primary care settings.**

In addition, the privacy laws that apply to behavioral health data are more complex than those applicable to general health data, and EHRs do not typically conform to the federal and state requirements that behavioral health medical data be accorded additional privacy safeguards. HIEs struggle with how to manage the patient consent requirements for behavioral health—and especially substance use treatment—data disclosure.

To aid in the integration of behavioral health and primary care using health IT, both EHR vendors and HIEs need to find ways to ensure their systems include the necessary functionality to support information sharing while complying with federal and state privacy protections.

Key questions addressed in this Issue paper include:

- What HIT capabilities do behavioral health and primary care providers need to better support integration across care settings?
- What HIT capabilities do behavioral health providers need to support current care practices? To support team-based, patient-centered approaches to care?
- What are the different needs inherent in specific care settings (mental health, substance abuse treatment facility, residential, out-patient, criminal justice, social work, etc.)?

## **HIT and Public Mental Health**

Persons with SMI experience high levels of co-morbid health conditions and die up to 25 years sooner than the general population.<sup>61</sup> The benefits of integrating personal behavioral health data with personal health data can be great, and appropriate policies and practices permitting the sharing of behavioral health data while protecting the confidentiality and privacy of personal health information could be instrumental in producing positive patient outcomes.

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<sup>61</sup>Parks, J., MD. et al., National Association of State Mental Health Program Directors Medical Directors Council, *Morbidity and Mortality in People with Serious Mental Illness* (October 2006).

However, recent federal enactments that have had a major impact on the promotion of HIT have failed to address the needs of mental health and substance abuse care providers. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) Provisions of the American Recovery and Reinvestment Act of 2009, authorized approximately \$20 billion for the payment of Medicare and Medicaid program incentive bonuses to physicians, hospitals, and other health providers who adopt electronic health records. In addition, the HITECH ACT included millions in funding for the implementation of HIEs designed to enable providers to share their EHR data and thereby better coordinate and improve care.<sup>62</sup>

**Persons with serious mental illness (SMI) experience high levels of co-morbid health conditions and die up to 25 years sooner than the general population.**

Unfortunately, mental health and substance abuse providers were not included in the categories of providers eligible to receive EHR incentives, which were primarily limited to hospitals and providers falling within the definition of “physician” under §1861(f) of the Social Security Act.<sup>63</sup> As a result, in many states, behavioral health providers have not been active participants in adopting EHRs or HIT.

The expansion of health coverage under the ACA changes the financing of mental health and substance abuse services and thereby greatly expands the number of individuals with mental health and substance abuse disorders who will now have insurance coverage for treatment. The ACA pushes to improve patient outcomes through the development and enhancement of ACOs and health homes as well as by making prevention and wellness programs available without patient cost-sharing to give service recipients more control over their own care.

Nevertheless, the ability to share data essential to facilitating improved patient outcomes will likely be adversely impeded by a lack of access by mental health and substance use treatment providers to HIT and related EHR initiatives. As states braid funding streams and methodologies, agencies should work together to incorporate behavioral health into the design, implementation, and use of EHR and HIEs, in order to share data and improve outcomes and accountability, while eliminating redundancy and administrative burden in reporting.

Where state leaders have failed to include behavioral health providers in strategizing and planning health information systems to this point, strong leadership is needed to ensure that health systems reach out to behavioral health leaders to work in concert in developing integrated or at least fully interoperable and accessible health records and systems.

If mental health providers are unable to implement EHRs or share information with primary care systems, and if state and local mental health authorities are not included in planning for HIE, critical information from the mental health system will not be fully included or have the ability to be integrated as primary care moves to electronic data-sharing.

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<sup>62</sup> Pub. L. No. 111-5 (2009).

<sup>63</sup> Ibid.

Without the development of HIEs that can accept electronic personal mental health data from mental health providers while meeting all of the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 42 C.F.R. Part 2, and other applicable regulations and statutes, even those providers that are able to implement EHRs will be unable to truly meet the HITECH Act's "meaningful use" criteria regarding the sharing of electronic data.

Mental health entities will be unable to effectively utilize any electronic personal health data that might help them to coordinate care between and among state psychiatric hospitals and community mental health centers (CMHCs), state psychiatric hospitals and general hospitals and emergency departments, CMHCs and primary care physicians, or any other complex linkages critical to increasing integration and improving care. As a result, coordination between behavioral health and primary care providers via the sharing of electronic personal health data may lag behind coordination within the rest of the healthcare continuum.

Absent the enactment of federal legislation making Medicaid and Medicare incentive payments available to behavioral health providers, HHS could still greatly assist behavioral health systems by providing training and technical assistance on how to utilize public funding to implement the use of EHRs. If behavioral health systems can find a way to implement and utilize EHRs in parallel service delivery systems, HHS should be able to access extracts of de-identified clinical data from HIEs to obtain outcomes and information about services funded under SAMHSA block grants and other HHS funding streams. If this can be accomplished, HHS could potentially eliminate the administrative burden of its current separate reporting systems for state behavioral health agencies, while reducing the impact of mental illness and substance use.

### **SBHAs should:**

- Consider developing or joining existing partnerships, with Medicaid, private issuers, 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 and improve behavioral health outcomes.
- Work with partners and stakeholder groups to incorporate those behavioral health quality and performance indicators identified by SBHAs.
- Consider collaborating with behavioral health providers to apply for Agency for Healthcare Research and Quality (AHRQ) grants to develop new innovative behavioral health quality metrics measures to improve outcomes and accountability that avoid redundancy and burden in reporting.
- Support and participate in the development of interoperable, integrated EHRs, as well as 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 HIEs. 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.
- Initiate conversations with state HIEs and QHPs operating in the state to obtain the use of behavioral health data for research and trends assessment designed to improve the quality of behavioral health services within the state.

# Summary of the Issue Paper

## On

### Behavioral Health and Community-Based Services in the Aftermath of Olmstead

#### Key Take-Aways

1. Title II of the American Disabilities Act (ADA) regulations required a public entity to administer services, programs, and activities *in the most integrated setting appropriate* to the needs of qualified individuals with disabilities. The U.S. Attorney General subsequently defined the “most integrated setting appropriate” as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”
2. The Supreme Court further accelerated the movement toward integrated settings with its decision in the 1999 *Olmstead v. L.C.* case. The Court found in *Olmstead* that unjustified segregation of persons with disabilities constitutes discrimination.
3. The Medicaid § 1915(c) waiver program provides a federal Medicaid match to states for three years (an additional five years with the renewal of a waiver) for the provision of home- and community-based services (HCBS) to individuals who would otherwise require institutional care, but only if the average annual cost of such services is not more than the annual cost of institutional services.
4. Eighteen states have submitted for approval State Plan Amendments (SPAs) to implement a separate five-year § 1915(i) State Plan option for implementing HCBS services enacted in 2006 and 12 SPAs had been approved by CMS.
5. As states strive to develop accurate and complete plans for the transition to home- and community-based settings, it becomes ever more critical that the states have a clear picture of what CMS expects with regard to standards for the siting of non-residential services.
6. States should be reaching out to stakeholders and CMS officials as soon as possible for ideas on how to creatively structure home- and community-based services to maximize federal financial participation.

Since the 1973 passage of § 504 of the Rehabilitation Act, federal and state agencies administering federally funded programs, such as Medicaid agencies and SBHAs, have been mandated to eliminate segregation of individuals with disabilities. The ADA and the implementing federal regulations accelerated the movement to eliminate segregation for individuals with disabilities. In passing the ADA, Congress said it had found that “discrimination

against individuals with disabilities persists in such critical areas as ... institutionalization.”<sup>64</sup>

Title II of the ADA prohibited state and local government agencies, departments, special purpose districts, and other instrumentalities from discriminating against people with disabilities in their programs, services, and activities. Public entities were mandated to make reasonable modifications to their policies, practices, and procedures to allow equal opportunity for individuals with disabilities to participate, unless to do so would fundamentally alter the nature of the service, program, or activity.

Title III of the ADA governing public accommodations and services<sup>65</sup> made it discriminatory to, directly, or through contractual, licensing, or other arrangements: (A) deny opportunity to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations; (B) provide a benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to non-disabled individuals; or (C) provide a benefit different or separate from that provided to other individuals, unless necessary to provide a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is as effective as that provided to others.<sup>66</sup>

Most importantly, the Title II ADA regulations required a public entity to administer services, programs, and activities *in the most integrated setting appropriate* to the needs of qualified individuals with disabilities. The U.S. Attorney General subsequently defined the “most integrated setting appropriate” as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”<sup>67</sup>

The Supreme Court further accelerated the movement toward integrated settings with its decision in the 1999 *Olmstead* case. The Court found in *Olmstead* that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the ADA. The *Olmstead* Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.<sup>68</sup>

However, the *Olmstead* court noted that, “[s]ince 1981, Medicaid has provided funding for state-run home and community-based care through a waiver program” under §1915(c) of the Social Security

**Most importantly, the Title II ADA regulations required a public entity to administer services, programs, and activities *in the most integrated setting appropriate* to the needs of qualified individuals with disabilities.**

<sup>64</sup> 2 U.S.C. § 12101(a)(2), (3).

<sup>65</sup> 2 U.S.C. §§ 12131 through 12134 (Part A).

<sup>66</sup> 2 U.S.C. § 12182(b)(1)(A).

<sup>67</sup> 28 C.F.R. 35.130(d).

<sup>68</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

Act.<sup>69</sup> In fact, the Court noted, HHS often approves more slots under a waiver than the approved state ultimately uses.<sup>70</sup>

The referenced §1915(c) waiver program provides a federal Medicaid match to states for three years (an additional five years with the renewal of a waiver) for the provision of HCBS to individuals who would otherwise require institutional care, but only if the average annual cost of such services is not more than the annual cost of institutional services. A §1915(c) waiver may include a waiver of the Medicaid requirement that a benefit be provided statewide and/or that benefits be not less in duration, amount, or scope than benefits provided under the State Plan.<sup>71</sup>

In addition, §1915(c) authorizes providing under a waiver, for individuals with chronic mental illness, day treatment, partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). Until 2005, the §1915(c) waiver was the mechanism states most frequently used to promote access to community-based services and supports for Medicaid. However, state HCBS waivers tended to primarily address developmental disability (including autism), elderly and individuals with disabilities, medically fragile and palliative care, and brain injury.

As of 2010, there were 284 § 1915(c) waivers in operation in 47 states and the District of Columbia. The three states not operating § 1915(c) waiver programs instead offered HCBS through their comprehensive § 1115 waiver programs.<sup>72</sup> However, despite their pervasiveness, §1915(c) waivers over the years have far less frequently targeted individuals with mental illness and/or related conditions than other Medicaid populations. As of August 7, 2014, 16 states were operating 18 separate § 1915(c) waivers for individuals with mental illness, while 18 states offered 22 § 1915(c) waivers for individuals with brain injury. There were 55 separate 1915(c) waivers for individuals with autism in 32 states, either separately or as part of larger waivers designed for individuals with developmental disabilities.<sup>73</sup>

Under §6086 of the Deficit Reduction Act of 2005 (the DRA),<sup>74</sup> Congress enacted a State Plan option under § 1915(i) of the Social Security Act<sup>75</sup> permitting states to serve individuals in the most integrated setting without need for a waiver or linkage to a need for an institutional level of care. States implementing § 1915(i) HCBS services would no longer be required to meet the “cost-neutrality” standard required for § 1915(c) HCBS waiver services. States would not need to produce cost estimate comparisons for institutional care and the State Plan benefit.<sup>76</sup>

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<sup>69</sup> Codified at 42 U.S.C § 1396n(c).

<sup>70</sup> *Olmstead*.

<sup>71</sup> 42 U.S.C. § 1396a(a)(1).

<sup>72</sup> Kaiser Family Foundation, Total Number of Medicaid Section 1915(c) Home and Community-Based Services Waivers (updated May 27, 2014), last accessed at <http://kff.org/medicaid/state-indicator/total-number-of-medicare-section-1915c-home-and-community-based-services-waivers/>.

<sup>73</sup> Centers for Medicare and Medicaid Services, “Medicaid-CHIP Dynamic Waivers List,” last accessed at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/dynamic-list/WA-508.xml>.

<sup>74</sup> P.L. 109-171 (Feb. 8, 2006).

<sup>75</sup> 42 U.S.C. § 1396n(i).

<sup>76</sup> 79 Federal Register 2948, 2951 (January 16, 2014).



However, as enacted in the DRA, states were unable to target § 1915(i) services to particular populations within the State, and could only serve individuals whose incomes did not exceed 150 percent of the federal poverty level (FPL). Additionally, the original service package available under § 1915(i) included some, but not all, of the HCBS available through waivers. To make the State Plan Option more attractive, Congress enacted § 2402(b) of the ACA to make additional changes to § 1915(i).

The ACA modifications to § 1915(i) specifically allow states to:

- Provide services to individuals with income up to 300 percent of the Supplemental Security Income (SSI) federal benefit rate (FBR) who would otherwise be eligible for HCBS under a § 1915(c), (d), or (e) waiver or § 1115 demonstration program;
- Target the HCBS benefit to one or more state-specified population groups, through one or multiple five-year § 1915(i) service packages;
- Make "other services" beyond State Plan services available to the population, including such services as behavioral supports, cognitive rehabilitative therapy, crisis intervention and counseling, health monitoring, family training, psycho-social rehabilitation services, partial hospitalization services, day treatment, and neuropsychology services; and
- Allow any or all HCBS to be self-directed, in accordance with an individualized plan of care based on an independent assessment and a person-centered process driven by the beneficiary.<sup>77</sup>

As highlighted, as of August 2014, 18 states had submitted for approval SPAs to implement the five-year § 1915(i) option and 12 SPAs had been approved by CMS. Arkansas, Delaware, and Maryland planned to implement the option in 2014. The District of Columbia, which was among the states whose SPA was approved earlier, planned to implement in 2014, Colorado in 2015.<sup>78</sup>

An additional option made available under § 2401 of the ACA was the "Community First Choice Option (CFC)" created under § 1915(k) of the Social Security Act.<sup>79</sup> The CFC option, which went into effect October 1, 2011, was created as a Medicaid State Plan optional benefit to provide home and community-based attendant services and supports. States that implement the CFC option are required to use a person-centered plan of services and supports, based on an assessment of functional need, and either be in an eligibility group that is entitled to receive nursing facility services or have an income not exceeding 150 percent FPL.

CFC benefits may include HCBS attendant services—also called personal care and attendant care services—intended to enable people with disabilities and chronic conditions to remain in their homes and communities by providing them human assistance in performing basic activities

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<sup>77</sup> State Medicaid Director Letter (SMDL) #10-015 (August 6, 2010).

<sup>78</sup> Ibid.

<sup>79</sup> 42 U.S.C. § 1396n(k).



of daily living (ADLs), instrumental activities of daily living (IADLs), and health related tasks they would do independently were it not for their disabilities.<sup>80</sup>

States that implement the CFC option receive a six percentage point increase in their Federal Medical Assistance Percentage (FMAP) during operation of the program. As of May 2014, 10 states had submitted SPAs to CMS to implement the CFC option.<sup>81</sup> However, a 2012 GAO report suggested that states seemed hesitant to apply for the CFC and the other options for home and community-based services included in the ACA due to budgetary concerns, lack of infrastructure, staff overburden and related hiring freezes, relative priority among all requirements and options authorized by the ACA, and a greater focus on broader Medicaid reform.<sup>82</sup>

On March 17, 2014, after numerous false starts, CMS adopted final regulations governing the implementation of HCBS services. The regulations, which apply to § 1915(c) HCBS waivers and § 1915(i) and (k) State Plan Option HCBS, prohibit the siting of HCBS—residential and non-residential—in nursing facilities, institutions for mental diseases, intermediate care facilities for individuals with intellectual disabilities, and hospitals.<sup>83</sup> In addition to these specific settings, the regulations state that “[a]ny setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution.”<sup>84</sup>

**The § 1915(i) State Plan Option and the § 1915(k) Community First Choice Option provide more opportunities for developing and financing a greater variety of home- and community-based services in a more specifically targeted manner than ever before. Yet states so far have largely been reluctant to adopt those options.**

A process is created under which the Secretary determines through heightened scrutiny, based on information presented by the state or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home- and

<sup>80</sup> Basic Activities of Daily Living include eating/feeding (including chewing and swallowing), toileting, grooming, dressing, functional mobility, and bathing/showering. Instrumental Activities of Daily Living include meal planning and preparation, managing finances, light housework, and transportation; and health-related tasks, such as tube feedings, catheterization, range of motion exercises and medication administration. Health-related tasks include tube feedings, catheterization, range of motion exercises, and medication administration.

<sup>81</sup> Kaiser Family Foundation, State Health Facts: Section 1915(k) Community First Choice State Plan Option (2014), last accessed at <http://kff.org/medicaid/state-indicator/section-1915k-community-first-choice-state-plan-option/>.

<sup>82</sup> U.S. Government Accountability Office (GAO), “States’ plans to pursue new and revised options for home and community-based services (GAO-12-649),” (2012), last accessed at <http://www.gao.gov/assets/600/591560.pdf>.

<sup>83</sup> 79 Federal Register 2948 (January 16, 2014).

<sup>84</sup> Ibid, 2969, 3031.

community-based settings.” There’s a presumption that services provided in other institutional settings or adjacent or on the grounds of a public institution do not meet standards set for HCBS sites, but that presumption can be rebutted by the state as part of the state’s waiver or SPA submission to CMS. The presumption is overcome by demonstrating that the setting meets qualities<sup>85</sup> listed in the proposed regulations.<sup>86</sup>

In order to be an eligible site for delivery of HCBS:

- The setting must be integrated in, and facilitate the individual’s full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities;
- The setting must be selected by the individual among all available alternatives and identified in the person-centered service plan;
- The individual’s essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint must be protected;
- The setting must optimize individual initiative, autonomy, and independence in making major life choices, including, but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
- Individual choice regarding services and supports, and who provides them, must be facilitated.<sup>87</sup>

States submitting SPAs for new §1915(i) benefits must provide assurances of compliance with the new regulatory requirements as of the effective date of their proposed SPA. For any existing §1915(c) waivers or §1915(i) SPAs for which a state requests a renewal or amendment by March 17, 2015, the request must include a “transition plan,” to be approved by CMS, describing the deliverables to be addressed and the time table—no longer than five years—for bringing the state into compliance. If a state does not have an SPA or waiver to be re-approved or amended within, it must have until March 17, 2015 to submit its transition plan. Transition plans must be published by the state prior to submission to CMS to afford 30 days of public comment, and evidence of the public comment process must be included with the CMS submission.<sup>88</sup>

While the final regulations apply to both residential and non-residential services, CMS acknowledged in January 2014 that there are issues specific to providing non-residential services traditionally provided in group settings which would need to be addressed in separate guidance. The agency held outreach discussions with interested stakeholders, including state Medicaid officials and Mental Health Agency directors to gain a better understanding of the specific issues that would have to be addressed. However, the guidance had still not been issued by September

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<sup>85</sup> 77 Federal Register 26362, 26383 (May 3, 2012).

<sup>86</sup> Ibid, 2968.

<sup>87</sup> Ibid.

<sup>88</sup> 79 Federal Register 2948, 3033 (January 16, 2014); 42 CFR 441.710.

2014 as agency officials continued to wrestle with how to provide services traditionally provided in group settings and involving group interaction while accommodating individual choice and preferences and any desire for the self-direction of services. The one basic principle enunciated by agency representatives was that non-residential services would have to meet all of the standards mandated for residential services, and that there would be no regulatory exceptions for non-residential services.

However, because states need to be able to describe how they will make the transition to community-based settings for non-residential services in the transition plans they must submit to CMS before March 16, 2015, and since some states have already been forced to supply bare bones transition plans with requests for extensions or amendments to existing SPAs or waivers already submitted, making the guidance available becomes more critical for states with each passing day.

### **SBHAs should:**

1. Explore *now* how they can partner with CMS to broaden service options in home and community settings. In doing so, states should keep in mind that SPAs generally require years to develop and months for CMS approval, but that approval process time frame can be significantly reduced when a state reaches out early in development to seek CMS input into concepts and structure.
2. States should be reaching out to CMS officials as soon as possible for ideas on how to creatively structure home- and community-based services to maximize federal financial participation.
3. CMS has required that state transition plans for HCBS—required to be included with submitted §1915(i) and (k) SPAs and requests for extensions or amendments to existing waivers, and by all states on or before March 16, 2015—be subject to a 30-day public comment, and that the public comment period be evidenced in transition plan submissions for approval. However, SBHAs should begin seeking stakeholder input long before transition plans are published for comment. States should be reaching out now to interested stakeholders to help them shape the elements of the required transition plans by identifying potential barriers—such as workforce or service shortages—to accessing their preferred home- and community-based services and providers.
4. As states strive to develop accurate and complete plans for the transition to home- and community-based settings, it becomes ever more critical that the states have a clear picture of what CMS expects with regard to standards for the siting of non-residential services. The promised guidance setting the standards for non-residential services, promised in January 2014, is still pending, with the deadline for final initial state transition plans only months away. Existing noncompliant providers will have to be retooled, or replaced by new community-based providers, and states will have to at least generally identify in their transition plans who those providers are to be and how they will be structured. It is imperative that SBHAs insist that CMS expedite the promised guidance on non-residential services to provide clarity for states, providers and their beneficiaries wishing to outline how they will access services

## CONCLUSION

**The ACA promotes changes to the way we deliver and pay for behavioral health, with the goal of improving quality and health outcomes through integration, but, as of yet, most of these efforts remain untested.**

States face significant challenges, including the growing numbers of uninsured, poor overall population health, rising healthcare costs, and the need to increase access to care and improve quality. The ACA begins to address many of these problems. Greater emphasis is placed on improving overall population health and the quality of healthcare services. Further, the ACA includes provisions aimed at slowing the rate of increase in healthcare expenditures.

The ACA does not address – or solve – all of the states’ healthcare or mental health financing and delivery problems. For example, while the ACA includes provisions to expand the health professional workforce, it includes little new funding to do so. Thus, policy leaders predict workforce shortages in response to the pent-up demand for behavioral health services, after many of the uninsured gain coverage and learn how to use that new coverage.

The ACA promotes changes to the way we deliver and pay for behavioral health, with the goal of improving quality and health outcomes through integration, but, as of yet, most of these efforts remain untested. While the ACA imposes significant new challenges, it also offers opportunities and new approaches to increase affordable coverage to more Americans with behavioral health conditions, improve population behavioral health, and improve quality of care for behavioral health clients. These opportunities – and more – are addressed in the seven issue papers summarized here. These highlighted issue areas are the key building blocks for the implementation of the ACA and healthcare reform going forward (see the “[Mental Health Infrastructure](#)” diagram).

We believe this issue paper series will help states identify new strategies that provide solutions in addressing the needs of individuals with behavioral health conditions and improve overall behavioral health systems and programs.