



October 15, 2012

TO: CMHDA Health Care Reform Committee

FROM: Molly Brassil, Associate Director, Public Policy

SUBJECT: Implementation of the Patient Protection and Affordable Care Act and Other Health Care Reform Activities – California Highlights & Recent Updates

MEMORANDUM

On March 23, 2010, President Obama signed into law the comprehensive health care reform legislation promising to extend coverage to 33 million Americans, the Patient Protection and Affordable Care Act (ACA). Key components of the ACA include changes to private insurance, an emphasis on quality improvement and prevention & wellness, the creation of state health insurance exchanges and the expansion of public programs. Please find below several highlights and recent updates related to ACA implementation and other health care reform activities as they pertain to California's public mental health system.

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Medi-Cal Expansion

Beginning January 1, 2014, the ACA establishes a new Medicaid eligibility group of non-pregnant adults between the ages of 19 and 64 with incomes at or below 138% of the

federal poverty level based on modified adjusted gross income. This new eligibility group consists of non-Medicare eligible childless adults and individuals receiving Aid to Families with Dependent Children. Participating states will receive 100% federal medical assistance percentage (FMAP) for the first three years of implementation, gradually declining to 90% in 2020 and thereafter. Participating states are required to provide essential health benefits (benchmark or benchmark equivalent coverage) to Medicaid beneficiaries in the new eligibility group. A notice of proposed rulemaking (NPRM) on the essential health benefits is expected to be issued for public comment later this fall. Although the NPRM is expected to include some discussion about how the essential health benefits interrelate with Medicaid, the Centers for Medicare and Medicaid Services (CMS) is also developing separate proposed guidance specific to the essential health benefits and Medicaid. The NPRM is expected to address a number of issues related to the scope of coverage offered through the essential health benefits, including the process for supplementing benefit coverage when that coverage is inadequate and fails to meet requirements of the ACA. CMHDA will continue to work closely with our federal and state partners to monitor the status of this anticipated guidance and weigh in as appropriate.

Essential Health Benefits for the Individual and Small Group Markets

Essential Health Benefits for the Individual and Small Group Markets Governor Brown recently signed complementary Senate (SB 951 – Hernandez) and Assembly (AB 1453 – Monning) bills related to the essential health benefits to be offered in the individual and small group market. This marks a significant step toward health care reform implementation in California. Commencing January 1, 2014, the ACA requires a health insurance issuer that offers coverage in the individual or small group market to ensure that such coverage includes the essential health benefits package, as defined. The U.S. Department of Health and Human Services (HHS) released a bulletin in December 2011 describing the approach the federal government intends to take in future rulemaking to define the essential health benefits under the ACA, which utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented, as necessary, to ensure that plans cover the ten statutorily required categories of essential health benefits. Of note to the mental health community, the ACA explicitly includes mental health and substance use disorder services, including behavioral health treatment, as one of ten categories of service that must be covered as essential health benefits. Furthermore, the ACA also mandates that mental health and substance use disorder benchmark coverage must be provided at parity, compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008). Essentially, states have the flexibility to select an existing health plan to set the “benchmark” for the items and services included in the essential health benefit package. If the benchmark does not initially cover one of the ten categories, the benchmark must

be supplemented. States may choose a benchmark from among the following health insurance plans: 1) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; 2) any of the largest three state employee health benefit plans by enrollment; 3) any of the largest three federal plan options by enrollment; or 4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

With the signage of these bills, any individual or small group health care service plan contract or health insurance policy that is issued, amended or renewed in California on or after January 1, 2014 shall at a minimum include coverage for essential health benefits (exceptions apply). Furthermore, this coverage requirement applies to individual and small group plans/policies offered to consumers and small businesses both inside *and outside* of the California Health Benefit Exchange. The legislation selects a Kaiser small group product as California's reference ("benchmark") plan. According to the Evidence of Coverage (EOC) for the identified benchmark plan, coverage should include services and benefits for a broad range of mental health conditions, utilizing the mental disorder definition as supplied by the DSM-IV-TR. To review the EOC for the identified benchmark product, [click here](#). CMHDA met with the Health Committee staff to discuss the bills and raise considerations regarding the intersection of essential health benefits and mental health parity laws. Specifically, CMHDA successfully advocated that language be added to the legislation to clarify that any individual or small group health care service plan or insurance policy issued, amended, or renewed on or after January 1, 2014 must comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and all corresponding rules, regulations and guidance. CMHDA, and our partners with the California Coalition for Whole Health (CCWH), felt that the inclusion of this reference to federal parity law was particularly important in order to ensure plan/policy compliance with both quantitative and *non-quantitative* limitations – the latter of which may not be easily discernable in the benchmark EOC. Some questions still remain regarding coverage of certain substance use disorder treatments, such as methadone maintenance treatment which is excluded from coverage in the benchmark EOC. The next step following the Governor's signature will be for HHS to review California's definition of essential health benefits and ensure appropriate inclusion of all ten statutorily required categories.

California Health Benefit Exchange

The California Health Benefit Exchange (HBEX) Board continues to meet monthly to tackle a host of issues in preparation for a January 1, 2014 marketplace launch. Among a number of other issues, the board has most recently focused on marketing and outreach, premium aggregation and agent payment options, the Small Business Health

Options Program (SHOP), Qualified Health Plan policies and contracting, the Service Center, and the Consumer Assistance/Ombudsman Program. Additionally, the Exchange has been engaged in ongoing work to “brand” the Exchange, including identifying a new name that might better resonate with potential consumers. The Exchange is currently preparing to submit a new Federal Establishment Grant application to support California’s ongoing planning work. After 2014, the Exchange must be self-supporting from fees paid by health plans and insurers participating in the Exchange.

Qualified Health Plans

In August, the Board approved a set of policies for the establishment of the structure for Qualified Health Plans (QHP) to participate in the Exchange. To review the final adopted policies, [click here](#). The adopted policies will inform the requirements for health plans offered through the Exchange, including plan and network design, assuring quality and affordability, alignment with other purchasers, supplemental health benefits and promoting wellness and improvements in the delivery of care. CMHDA, working alongside CCWH, was able to submit comments earlier this month to inform the staff recommendations brought to the board for consideration. In order to ensure that essential, medically necessary mental health and substance use disorder services are accessible to consumers in a timely fashion, and that parity and equity standards are appropriately met, CCWH primarily focused our comments on plan regulation and oversight and provider network adequacy. To review our coalition comments, [click here](#). CMHDA was pleased to find an important acknowledgement of our feedback in the staff recommendations, where it was emphasized that the HBEX would need to have an ongoing role in ensuring that QHPs meet all the applicable requirements relevant to the provision of mental health and substance use disorder services. Subsequent to the adoption of QHP policies, the Exchange circulated for stakeholder review the Draft QHP Solicitation. Essentially, the Solicitation implements the QHP policies adopted by the Exchange in August. Once the final proposed solicitation is posted later this month, bidders will have the fall to submit questions and indicate their intent to bid. The Exchange anticipates that final QHP selection shall be completed by May 31, 2013. CMHDA, alongside our coalition partners with CCWH, submitted comments last week to the Exchange in response to the invitation to provide stakeholder feedback on the Draft QHP Solicitation. To review CMHDA and CCWH’s comments on the draft solicitation, [click here](#). To review the draft QHP solicitation, [click here](#). Additionally, the Exchange is working to develop draft standardized benefit plan designs that should be circulated for comment shortly.

Service Center

Starting in 2014, the California Health Benefit Exchange will be offering a statewide health insurance exchange to make it easier for individuals and small businesses to compare plans and buy health insurance in the private market. Although the focus of the Exchange will be on individuals and small businesses who qualify for tax credits and subsidies under the Affordable Care Act, the Exchange's goal is to make insurance available to all qualified individuals and to all California businesses with less than 50 employees. The Exchange is charged under both federal and state law with the role of being one of the main entry points for millions of Californians to obtain their health care coverage starting in 2014 – including for eligibility in Medi-Cal as well as for tax credits and unsubsidized Exchange products. The Exchange is required to screen individuals for eligibility for the coverage subsidies and cost-sharing reductions offered through the Exchange, as well as for public programs such as Medi-Cal and Healthy Families, and facilitate enrollment of these individuals. The Exchange will offer persons eligible for the Exchange a choice of qualified health plans consistent with state and federal laws and requirements, including coverage options for individuals not eligible for public programs or subsidies and for small employers and their employees. In August, the Board approved policies for the design of the Service Center to help consumers access information regarding coverage options. The adopted design is a “Centralized Multi-Site Hybrid Model” which involves two or three state locations for centralized screening and plan enrollment. Medi-Cal eligible consumers identified through the centralized screening process will be referred to their county of residence for determination. More information and discussion on the protocol for the centralized multi-site service center to screen for Medi-Cal eligibility is forthcoming. CMHDA, alongside our CCWH partners, submitted comments to the Board in June to inform the development and implementation of the Service Center to ensure California consumers, including those with mental health and substance use disorder treatment needs, receive the essential assistance necessary to help navigate the complex health coverage market and programs. Foremost, CMHDA and CCWH have strongly encouraged the Service Center design to ensure that staff members are sufficiently knowledgeable about mental health and substance use disorder parity and equity laws as they apply to qualified health plans, and the scope of mental health and substance use disorder benefits typically available to consumers by qualified health plans and public coverage options. CCWH has created a consumer workgroup to further develop recommendations that may be shared with the Board and its contractors. To review the coalition comments submitted to the Exchange in June, [click here](#). To review the adopted service center design recommendations, [click here](#).

Consumer Assistance/Ombudsman Program

The Exchange is planning a broad range of outreach and support for consumers to help them enroll in coverage and access their benefits, including web-based support, and Service Center and in-person support through Navigators and assisters. Through these outreach and support services, the Exchange hopes to enable consumers to address enrollment and access issues simply and quickly. However, in an acknowledgement that additional assistance for regulators and other partners may be needed to resolve complicated issues, the Exchange is exploring the development of an independent consumer assistance/ombudsman program to serve as another important source of help for consumers and a way to identify systemic issues such as problems with eligibility determinations, grievances and appeals, and benefits and coverage. The Exchange is currently considering a number of strategies and options for providing this level of consumer assistance. Given the long history of significant barriers to accessing benefits faced by mental health consumers with coverage in the private market, CMHDA plans to work with our coalition partners to submit comments to the Exchange to highlight the issues most pertinent to the mental health community, including providing examples of common barriers faced by mental health consumers and recommendations for how a consumer assistance program can best support mental health consumers in accessing benefits.

Section 1115(a) Waiver – California's Bridge to Reform

Behavioral Health Service Plan

As part of the Special Terms and Conditions (STCs) of the 1115 Bridge to Reform Waiver, the Centers for Medicare and Medicaid Services (CMS) has required DHCS to develop a behavioral health needs assessment and service plan to prepare for the 2014 Medicaid expansion. As outlined in the STCs, the state must submit a detailed plan to CMS outlining the steps and infrastructure necessary to meet requirements of a benchmark plan and ensure strong availability of behavioral health services statewide no later than 2014. This plan is due to CMS by October 1, 2012. However, DHCS recently requested a six-month extension from CMS in order to provide sufficient time to draft the proposal and ensure continued meaningful public input and transparency in the decision making process.

Per agreement between DHCS and CMS, DHCS submitted a plan outline to CMS on October 1, 2012, to satisfy the due date listed in the STCs. DHCS will plan to submit a revised Services Plan by April 1, 2013. In drafting the original October due date for this STC, both California and CMS had anticipated that federal guidance for both the Medicaid Benchmark Benefit and Medicaid Behavioral Health Parity would be available. According to DHCS, this federal guidance is needed in order to complete the Behavioral

Health Services Plan. Guidance is expected to be released later in the fall of this year. Once CMS releases this guidance, DHCS will require several months to consult with stakeholders, analyze options and make decisions critical to the development of the Services Plan. These decisions include: which benchmark benefit package California will choose, the delivery system(s) for those benefits, and concurrent implementation strategies for financing, enrollment, quality oversight and monitoring, access, and work force development. The finalized Services Plan will describe California's recommendations for serving the Medi-Cal expansion population and demonstrate the State's readiness to meet the mental health and substance use disorder needs of this population. To review the outline, [click here](#). In the meantime, as the state awaits federal guidance, DHCS has indicated that they plan a larger stakeholder convening later this fall to address benchmark benefit design. CMHDA plans to participate in this process.

Low Income Health Program

The Low Income Health Program (LIHP) began program implementation on July 1, 2011, with 10 local LIHPs. By June 30, 2012, a total of 15 local LIHPs were implemented, including the County Medical Services Program (CMSP), which represents 35 rural counties. As of September 2012, 16 local LIHPs have been implemented, representing 50 counties, and at least four additional counties are planning to implement by January 2013. As of June 30, 2012, the number of unduplicated eligible individuals enrolled in 15 local LIHPs represented 49 counties and totaled 552,553. This enrollment number exceeds the enrollment projection of 512,000 total enrollees for the entire length of the LIHP. The LIHP is scheduled to end December 31, 2013 with the transition of eligible LIHP enrollees to Medi-Cal or a coverage option available under the California Health Benefit Exchange, as authorized by the federal Affordable Care Act, effective January 1, 2014. *The Low Income Health Program has already met and exceeded the enrollment target for the duration of the program.* This represents a remarkable accomplishment for the LIHP programs throughout California.

DHCS has begun planning for the upcoming transition of LIHP enrollees to the new coverage options available in 2014 under the ACA. For more information on the transition, including the state's initial transition plan and Frequently Asked Questions, [click here](#). To review CMHDA's comments to DHCS on the draft transition plan, [click here](#).

Finally, CMS recently approved the claiming protocols for services provided to individuals enrolled in the LIHP. For more information on the LIHP, [click here](#).

California's Proposed Coordinated Care Initiative – State Demonstration to Integrate Care for Dual Eligible Beneficiaries

The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) was established within CMS pursuant to Section 2602 of the Affordable Care Act. California is one of 15 states awarded a federal contract from the Coordinated Health Care Office to develop new models of coordinated care for people eligible for both Medicare and Medicaid (Medi-Cal), also known as dual eligibles. Currently, only a small portion of California's dual eligibles are enrolled in organized care systems. The Duals Demonstration will involve models through which one entity is coordinating care for the total needs of a person – medical and social. That includes behavioral health, social supports, medical care, and long-term care. SB 1008 (Committee on Budget – 2012) authorizes the state to initially implement the demonstration in up to eight counties in 2013. Additionally, SB 1008 includes intent language that the Initiative be expanded statewide within three years of the start of the demonstration project, contingent upon statutory authorization and a subsequent budget appropriation. The demonstration will expand the managed care benefits for selected demonstration health plans to include the In-Home Supportive Services (IHSS) program, as well as Multipurpose Senior Services Programs (MSSP), Community-Based Adult Services, and skilled nursing facility services as part of the blended capitated rate to the participating managed care organizations. While county-administered Medi-Cal mental health and substance use disorder services are not to be initially included in the health plans' blended capitated rate, demonstration plans will be charged with managing the entire Medicare benefit, including mental health services covered by the Medicare program.

CMHDA has been actively involved over the last year in monitoring the development of the demonstration and providing guidance to the state to inform the state's proposal to CMS. Per CMHDA's feedback to the state's draft proposal circulated for comment earlier in the year, the final proposal submitted to CMS in May included an additional appendix outlining a framework for shared savings and accountability between demonstration health plans and county mental health and substance use disorder authorities. To review CMHDA's comments to CMS, [click here](#). To review the state's proposal, [click here](#). More recently, the Department of Health Care Services (DHCS) developed and circulated for comment *Draft Behavioral Health Readiness Criteria* and *Draft Shared Accountability for Behavioral Health*. The draft shared accountability proposal largely built upon the framework included in the state's proposal to CMS to describe how the proposed "quality withhold" process might be an opportunity to incentivize coordination by sharing savings between systems. To access those drafts, [click here](#). Guided by the expertise of our members in the eight selected duals demonstration counties, CMHDA submitted comments to DHCS last month to provide feedback on the draft proposals. In terms of the readiness criteria, CMHDA primarily

took the opportunity to provide more information and recommendations for the MOU process between the health plans and the mental health plans (MHPs) in the context of this demonstration. In terms of the proposed shared accountability structure, CMHDA was largely pleased with the direction of the draft as the proposed structure aligns with the recommendations forwarded by CMHDA in previous comments. CMHDA took the opportunity to offer only some minor recommended changes to ensure that the process outlined will be workable for both the county MHPs and the demonstration health plans. To review CMHDA's comments as submitted in August, [click here](#).

CMHDA's priority areas for further consideration include risk and cost shifting concerns, information exchange barriers and opportunities, health plan payment and financial incentives, conflict resolution, network coordination, performance measures and shared savings opportunities, among others. Contingent on CMS approval, the demonstration is slated to begin June 2013. In addition to participating as a co-lead in the state's Behavioral Health Workgroup to further vet and define demonstration policies relevant to mental health and substance use disorders ([click here](#) for more information on the state's workgroup), CMHDA has also been hosting monthly calls for our members in the eight participating counties in order to provide an opportunity for county-to-county exchange and share local implementation opportunities and challenges. Per DHCS's request, CMHDA was able to work with members in the eight counties to develop proposed elements for the Department's consideration to include in the required MOU between health plans and MHPs. For more information on California's proposed Duals Demonstration, [click here](#).

Let's Get Healthy California Task Force

Per the Governor's Executive Order, the California Health and Human Services Agency (CHHS) Secretary, Diana S. Dooley announced in June the creation of the "Let's Get Healthy California Task Force." The Task Force, made up of 25 appointed members and 20 appointed expert advisors is charged with developing a 10-year plan to make Californians healthier. The Task Force will be Co-Chaired by Secretary Dooley and Don Berwick, MD MPP, who is a senior fellow at the Center for American Progress. To review the roster of task force members and advisors, [click here](#). The Task Force and the Expert Advisors will work together to gather, evaluate and prioritize the best ideas and practices and organize them into a 10-year plan to improve quality, control costs, promote personal responsibility for individual health, and advance health equity. The report will establish baselines for key health indicators, identify obstacles, inventory best practices, provide fiscally prudent recommendations and create a sensible framework for measuring improvements in key areas including: 1) Reducing diabetes, asthma, childhood obesity, hypertension, and sepsis-related mortality, 2) Reducing hospital readmissions within 30 days of discharge and 3) Increasing the number of children

receiving recommended vaccines by age three. CHHS has held calls and webinars throughout the summer to gather stakeholder input and begin to outline a framework for improving the health of the population. The final product will be a comprehensive report to be released by December 19, 2012. CHHS held a stakeholder call in September to solicit feedback on the draft framework that will be reviewed and discussed by the Task Force at their meeting later this month. CMHDA was able to take the opportunity to weigh in to support the inclusion of screening and treating depression as one of only a few leading indicators identified in the framework. The majority of the discussion focused on issues related to healthy communities, such as safe and clean neighborhoods, access to nutritious foods and promotion of physical activity. In response to comments raised by CMHDA on last week's Task Force stakeholder call, Task Force staff reached out to CMHDA this week to invite additional feedback on the depression indicator proposed in the framework to inform the work of the Task Force. With the help of our System of Care Committee members, CMHDA was able to pass along a number of informative depression screening and treatment resources to the Task Force. Additionally, CMHDA took the opportunity to make several recommendations for how mental health issues might be better included throughout the framework. To review the draft framework and dashboard, including the proposed leading indicators, [click here](#). For more information on the Task Force, [click here](#). CMHDA plans to work with partner mental health organizations to provide more formal input to this process in order to ensure that issues pertinent to our system are included in the discussion.

Contact

For any other health care reform inquiries or to learn more about CMHDA's new Health Care Reform Committee, please contact Molly Brassil at mbrassil@cmhda.org or (916) 556-3477, ext. 152.