



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

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

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

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

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

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

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

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

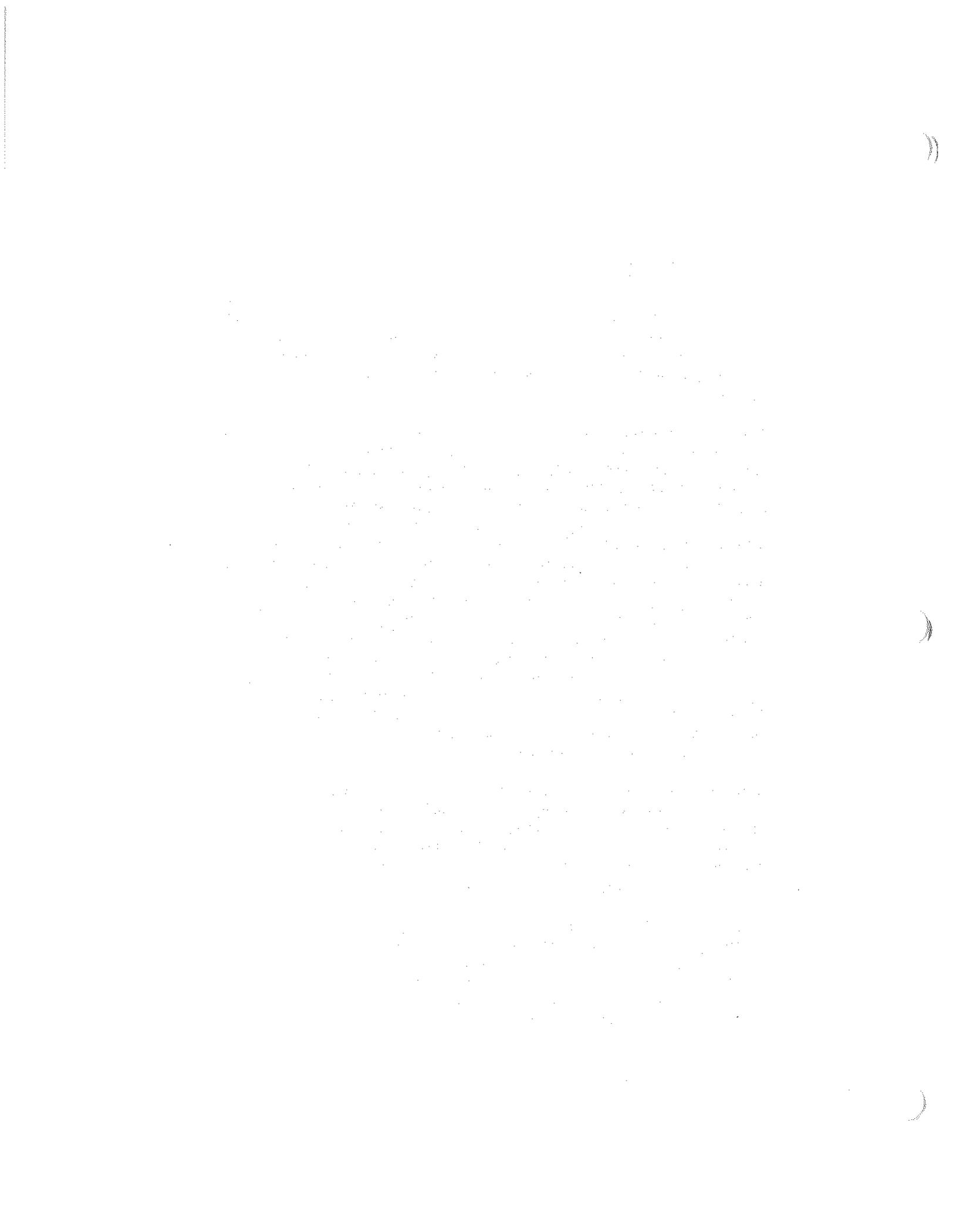
- 1) **Health equity must be integrated into all aspects of ACA implementation.** This includes addressing systematic disparities in health status related to race, ethnicity, gender, sexual orientation, income and geography. People of color and people living in rural areas are more likely to be low-income,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

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

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

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

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





December 18, 2012

Diana Dooley, Task Force Co-Chair
Donald Berwick, MD, Task Force Co-Chair
Let's Get Healthy California Task Force
1600 Ninth Street, Room 460
Sacramento, CA 95814

SUBJECT: Let's Get Healthy California Task Force Final Report, Dated December 19, 2012 (As Released December 18)

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, I am writing to communicate our perspective on the *Let's Get Healthy California Task Force Final Report – As Released December 18, 2012*.

Foremost, CMHDA would like to acknowledge and support the inclusion of “mental health and well-being” as one of the key priorities for Goal 1 – *Health Beginnings: Laying the Foundation for a Healthy Life* and Goal 2 – *Living Well: Preventing and Managing Chronic Disease*. Lack of timely access to appropriate, medically necessary mental health services can cause conditions to worsen, and lead to costly emergency and inpatient care. Coordination of mental health, substance use and primary care is essential to ensuring quality care and realizing cost savings. The Patient Protection and Affordable Care Act (ACA 2010) presents an unprecedented opportunity to expand coverage to tens of millions of Americans, and to ensure that coverage, both in the public and private markets, includes essential 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 mandates that mental health and substance use disorder benchmark coverage be provided at parity with other medical and surgical benefits offered by the health plan, pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA 2008). Individuals with mental illness and substance use disorders have the opportunity to significantly benefit from the health care law, as insufficient insurance health care coverage for these conditions has traditionally prevented countless people from obtaining needed treatment. If applied correctly in California, the health care reform law has the opportunity to ensure that clients, families and communities struggling with mental illness and substance use disorders have access to culturally competent prevention and treatment opportunities.

In order to support effective implementation, CMHDA offers the following comments on the final report, as released December 18, 2012:

- 1) Goal 1, Indicator 13 (Pages 9 and 11) – CMHDA recommends that the indicator “frequency of feeling sad within last 12 months,” be reframed to instead measure “screening for trauma and depression.” While other indicators described under this goal are generally objective and relatively easy to quantify, the mental health indicator (“frequency of feeling sad within the last 12 months”) may pose significant challenges for meaningful data collection in those regards. Screening for trauma and depression among children and adolescents is and should be a leading indicator for effectively addressing childhood trauma and preventing future negative outcomes associated with unaddressed trauma. A screening indicator, as proposed above, is more objective and quantifiable than the indicator described in the draft report for the priority of mental health and well-being.
- 2) Goal 2, Indicator 23 (Pages 12 and 14) – CMHDA recommends that the indicator “proportion of adults and adolescents with a major depressive episode,” be reframed to instead measure “proportion of adults screened, diagnosed, and treated for behavioral health needs, including depression.” As discussed above, a screening indicator is more objective and quantifiable than the indicator described in the draft report for the priority of mental health and well-being.
- 3) Goal 4, *Access to Primary and Specialty Care* (Pages 17) – CMHDA acknowledges and strongly supports the multiple references to behavioral health, including mental health specialists, in this section. Network adequacy has been a longstanding barrier to access for consumers seeking mental health services. Mental health provider networks for many plans have historically been inadequate. This issue must be addressed in order to ensure timely access to medically necessary mental health services that aim to achieve the stated priority of mental health and well-being for children and adults.
- 4) Goal 4, *Coordinated Outpatient Care* (Page 18) – CMHDA recommends that the discussion of “preventable hospitalizations” also include acute psychiatric hospitalizations that may often be preventable.

Effective partnership and collaboration with community mental health is critical in order to ensure that Californians have access to a wide variety of mental health services and supports. Increasing screening for behavioral health needs is an essential step to ensuring that Californians with mental health needs, including depression, have access to effective outpatient and crisis stabilization services. Screening for and appropriately treating mental health conditions provides an important opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental illness in the least restrictive manner possible.

Thank you for your continued commitment to California’s community mental health system. We welcome the opportunity to work collaboratively with the Let’s Get Healthy California Task Force to ensure a successful implementation of the goals outlined in the report. If you have any additional questions, please do not hesitate to contact me directly at pryan@cmhda.org or Molly Brassil at mbrassil@cmhda.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Pat Ryan". The signature is fluid and cursive, with the first name "Pat" being larger and more prominent than the last name "Ryan".

Patricia Ryan
Executive Director
California Mental Health Directors Association

cc: Vanessa Baird, Department of Health Care Services
Kiyomi Burchill, California Health and Human Services Agency
Ron Chapman, MD, California Department of Public Health





December 20, 2012

Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: **CMS-9980-P**, Patient Protection and Affordable Care Act Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Administrator Tavenner:

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, I am writing to communicate our perspective on the proposed rule detailing standards related to *Essential Health Benefits, Actuarial Value, and Accreditation*. We thank you for your strong commitment to making mental health (MH) and substance use disorders (SUD) a top priority and for working to ensure that individuals with MH/SUD needs receive quality care.

Although we have a number of very serious concerns with the proposed essential health benefit (EHB) rule that we discuss below, we do appreciate the proposed rule's explicit recognition of the ACA requirement for the EHB to include MH and SUD services, and in a manner consistent with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). Congress mandated that all public and private plans subject to the EHB, inside and outside insurance exchanges, be required to offer MH and SUD benefits, at parity with the medical/surgical benefits offered by the plan. We appreciate the Department's continued recognition of these critically important ACA requirements. We also appreciate that the proposed rule improves on the preliminary guidance released last year by including all State mandates that were in place in December, 2011 in the EHB, regardless of the base-benchmark option chosen by the State, and we appreciate the proposed rule's reassertion that all preventive services described in Section 2713 of the ACA be included in the EHB.

Below we offer our specific comments and recommendations in response to the proposed rule. We also support and have signed on to the comments submitted by the Coalition for Whole Health, and refer you to those comments for more specific detail and recommendations for how the final EHB rule can be improved to better address the needs of individuals with MH and/or SUD. In the final rule on EHB we ask the Department of Health and Human Services (HHS) to:

- Provide detailed regulations clarifying how to apply the requirements of MHPAEA to the EHB, with a framework and specific examples of violations. HHS should also conduct a

California Mental Health Directors Association (CMHDA) Comments to HHS on Proposed Rule Related to Essential Health Benefits (CMS-9980-P) December 20, 2012

review of all EHB packages to ensure parity compliance and release full and detailed benchmark plan information for all States to allow for benefit and parity analysis and oversight.

- Give States clear direction on their responsibilities for supplementing a base-benchmark to bring it into compliance with parity, be clear with States that MH/SUD parity is required of all EHB packages, and clarify that States will not be held financially responsible for any costs associated with supplementing the EHB to bring it into compliance with federal law.
- Identify a non-discrimination standard, develop a non-discrimination framework for States, and provide detailed examples of what would constitute violations of the requirements in the ACA that the EHB be designed in a way that does not discriminate based on age, disability, or expected length of life and that the EHB takes into account the health needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.
- Clarify what benefits would constitute coverage in each of the ten EHB categories, and define with examples the minimum coverage allowed in each category under the law. The Department's position seems to be that covering any benefit in a given category—no matter how limited—would meet the EHB requirement. This proposed standard does not meet the non-discrimination, balance, and other EHB consumer protective requirements of the law and needs additional attention in the final rule.
- Adopt a comprehensive standard for the prescription drug EHB category that would require plans to offer all or substantially all prescription medications in each class, including all FDA-approved medications for MH and SUD.
- Limit the flexibility in the proposed rule allowing plans to substitute benefits within the EHB categories, to ensure that plans cannot undermine coverage in any way.
- Take a more active role in defining habilitative services, and abandon the approach in the proposed rule to allow plan issuers to develop their own definition of habilitative services.
- Aggressively enforce the MHPAEA compliance requirements on the federal level and work with appropriate State officials to enforce the MHPAEA requirements on the State level to ensure meaningful compliance.
- Ensure transparency and stakeholder involvement at the State and federal levels to ensure consumers and others have the opportunity to fully participate in the process of determining and updating the EHB that will impact access to care in their State.
- Explain why the intended approach of designing State-specific EHB packages based on existing large or small group coverage in the State is temporary and explain the criteria by which the current approach will be evaluated at the end of the two-year period. HHS should also reconsider adopting a national EHB in 2016 that ensures access to the full array of MH and SUD services that enrollees need to get and stay well.

Additionally, CMHDA would like to take this opportunity to note our ongoing concern with the exclusion of non-pregnancy-related methadone maintenance treatment in the benchmark plan selected by California to define the essential health benefits for the individual and small group market (*Kaiser Foundation Health Plan Small Group HMO 30 plan – federal product identification number 40513CA035*). CMHDA strongly believes that California's EHB package should and must cover medication-assisted treatment that utilizes methadone. CMHDA believes that excluding use of methadone from ACA coverage in California violates several provisions of the ACA, including the parity and non-discrimination provisions of the federal law. To be brought into compliance with the requirements of the law, California's base-benchmark plan must be supplemented to cover medication-assisted treatment that utilizes methadone. The exclusion of

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methadone not only threatens to violate parity and non-discrimination provisions of the federal law, but also poses a significant threat to our public safety net system in California. If qualified health plans are not required to provide coverage for methadone in the treatment of opioid addiction, the burden of care for this vulnerable population will likely fall to our public system – in California being our “Drug Medi-Cal” system. California counties who manage this program would be in the position of using scarce public dollars to cover the cost of care for individuals who can and should be covered through their qualified health plan.

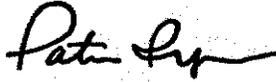
Foremost, CMHDA believes that excluding coverage for treatment with methadone, one of the three medications approved for the treatment of opioid addiction, would violate the parity requirements of the ACA. There are only three federally approved medications to treat chronic opioid addiction. California’s selected benchmark plan covers a number of medications to help in the treatment of other chronic illnesses including hypertension, cancer and heart disease. Allowing the methadone exclusion to remain in California’s EHB plan would be the equivalent of the plan also excluding coverage for one third of the medications approved for the treatment of another chronic illness. Under the parity requirements of the ACA, criteria used to determine which medications to assist in the treatment of SUD or mental illness should be covered should not be different from and/or applied more stringently than the criteria used to determine coverage for medications used to assist in the treatment of other illnesses. A difference in criteria or application of criteria would represent a violation of the parity law. To be brought into compliance with the parity requirements of the ACA, the base-benchmark plan must be supplemented to cover treatment that utilizes methadone.

Secondly, excluding use of methadone for the treatment of opioid addiction would be inconsistent with the non-discrimination requirements of the ACA. Allowing EHB plans to exclude use of methadone from coverage is contradictory to the ACA’s requirement that the EHB addresses the healthcare needs of diverse segments of the population. If medication-assisted treatment utilizing methadone is excluded as a service, individuals with opiate addiction will have their choice of treatment severely restricted. Singling out for denial of coverage a specific medication which is essential for a significant number of people with a disability to become and stay well suggests the type of discrimination that is precluded by the ACA. Excluding coverage for one of the three medications approved to help treat opioid addiction also is contrary to ensuring meaningful consumer choice in care, a central principle of the ACA. The full range of medications approved for the treatment of MH and SUD should be covered in the EHB-benchmark plan. To be brought into compliance with the requirements of the law, CMHDA believes that California’s base-benchmark plan must be supplemented to cover medication-assisted treatment that utilizes methadone. CMHDA urges HHS to provide California with clear guidance on this matter.

We appreciate the opportunity to comment on the Essential Health Benefits proposed rule. We strongly support the goals of the ACA to ensure that all Americans have access to high-quality, affordable health care, including comprehensive care for MH and SUD. We thank you for your careful consideration of our comments and the comments on the proposed rule that were submitted by the Coalition for Whole Health, and we refer you to the Coalition for Whole Health’s comments for more detailed recommendations on how the final EHB rule can best meet the MH and SUD needs of enrollees. If you have any additional questions, please do not hesitate to contact me directly at pryan@cmhda.org or Molly Brassil at mbrassil@cmhda.org.

California Mental Health Directors Association (CMHDA) Comments to HHS on Proposed Rule
Related to Essential Health Benefits (CMS-9980-P) December 20, 2012

Sincerely,



Patricia Ryan, MPA
Executive Director
California Mental Health Directors Association

cc: Peter Lee, California Health Benefit Exchange Board
David Panush, California Health Benefit Exchange Board
Dave Jones, California Department of Insurance
Brent Barnhart, California Department of Managed Health Care
Toby Douglas, California Department of Health Care Services
Len Finocchio, California Department of Health Care Services
Vanessa Baird, California Department of Health Care Services
Kiyomi Burchill, California Health and Human Services Agency
Herb Schultz, U.S. Department of Health and Human Services
Tom Renfree, County Alcohol and Drug Administrators of California
Kelly Brooks, California State Association of Counties