The Affordable Care Act: Overview and Implications for County and City Behavioral Health and Intellectual/Developmental Disability Programs

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Abstract

We begin by reviewing the five key intended actions of the ACA—insurance reform, coverage reform, quality reform, performance reform, and IT reform. This framework provides a basis for examining how populations served and service programs will change at the county and city level as a result of the ACA, and how provider staff also will change over time as a result of these developments. We conclude by outlining immediate next steps for county and city programs.

Introduction

The Affordable Care Act (ACA) holds very considerable promise to improve the future of behavioral healthcare. Put into an historical perspective, the ACA also represents a once-in-a-century opportunity to transform our broader insurance and care systems. For these reasons, it is imperative to review the key features of the ACA and to explore their implications for the evolution of county and city behavioral health and intellectual disability/developmental disability programs. Now that President Obama has been re-elected, we can expect ACA implementation to begin and proceed quickly.

As will become obvious in our discussion below, the current environment is not conducive to traditional steady-state incremental planning. Rather, we are in a period of very rapid change that demands strategic planning and design. Therefore, attention to the changes discussed here will be very important in order to undertake this type of planning successfully.

As a final element of context, we must note that the ACA specifically addresses social justice concerns regarding health status and care (see Braveman, et al., 2011). One's health status is correlated closely with one's social class and race; hence, we find major negative health disparities, including behavioral health disparities, among persons of lower status and minority groups. These health disparities are associated with disparities

in access to care. Social justice demands that we value all people equally. Thus, we need to address these class- and race-related health disparities by promoting equity in health status and care. A major focus of the ACA is the promotion of equity in health insurance coverage and care access to reduce these health disparities.

Components of the ACA

The ACA legislation is approximately 2,300 pages in length (full Act can be accessed at http://www.healthcare.gov/law/full). Almost 2,000 of those pages are devoted to Insurance Reform and Coverage Reform, the two features of the Act that commit federal dollars. The remaining 300 pages are devoted to Quality Reform, Performance Reform, and IT Reform, all of which have been assigned to the U. S. Secretary of Health and Human Services (HHS) to implement.

Below, we will review the major features of each of the five ACA reforms:

1. Insurance Reform

The purpose of Insurance Reform is to expand health insurance coverage to approximately 32 million adult Americans who currently lack it. This will be accomplished through a Medicaid Expansion, intended to cover all persons up to 138 percent of the federal poverty level who currently lack health insurance, and through State Health Insurance Exchanges, intended to cover all persons without insurance who are above 138 percent of the federal poverty level. (Estimates of the uninsured population for 2011 are available from http://www.census.gov/prod/2012pubs/p60-243.pdf).

Medicaid Expansion is intended to begin on January 1, 2014, and to cover about 16 million persons. Prior research indicates that about 40 percent of these persons, about 6.4 million, will already have a behavioral health condition at the time that they enroll, and that a majority of this latter population will have a primary substance use condition. (See an analysis at http://www.acmha.org/content/events/national/WHC_Universal_Coverage.pdf and http://www.ncbi.nlm.nih.gov/pubmed/21969638 (Strine, et al, 2011)). Fully 100 percent of the cost of the Medicaid Expansion will be paid by the federal government in 2014-2016, after which the federal contribution will decline to and remain at 90 percent by 2020.

Originally intended to be mandatory, the Medicaid Expansion is now at state option as a result of the Supreme Court decision sustaining the ACA (the full text of the Supreme Court decision is available at http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.). However, the financial benefit to states is so considerable that most are expected to take advantage of this opportunity as soon as it becomes available. For example, since about 30 percent of the Texas population is currently uninsured, Texas can expect to receive about $52.5 billion in federal funds by 2020 as a result of the Medicaid Expansion for a state investment of about $2.5 billion. (Estimates for all states

are available at http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf).

State Health Insurance Exchanges also are slated to begin operation on January 1, 2014. Those insured through this mechanism who are between 139 and 400 percent of the federal poverty level will receive a sliding scale federal tax subsidy. Exchanges will be expected to offer a range of health insurance products, classified from bronze to platinum, and to include at least two interstate health insurance plans. The Exchanges are expected to cover about 16 million persons, about a quarter of which, or about 4 million persons, will have a behavioral health condition at the time that they enroll.

About a quarter of the states currently are developing Exchanges. The remaining states have various levels of indifference or opposition to the Exchange concept. After January 1, 2013, the U.S. Secretary of HHS will make a determination regarding each state's readiness to implement an Exchange. If she determines that a state will not implement an Exchange, then the Secretary will develop an Exchange for that state. (The status of state exchange development as of August 2012 is available at http://statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17).

The floor benefit for both the Medicaid Expansion and the State Health Insurance Exchange is the ***Essential Health Benefit (EHB).*** This benefit must cover 10 specific types of benefits including mental health and substance use care and prevention. Both the mental health and the substance use benefits must be at parity with those for primary care. (You can view a model mental health and substance use benefit at http://www.coalitionforwholehealth.org/2012/01/ehb-consensus-principles-and-service-recommendations/). Each State is currently defining its EHB from a benchmark health insurance plan it has chosen from among 10 options defined for it by the U.S. Secretary of HHS. The EHB is exceptionally important because it will define the amount of federal funds a state will receive for its Medicaid Expansion and the size of the tax subsidy available to those insured under the State Health Insurance Exchange.

2. Coverage Reform

Many of the features of coverage reform have been in effect since September 23, 2010, six months after the signing of the ACA legislation. These features have been very well received by most Americans, since they address major deficits in our previous health insurance coverage. Here, we will provide a brief overview of these changes.

Elimination of Pre-Existing Condition Exclusions. Perhaps most important, no one under the age of 19 can any longer be excluded from health insurance coverage because they have a pre-existing condition. This change will be extended to all age groups on January 1, 2014.

Family Coverage to Age 26. Similarly, no one under the age of 26 can any longer be excluded from their family's health insurance policy.

Both of these changes have major implications for behavioral health care, since most behavioral conditions originate in the teenage years, and most behavioral health treatment first occurs in the early 20s.

Elimination of Co-Pays, Deductibles, and Limits. Disease prevention and health promotion interventions can no longer have a co-pay or deductible, and annual and lifetime limits for health insurance are eliminated. The latter changes have significant implications for persons suffering from major behavioral health conditions, such as schizophrenia, where family financial ruin as a result of insurance limits has been commonplace.

Insurance Plan Direct Care Expenditures. Other changes apply directly to insurance plans. Large insurance plans must now spend at least 85 percent of their revenue on care delivery, and small plans must spend at least 80 percent on care. Beginning in 2012. these changes have led to rebates of some insurance premiums when required thresholds were not met.

3. Quality Reform

Key values around ACA quality reform include person-centered care, whole health care, and shared decision-making. In other words, health care should consider all of a person's health care needs, and the person should be engaged in improving his or her health and in reducing illness (see Manderscheid, 2012). Clearly, our core behavioral health concepts of whole health, wellness, resiliency, and recovery fit very well with these ACA values.

The principal tool envisioned by the ACA to improve the quality of health care is the Health Home. The mechanism to foster the development of a Health Home is an Accountable Care Organization (ACO). Both are explained further below.

Health Homes integrate behavioral healthcare and primary care so that all of a person's health needs can be addressed through a single entity. They also offer disease prevention and health promotion interventions. Typically, they are responsible for the health care of a defined population. (You can read more about Health Homes at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html).

Health homes relate closely to the care integration initiatives that have been pursued by the federal government and private foundations for the past half decade. The primary motivation for these initiatives has been to provide primary care to persons with behavioral health conditions who also suffer from chronic physical illnesses, and to provide behavioral health care to persons who also have health problems. An example of the former would be diabetes care for a person who has schizophrenia; an example of the latter would be depression care for a person suffering from heart disease. Physical health conditions in public mental health clients have been found to lead to premature death and lifespan shortened by as much as 25 years (Colton and Manderscheid, 2006).

ACOs represent the organizational arrangements being put in place to operate Health Homes. An ACO can be a lead organization that coordinates the activities of several subsidiary organizations, or it can be an entire new entity created specifically to operate a Health Home. In either case, it represents a new organizational arrangement for delivering coordinated health care and behavioral healthcare. (You can read more about ACOs at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf).

Generally, we expect that ACOs are unlikely to be led by community behavioral healthcare entities, but rather by hospitals, primary care practices, federally qualified health center, and rural health centers. Clearly, considerable field work will be necessary to integrate behavioral healthcare entities into ACOs.

The word "accountable" is quite significant in this context. The ACA envisions a situation in which the ACO is accountable for the health of the population it serves. Hence, the ACO will be expected to report performance measures, to be paid on an annual case or capitation basis, and to "go at risk" financially for the care delivered through the Health Home.

HHS has already issued field letters to announce a new state plan amendment for Medicaid programs to create Health Homes. Care of persons with mental illness or substance use is an approved focus for a state plan amendment. (See this guidance at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf). Similarly, the HHS Health Resources and Services Administration is moving quickly toward Health Homes through its grant programs for Federally Qualified Health Centers (FQHCs). (Read more about FQHCs at http://bphc.hrsa.gov/about/index.html).

4. Performance Reform

Stated in simple terms, the goal of performance reform is to have all provider entities, including the new ACOs, report a small number of comparable performance measures on a periodic basis. It also is expected that these performance measures will not only reflect quality, but will also include summaries of outcomes achieved by the persons served. (For a current review of outcome measures in behavioral healthcare and social services, see Magnabosco and Manderscheid, 2011.)

These performance measures will be accompanied by changes in the manner in which care is financed. Currently, care typically is financed on a piecemeal basis, encounter by encounter. To adapt our financing mechanisms toward person centered and whole health care, the Center for Medicare and Medicaid Services (CMS) is moving Medicaid and Medicare financing systems toward annual case rates (per person served) or annual capitation rates (per person covered). A little reflection will help you realize that these are not only financing systems, but also systems to manage care that have the potential to replace traditional approaches to managed care.

5. IT Reform

The ACA assumes that provider entities, such as ACOs, already have and are using electronic health records (EHRs) in a meaningful way. Thus, the ACA encourages their use through financial incentives. For example, if an entity reports its performance measures to the federal government using EHRs, it will receive a federal financial incentive.

Since behavioral healthcare entities were virtually excluded from American Recovery and Reinvestment Act (ARRA) funds allocated to provider entities to develop EHRs, an effort currently is underway to extend these grant funds to behavioral healthcare. Senate Resolution S-539 and House Resolution HR-6043 have been introduced in 2012 to remedy this problem. Further action on these resolutions is expected before the end of the 2012 Lame Duck Session of Congress. (Read S-538 at http://thomas.loc.gov/cgi-bin/query/z?c112:S.539; read HR-6043 at http://thomas.loc.gov/cgi-bin/query/z?c112:H.R.6043).

Population and Service Implications for County and City Programs

Both the Medicaid Expansion and the State Health Insurance Exchanges will have a considerable impact upon the populations served by county and city behavioral healthcare and intellectual/developmental disability programs. First, we expect that the numbers of adults served will grow considerably, beginning on January 1, 2014. Second, we expect that the relative balance of this new adult service population will favor persons with primary substance use conditions. Third, we expect that uninsured children will be identified through the adult health insurance enrollment process, that they will become newly insured either through Medicaid or through the State Children's Health Insurance Program (SCHIP), and that a subset will enter the public behavioral health service population. Fourth, we expect that a set of previously uninsured adults with intellectual/developmental disabilities will be identified and become insured.

Clear implications exist for county and city programs. First, it will be exceptionally important to develop an understanding in advance about the characteristics of the anticipated new service population: What are the demographic characteristics? The clinical characteristics? The service needs? Second, at the appropriate time, it also will be very important to help these people enroll in the new insurance programs. Software tools will be made available by HHS for this purpose. Third, many of these new service users will need to be taught how a behavioral healthcare clinic operates and how to access care through a clinic.

County and city service programs also will need to change. Likely, there will be at least two phases to this transformation.

First, programs will need to adapt not only to the behavioral health and intellectual/developmental disability needs of newly insured persons, but also to their

social service needs. We can expect that many newly insured persons in the Medicaid Expansion will come from among the homeless population or the jail population. At the same time, service programs will need to adapt so that they can offer disease prevention and health promotion interventions to those with behavioral health service needs, as well as to newly insured persons who do not have behavioral health conditions.

Second, county and city program directors will need to begin planning for the introduction of Health Homes and ACOs. Initially, this may involve improvements to coordinated care for public services. Subsequently, counties and cities may wish to take the lead in forming and providing oversight for ACOs that operate Health Homes. Although this latter topic is very important going forward, further development here is beyond the scope of the present paper.

Staffing Implications for County and City Programs

At the present time, it is crucial for county and city programs to identify a strategy officer or strategy workgroup who will assume responsibility for helping to adapt these programs into the new demands of the ACA. Such a person or group should be able to collaborate easily outside the organization and be sensitive to changes occurring in that environment. Of great importance, this person or group also must be able to translate these external changes into organizational strategies and actions that help the organization work more effectively with external partners. The ACA era is expected to be characterized by collaboration and partnerships, rather than by solitary action.

Because of the anticipated expansion of the service population, even in the short term, county and city organizations will need to expand their workforce rapidly to accommodate the newly emerging demands. Peer supporters represent a readily available workforce that is well suited to undertake the new tasks that will be required. Peer supporters will be able to help the new clients navigate the Medicaid Expansion and the State Health Insurance Exchange, and to enroll in health insurance, They also will be able to help these new clients navigate access to care and will provide necessary support based on their personal experiences. (You can read more about peer support at http://schizophreniabulletin.oxfordjournals.org/content/32/3/443.full (Davidson, et al., 2006). You can read more about health insurance navigation under the ACA at http://www.governing.com/blogs/view/gov-health-exchange-navigators-still-an-unknown-for-most-states.html).

Another potential resource pool is comprised of primary care providers in the community. These may be providers from the local hospital, health center, or primary care practice. Many of these providers have developed expertise serving behavioral health clients, and they may be willing to make these skills available to county or city programs. Currently, about 60% of behavioral healthcare services are provided by primary care practitioners. (See further detail at http://archpsyc.jamanetwork.com/article.aspx?articleid=208673 (Wang, et al., 2006)).

Finally, greater reliance will need to be placed on IT tools used to conduct assessments and deliver care. Such tools can range from phone apps, to in-office assessments, to telemedicine at a distance, to online cognitive-behavioral therapy. Feasibility work should be undertaken right now to determine which are most suitable.

Immediate Next Steps

The very best way to characterize the immediate next steps is for county and city programs to answer the following four questions:

- Have we undertaken intensive strategic planning for implementing the ACA?
- Have we identified and initiated discussions with potential partner organizations in the community?
- Have we developed an understanding of the personal and clinical characteristics of the newly insured service population?
- Have we begun to identify and address our future staffing needs?

The ACA provides a wonderful opportunity to address many intractable behavioral health care problems in our communities. We will only be able to take advantage of this opportunity if we prepare effectively right now.

Good luck on this exciting journey!

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