

National Council

MAGAZINE

SHARING BEST PRACTICES IN MENTAL HEALTH & ADDICTIONS TREATMENT

| www.TheNationalCouncil.org



HEALTHCARE REFORM

MENTAL HEALTH & ADDICTION SERVICES

Let's Get Down to
Business

Linda Rosenberg

Page 6

EXCLUSIVE Interview
with Governor Howard Dean

Page 8

Will We Need a Separate
Mental Health System?

Michael Hogan

Page 10

New Directions

*National Council's
2009 Annual Report*

Page 44

The most intuitive way to work with Clinical Information

the
echo
vhr™

visual health record



Seeing EHR for the first time

Complete Case Data • Easy to Learn • One Click Navigation
Visual Alerting • Customizable

The Echo VHR is all part of our award-winning EHR, Front Desk and Billing Software



▶ Clinician's Desktop®
Revenue Manager™

▶ ShareCare®

▶ Billing Services

Software and Service Solutions for Behavioral Healthcare
www.echoman.com 1.800.635.8209 info@echoman.com



Healthcare Reform Impact At A Glance

What's In It for Persons with Mental and Addiction Disorders

“With healthcare reform, we’ve got what we always wanted — to have mental health and addiction disorders treated the same way as other illnesses. It’s a huge victory. We’ve now become part of the healthcare system. We must become savvy about positioning ourselves to take advantage of new markets and new opportunities to help control the design and delivery of healthcare services.”

Linda Rosenberg
President and CEO
National Council for Community Behavioral
Healthcare

On March 21, 2010 President Barack Obama signed into law the most sweeping piece of healthcare legislation that members of the U.S. Congress have voted on in more than 40 years — the Patient Protection and Affordable Care Act, commonly referred to as national healthcare reform. Increased access to mental health and addictions services is at the core of national healthcare reform, promising better access to treatment and supports for the one in four Americans that live with a mental illness.

What does healthcare reform mean for persons with mental illness and addiction disorders and the providers and organizations that care for them?

>> More people than ever before will have access to treatment for mental health and addiction services through expanded public and private insurance coverage.

>> Medicaid coverage will expand to persons at 133% of the Federal Poverty Level — this means 15 million more people will be eligible to enroll in Medicaid by 2019, taking the total Medicaid population to 50 million people. Those covered by Medicaid will receive mental health and substance use services on par with other healthcare services.

Note: A new study tells us that 49% of current Medicaid beneficiaries with disabilities have a psychiatric illness.

>> Private insurance coverage will expand to include an additional 16 million people by 2019 — and the parity law embedded in healthcare reform specifies that private insurers must cover mental health and substance use treatment at the same level as other health conditions.

>> Community behavioral health providers must provide services that address the overall health and well being of patients and coordinate with other healthcare providers. Like people with other chronic illnesses, persons with serious mental illness and addiction disorders will be eligible to receive care in state-funded medical homes, which can be established in community behavioral health organizations. And the federal government is authorized to provide grants to co-locate primary care and specialty mental health care in community mental health settings.

>> Behavioral healthcare organizations will need to considerably expand capacity to meet increased demand for specialty mental health and addictions treatment. They must be able to provide measurable, high-performing prevention, early intervention, recovery, and wellness-oriented services and supports.

>> States will need to undertake major change processes as they redesign their Medicaid systems to prepare for the new Health Insurance Exchanges. Provider organizations will need to be able to work with new Medicaid systems and contract with and bill services through the Exchanges.

>> Behavioral healthcare providers will need to adapt their practice management and billing systems and work processes to work with new mechanisms including case rates and capitation that contain value-based purchasing and value-based insurance design strategies.

Health Care Reform

1 Healthcare Reform Impact At A Glance
What's In It for Persons with Mental and Addiction Disorders

4 Implementation Timeline for Healthcare Reform's Medicaid Provisions

LEADERS SPEAK

6 EDITORIAL
Healthcare Reform — Let's Get Down to Business!
Linda Rosenberg

8 This is Not Healthcare Reform!
Meena Dayak Interviews Howard Dean

10 Will We Need a Separate Mental Health System?
Michael Hogan

12 Capital Perspectives
Robert Bernstein, Mark Covall, John Draper, Daniel Fisher,
Michael Fitzpatrick, Robert Glover, Carol Goodheart, Pamela Hyde,
Ron Manderscheid, Clarke Ross, Becky Vaughn WITH Harold Graham,
William Bierie, Klaas Schilder

18 State Views
Rusty Selix, Andrea Smyth, Debra Wentz

20 Finishing the Unfinished Business of Healthcare Reform
Charles Ingoglia

22 Substance Abuse Treatment — Can Reform Close the Gap?
Robert Morrison, Kara Mandell, Rick Harwood

24 Advocacy Works! Parity Tills the Soil for Healthcare Reform Harvest
Carol McDaid

26 The Parity In Healthcare Reform
Pamela Greenberg

INFRASTRUCTURE AND PAYMENT REFORM

28 Guess Who's at the Core of Your Workforce?
John Morris, Michael Flaherty

30 Reform a Game Changer — Only if You Create a New Game
Brad Zimmerman

32 Rush Hour on the Reform Timeline — Management Matters
Patrick Gauthier, Kathryn Alexandrei

35 No Health Without Health IT
Dennis Morrison

36 What Is Meaningful About "Meaningful Use" for Behavioral Health IT?
Michael Lardiere

40 Comprehensive Coverage: The Minnesota Mix
Ron Brand, Mohini Venkatesh

46 No Reform Without Payment Reform: The Massachusetts Experience
Vic DiGravio, Stephanie Hirst

48 Transitioning Patients from Safety Net to Insurance Coverage
Norah Mulvaney-Day

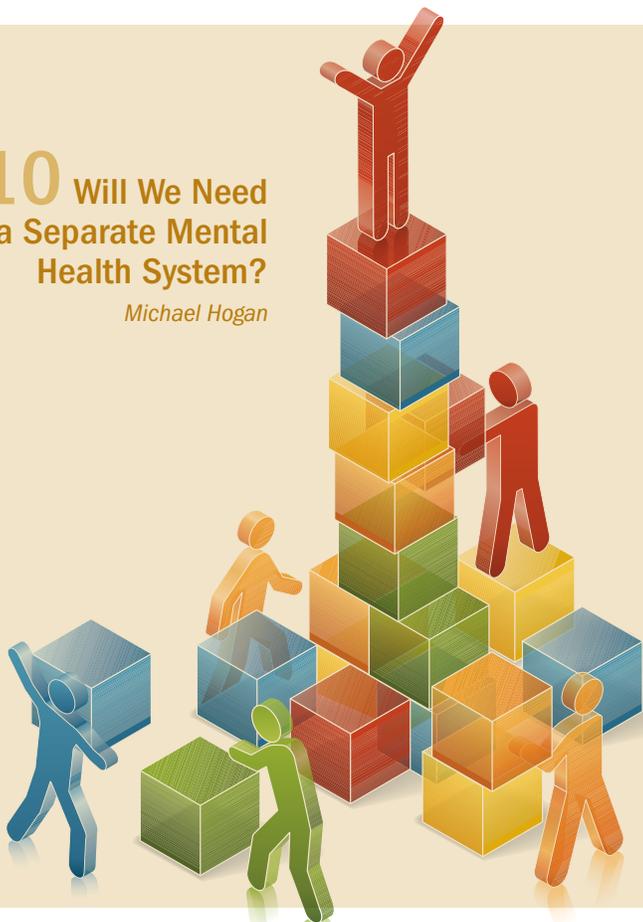
50 Health Integration — Are You Covered?
Nicholas Bozzo

52 Contracting With Managed Care Organizations
Julianna Gonen

54 Healthcare Reform Toughens Up On Compliance
Mary Thornton

10 Will We Need a Separate Mental Health System?

Michael Hogan





46 No Reform Without Payment Reform: The Massachusetts Experience

SYSTEM REDESIGN

- 58 Be Prepared or Be Trampled: The Next 36 Months
Monica Oss
- 60 Payment Reform, Pilot Programs, and the New Alphabet Soup
Dale Jarvis
- 62 Fostering System Reform for Adults With Serious Mental Illness
Joseph Parks, Arthur Evans
- 64 Patient-Centered Medical Homes: Caring for the Whole Person
Barbara Mauer

SERVICE DELIVERY

- 68 Are Your Full Caseloads Really Full?
David Lloyd
- 72 No More No Shows
Noel Clark
- 74 Stop Waste, Eliminate Wait... Save \$200,000
Scott Lloyd
- 76 Prevention Is Better than Cure
David Shern, Kirsten Beronio
- 77 Workplace Wellness — On a Budget
Anna Konger
- 78 Weaving Mental Health First Aid into Workplace Wellness
Meena Dayak
- 80 Comparative Effectiveness — Cost Control or Quality Improvement?
Linda Rosenberg, Charles Ingoglia

MEMBER SPOTLIGHT

- 82 2010 National Council Awards of Excellence Honorees

National Council Magazine, 2010, Issue 2

Healthcare Reform — Mental Health and Addiction Services

PDF available at www.TheNationalCouncil.org
(Resources and Services, National Council Magazine)



National Council Magazine is published quarterly by the National Council for Community Behavioral Healthcare, 1701 K Street, Suite 400, Washington, DC 20006.

www.TheNationalCouncil.org

Editor-in-Chief: Meena Dayak

Specialty Editors, Healthcare Reform: Charles Ingoglia, Mohini Venkatesh

Editorial Associate: Nathan Sprenger

Editorial and Advertising Inquiries:
Communications@thenationalcouncil.org or
202.684.3740.

The National Council is the unifying voice of America's behavioral health organizations. Together with our 1,700 member organizations, we serve our nation's most vulnerable citizens — more than 6 million adults and children with mental illnesses and addiction disorders. We are committed to providing comprehensive, quality care that affords every opportunity for recovery and inclusion in all aspects of community life.

The National Council advocates for policies that ensure that people who are ill can access comprehensive healthcare services. And we offer state-of-the-science education and practice improvement resources so that services are efficient and effective.

Implementation Timeline for Healthcare Reform’s Medicaid Provisions

The Patient Protection & Affordable Care Act includes several key reforms to the Medicaid program which expand eligibility and authorize demonstration and pilot programs to enhance the availability of services for individuals with mental health and substance use disorders. The following briefly describes key Medicaid reforms as well as the implementation timeline outlined in the PPACA. Given the multi-year roll-out of these provisions, the involvement of National Council for Community Behavioral Healthcare members and other key stakeholders will be necessary through the planning and development process to ensure that the clients we serve have access to these new opportunities.

For more information about these and other provisions of the PPACA, please visit the National Council’s healthcare reform webpage at www.thenationalcouncil.org/cs/healthcare_reform

	2010	2011	2012	2013	2014	BEYOND
Ensuring Medicaid Flexibility for States: States may begin to expand Medicaid eligibility up to 133% of the Federal Poverty Level and receive their current federal matching rate (FMAP).	Apr. 1					
Maintaining CHIP Eligibility: States must maintain current eligibility levels for CHIP through Sept. 2019 (“current” refers to the eligibility levels as of the date of enactment of the health care reform bill). States will receive a 23% increase in the CHIP match rate through 2019. There is no provision to reauthorize CHIP after 2019.	Date of enactment			Increased Match Begins Oct. 1		No provision to reauthorize CHIP after 2019
Medicaid Medical Home Pilot: Provides states the option of enrolling Medicaid beneficiaries with chronic conditions, including serious and persistent mental illness, into a health home. Grants of up to \$25 million will be provided.		Jan. 1				
Improving Health Care Quality and Efficiency: Establishes a new Center for Medicare & Medicaid Innovation to test innovative payment and service delivery models.		Jan. 1				

	2010	2011	2012	2013	2014	BEYOND
Partial Hospitalization Providers: Establishes new requirements for community mental health centers that provide Medicare partial hospitalization services in order to prevent fraud and abuse.		Apr. 1				
Increasing Access to Home- and Community-Based Services: Creates a new Community First Choice Option, allowing States to offer HCBS to disabled individuals through Medicaid.		Oct. 1				
Medicaid Emergency Psychiatric Demonstration Project: HHS will establish a 3-year, \$75 million Medicaid demonstration project to reimburse certain institutions for mental disease for services provided to Medicaid beneficiaries age 21-65 who are in need of medical assistance to stabilize an emergency psychiatric condition.		Oct. 1*				
Medicaid Accountable Care Organization Pilot Program: Establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as ACOs under Medicaid.			Jan. 1			Ends on Dec. 31, 2016
Improving Preventive Health Coverage: Provides an enhanced federal match rate for State Medicaid programs to cover evidence-based preventive services with no cost-sharing.				Jan. 1		
Payments to primary care physicians: Requires that Medicaid payment rates to primary care physicians for primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. Provides a 100% federal match for meeting this requirement.				Jan. 1		
Increasing Access to Medicaid: Medicaid eligibility in all states will increase to 133% of poverty for all non-elderly individuals.**					Jan. 1	

*Funding is authorized for FY 2011. Actual implementation date will depend on regulations to be issued by HHS.

**From 2014-2019, federal match rates for the expansion vary by year and by whether the state is considered an “expansion” state. By 2020, the federal government will bear 90% of the costs of the expansion in all states.

Healthcare Reform – Let’s Get Down to Business!

Linda Rosenberg, MSW, President and CEO, National Council for Community Behavioral Healthcare

With healthcare reform the law of the land, we’ve had much to celebrate. We’ve applauded President Obama and Congress for passage of a healthcare reform package that includes parity for mental health and addiction services, expansion of Medicaid to 133% of Federal Poverty Level, inclusion of behavioral health organizations and individuals with mental illnesses in the new Medicaid medical home state option, and authorization and increased funding for the SAMSHA grants co-locating mental health treatment and primary care.

These and a host of other provisions expand the opportunities for individuals with mental illnesses and addictions to obtain and maintain insurance coverage and access needed services. If you haven’t already done so, I urge you to thank your Senators and Representatives who voted for the most sweeping piece of healthcare legislation in more than 40 years. We very much appreciate their commitment to the behavioral health community and will continue to work with them – to be certain that reform is the good idea we believe it can be.

But we can’t do this alone. As the National Council’s lobbyist is fond of saying, government relations is a team sport. At so, we also celebrate you – your committed advocacy and passionate leadership encouraged the most pro-consumer parity rules in history and enabled key provisions of the Patient Protection and Affordable Care Act. And if this wasn’t enough, thanks to you, the push for creation of Federally Qualified Behavioral Health Centers is now a top agenda item. With your help, we are continuing to lobby to bring “parity” to public behavioral health and end the second-class status of community mental health and addiction providers in America’s safety net.

Due to greater understanding of how many Americans live with mental illnesses and addictions and how expensive the total healthcare expenditures are for this group, we have reached a critical tipping point. We understand the importance of treating the healthcare needs of individuals with serious mental illnesses and responding to the behavioral healthcare needs of all Americans. This is creating a series

of exciting opportunities for the behavioral health community and a series of unprecedented challenges – and the National Council is determined to provide expertise and leadership that supports member organizations, federal agencies, states, health plans, and consumer groups in ensuring that the key issues facing persons with mental health and substance use disorders are properly addressed and integrated into healthcare reform.

In anticipation of parity and reform legislation, the National Council’s public policy committee created a Healthcare Reform Workgroup that has been thinking, meeting and writing for well over a year. Their work continues and their outputs guide our activities in addressing eleven planning, design and implementation issues in three areas – service delivery, system management, and infrastructure.

SERVICE DELIVERY

1. Mental Health/Substance Use Health Provider Capacity Building: Community mental health and substance use treatment organizations, group practices, and individual clinicians will need to improve their ability to provide measurable, high-performing, prevention, early intervention, recovery and wellness oriented services and supports.

2. Person-Centered Healthcare Homes: There will be much greater demand for integrating mental health and substance use clinicians into primary care practices and primary care providers into mental health and substance use treatment organizations, using emerging and best practice clinical models and robust linkages between primary care and specialty behavioral healthcare.

3. Peer Counselors and Consumer Operated Services: We will see expansion of consumer-operated services and integration of peers into the mental health and substance use workforce and service array, underscoring the critical role these efforts play in supporting the recovery and wellness of persons with mental health and substance use disorders.

4. Clinical Guidelines: The pace of development and dissemination of mental health and substance use clinical guidelines and clinical tools will increase

with support from the new Patient-Centered Outcomes Research Institute and other research and implementation efforts.

SYSTEM MANAGEMENT

5. Medicaid Expansion and Health Insurance Exchanges: States will need to undertake major change processes to improve the quality and value of mental health and substance use services at parity as they redesign their Medicaid systems to prepare for expansion and design Health Insurance Exchanges. Provider organizations will need to be able to work with new Medicaid designs and contract with and bill services through the Exchanges.

6. Employer-Sponsored Health Plans and Parity: Employers and benefits managers will need to re-define how to use behavioral health services to address absenteeism and presenteeism and develop a more resilient and productive workforce. Provider organizations will need to tailor their service offerings to meet employer needs and work with their contracting and billing systems.

7. Accountable Care Organizations and Health Plan Redesign: Payers will encourage and in some cases mandate the development of new management structures that support healthcare reform including Accountable Care Organizations and health plan redesign, providing guidance on how mental health and substance use should be included to improve quality and better manage total healthcare expenditures. Provider organizations should take part in and become owners of ACOs that develop in their communities.

INFRASTRUCTURE

8. Quality Improvement: Organizations including the National Quality Forum will accelerate the development of a national quality improvement strategy that contains mental health and substance use performance measures that will be used to improve delivery of mental health and substance use services, patient health outcomes, and population health and manage costs. Provider organizations will need to develop the infrastructure to operate within this framework.

9. Health Information Technology: Federal and state HIT initiatives need to reflect the importance of mental health and substance use services and include mental health and substance use providers and data requirements in funding, design work, and infrastructure development. Provider organizations will need to be able to implement electronic health records and patient registries and connect these systems to community health information networks and health information exchanges.

10. Payment Reform: Payers and health plans will need to design and implement new payment mechanisms including case rates and capitation that contain value-based purchasing and value-based insurance design strategies that are appropriate for persons with mental health and substance use disorders. Providers will need to adapt their practice management and billing systems and work processes in order to work with these new mechanisms.

11. Workforce Development: Major efforts including work of the new Workforce Advisory Committee will be needed to develop a national workforce strategy to meet the needs of persons with mental health and substance use disorder including expansion of peer counselors. Provider organizations will need to participate in these efforts and be ready to ramp up their workforce to meet unfolding demand.

Simply put, we must be ready to play in a new game, in a world where increasing numbers of individuals – by virtue of Medicaid expansion, the emerging Health Insurance Exchanges, and parity regulations – will have access to behavioral health services. We expect to see an additional 15 million individuals – an increase of 43% – eligible for Medicaid alone, with more than 30 million individuals overall who will, in the not too distant future, have insurance coverage.

But this is far more than a matter of numbers – it's about working smarter. We anticipate that healthcare reform-driven service delivery redesign and payment reform will unfold at a rapid pace. In order to bend the cost curve, payment reform and service delivery redesign will change how health, mental health and substance use services are integrated, funded, and managed. We must learn to practice healthcare the way healthcare will be done.

We must become savvy about positioning ourselves to take advantage of new markets and new opportunities to help control the design and delivery of healthcare services. We must begin to build relationships

“**Payment reform and service delivery redesign** will change how health, mental health and substance use services are integrated, funded, and managed. We must learn to practice healthcare the way healthcare will be done... We must retool our organizations with the knowledge that all individuals will now become true ‘consumers’ of healthcare services.”

within and across the entire healthcare sector. As we revisit the concept of “managing care” for individuals and whole populations, we have to be certain that our focus on person-centered, recovery-focused treatment and services is not subsumed by the drive to “bend the curve” in healthcare costs. We must be able to demonstrate our value not only to our customers, but also as key players in these new healthcare consortia.

We must become accountable for efficient and effective services that show results across all health domains. We believe fee-for-service reimbursement will slowly become a thing of the past. So, too, will be the ability to claim that caseloads are full with no-show rates of 50% and more. We risk being left on the sidelines if we don't move with deliberate speed to ensure continuity and timely access to care; comply with third-party payer requirements; coordinate care with a full range of health providers; and if necessary take on payers that refuse to honor the spirit and letter of the parity regulations.

We must become increasingly customer-focused, from the way we greet individuals who come through our door to the way we market our services. We should expect that with more money available in healthcare – particularly for mental health and addiction treatment – that new and well capitalized players will find behavioral health, traditionally a financially unattractive healthcare sector, far more appealing.

People will be insured and will have an increasing

range of options available to them. What differentiates our services? Why should an individual choose to receive treatment and support from us? Are we offering services that will help them meet a full range of healthcare needs? Are our services culturally appropriate for the communities we serve? Can we help them understand and make appropriate use of their insurance coverage? We must retool our organizations with the knowledge that all individuals will now become true “consumers” of healthcare services.

At the same time, we must also be aware that our work is far from over at the state and federal level. Forty-eight of 50 states are experiencing severe budget shortfalls. The threat is very real and the National Council's state and local partner associations and their stakeholder communities are fighting hard to hold on to current funding as legislatures see an opportunity to continue to withdraw needed funds. We know this is a bad idea – even the most generous healthcare benefits will likely not cover the full range of wraparound supports that people with mental illnesses and addictions need to recover.

At the federal level, we must work to ensure that SAMSHA funds are similarly maintained. In an environment where dollars and emphasis are focused on disease prevention, health promotion, and comparative effectiveness research, we must increase understanding of the contributions behavioral health has made to each of these areas.

Eleanor Roosevelt once said, “It takes as much energy to wish as it does to plan.” All of our planning, advocacy, and leadership to date have borne fruit, but we must not be content to wish it all works out well. We must fight for our future – and the future of the individuals we are privileged to serve – by acting as key players in the brave new world of healthcare.

Linda Rosenberg is an expert in mental health policy and practice with 30+ years of experience in the design, financing, and management of psychiatric treatment and rehabilitation programs. Under Rosenberg's leadership since 2004, the National Council for Community Behavioral Healthcare has more than doubled its membership; helped to secure the passage of the federal mental health and addiction parity law; expanded financing for integrated behavioral health/primary care services; was instrumental in bringing behavioral health to the table in federal healthcare reform dialogue and initiatives; and played a key role in introducing the Mental Health First Aid public education program in the United States. Prior to joining the National Council, Rosenberg served as the Senior Deputy Commissioner for the New York State Office of Mental Health.

This Is Not Healthcare Reform!

Howard Dean — a *National Council Magazine* Exclusive



Before he was Governor of Vermont, presidential candidate, or chairman of the Democratic National Committee, Howard Dean was a family doctor, which him understand healthcare in a way that other politicians don't. He has been one of the most outspoken advocates for healthcare reform with a public option. At the 40th National Council Conference in Disney World, Florida in March 2010, Governor Dean was the opening keynote speaker, and shared his vision on the future of healthcare for America. Dr. Dean also offered unique perspectives on citizen involvement to bring about real change and real progress — drawing from his experience in the use of grassroots advocacy and online technologies during his campaign for President.

In an exclusive interview for National Council Magazine, Governor Howard Dean spoke to Meena Dayak, Vice President, Marketing and Communications, National Council for Community Behavioral Healthcare

Meena: You've been widely quoted in media as saying that the bill passed in March is NOT healthcare reform?

Dr. Dean: No, it's certainly not healthcare reform, it's coverage expansion.

Meena: So what would really healthcare reform look like?

Dr. Dean: Real healthcare reform would give consumers choices, WITH A PUBLIC OPTION. We have a perfect example in the Medicare model. Real healthcare reform would include cost reform. It would incentivize providers to make changes for the better.

Meena: Are you saying the "historic" national healthcare reform bill will do no good?

Dr. Dean: Not at all. It is a good bill, it sets us on the road to universal coverage. This is really Governor Mitt Romney's Massachusetts healthcare bill from 2006 and it's a good start. It's better to have passed a bill than not to have. One thing we must be prepared for is that the system gets more expensive as more people get services. We'll learn what works and what does not. And we know that the Obama administration is committed to learning and fixing.

Meena: Some people are afraid this is a government takeover of healthcare or the government interfering between providers and patients...

Dr. Dean: No way, this is very much a private insurance bill. It's not government bureaucrats that are the problem; it's insurance company bureaucrats!

Meena: What is your greatest concern about national healthcare reform then?

Dr. Dean: I'm concerned because it has become a debate about money not medicine. Congress knows a lot about money but not about healthcare. Transitioning from policy to service delivery is the biggest challenge. And the most vulnerable group for delivery — the group most likely to get the short end of the stick — is behavioral health. Mental health services can only be effective if there are wraparound services and supportive social services offered along with treatment. Why are things like supportive social services missing from the healthcare reform dialogue?

Meena: You mentioned the Medicare model but behavioral health providers have traditionally had tremendous reimbursement challenges with Medicare.

Dr. Dean: Yes, it's true Medicare is a lousy, lousy payer on the mental health side and seniors have not been well served by Medicare when it comes to reimbursement for mental health services. Parity was not that great, it was just a minor improvement — and it seems that the federal government often exempts itself from the laws it sets. If Medicare is to be any kind of a reasonable player and be expanded, parity must apply to Medicare as much as it applies to private insurance companies.

But Medicare has done a far better job of being innovative about keeping costs down — while holding themselves to a moral compass — than private insurers have. However our real solution lies in an integrated system with global budgeting, which would be far superior to Medicare. Global budgeting

is where Washington says “Here’s your money,” and providers and patients who know more about care than use a rational system to work who gets what.

Meena: Can you talk more about the changes for providers you mentioned earlier?

Dr. Dean: WE NEED TO FIX COSTS! Right now, healthcare professionals are kept from doing the best they can do due to tremendous cost pressures. We want to move to a system where healthcare providers, not insurance companies, make the treatment decisions. And we want providers to be accountable and to deliver quality services – so we need to capitate payments.

Meena: So in a nutshell, what’s your ideal for the healthcare system in the U.S. ten years from now?

Dr. Dean: Ten years from now, I’d like to see lots of Kaiser like companies, built on the integrated care model [Kaiser Permanente has a unique integrated structure that allows the health plan, the hospital and the physicians and medical group to work together in a coordinated fashion for the benefit of the patient. This level of integration, supported by sophisticated information technology, means that the patient, along with her/his appropriate medical information, can move smoothly from the clinic to the hospital or from primary care to specialty care].

I want to see consumer choice, with a public option.

And I want to see providers being able to make decisions.

Meena: You were one of the first in American politics to successfully tap into the power of the Internet during your legendary Presidential campaign. What role would you say online technologies play in healthcare reform?

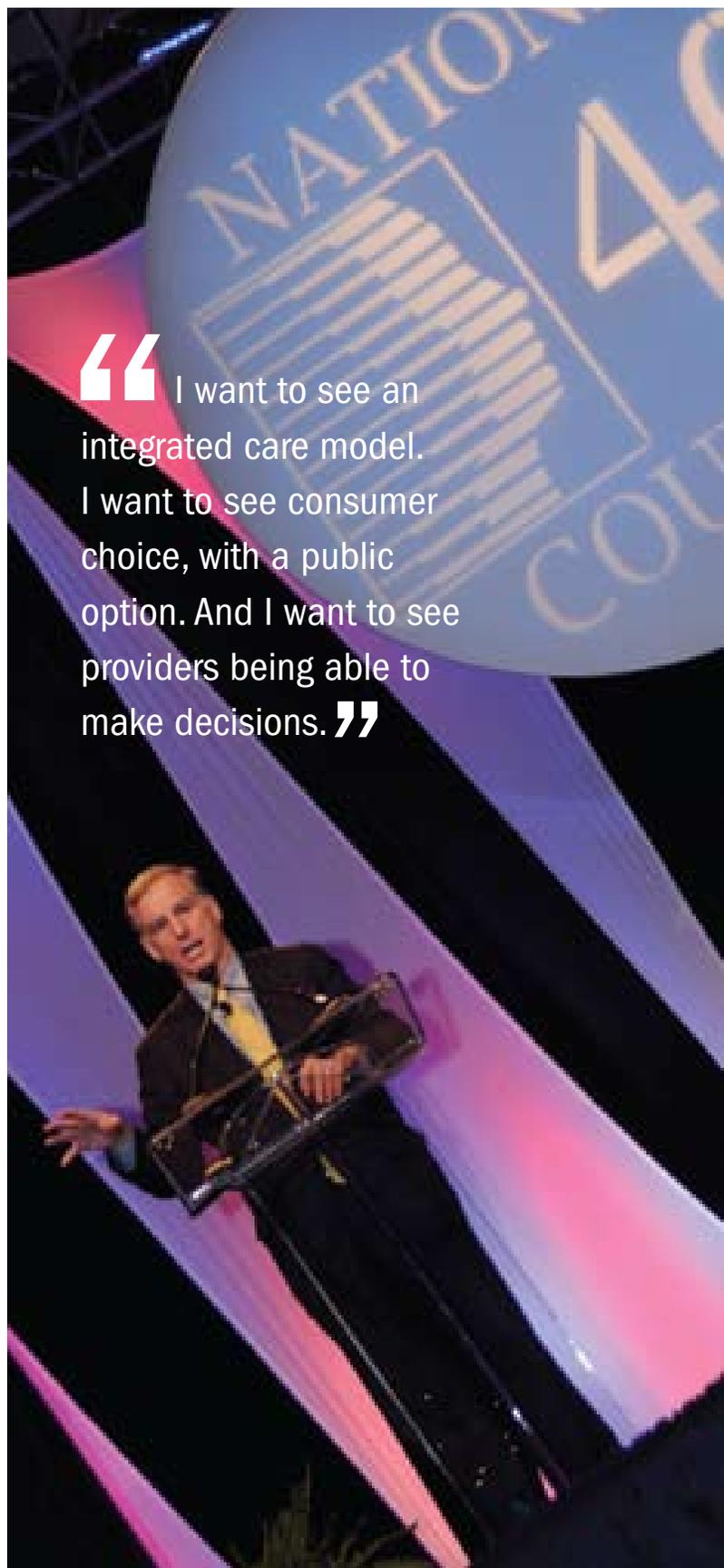
Dr. Dean: The web is a tremendous source of healthcare information but the challenge lies in ensuring the accuracy of all that information, we don’t want people to be misled. As for delivery of healthcare services, I don’t think the web is a game changer. And in cost control, there is not much of a role for the web either.

Meena: What are you working on right now?

Dr. Dean: I have more to do than ever before. I continue to work on healthcare of course and I’m also involved in some international political work.

Meena: Do you think you might run for President again?

Dr. Dean: I’m not thinking about it right now but you never rule out anything in politics!



“ I want to see an integrated care model. I want to see consumer choice, with a public option. And I want to see providers being able to make decisions. ”

Will We Need a Separate Mental Health System?

Michael F. Hogan, PhD, New York State Mental Health Commissioner

“We should not maintain state systems if the alternative is being part of the mainstream... We must lead to achieve integration of care, everywhere... I believe that a few entrepreneurial leaders will embrace the challenge of achieving true integration at every level, from policy to plan to practice. These entrepreneurs will also succeed in business, because the game will come to them.”

“If the new federal law equalizing coverage for mental conditions with that for medical-surgical care works as hoped, there may no longer be a need for a public system to handle mental health in the long run,” says Michael Hogan, New York State’s mental health commissioner.”

This was the headline and lead on the Wall Street Journal health blog’s April 16 story, by Shirley Wang, following my comments at a New York City mental health conference (sometimes you know there’s a reporter in the crowd, and sometimes you don’t.) In this case, however, I won’t claim I was misquoted. Rather, given the history of behavioral healthcare and the road ahead, it’s a good time for serious thinking about the future.

The theme is not new. In 1993, in an earlier era of (anticipated) healthcare reform, a group of state mental health commissioners met with the mental health task force of the Clinton health reform effort, chaired by Tipper Gore.

We had lots to talk about. The Clinton reform proposal was to recommend universal health coverage, with mental health parity. Surely part of the conversation had to consider the role of the states’ public mental health systems.

The commissioner’s group, meeting as an ad hoc task force of the National Association of State Mental Health Program Directors, had already considered this issue. So when the question came “If health reform includes universal coverage

and full parity, are you willing to discuss folding state resources into the larger system?” we were prepared. Our answer was “Yes, we have lots to discuss. State responsibilities extend beyond healthcare. Obligations such as forensic services and housing need to be fulfilled. And we’ll need a careful transition. But we should not maintain state systems if the alternative is being part of the mainstream.”

Almost two decades later, the seemingly impossible future has been promised to the American people, with the combination of national healthcare reform, parity for both mental health and addiction



treatment, and aggressive parity regulations that raise the bar on acceptable treatment. What can we expect in this new environment?

My crystal ball predicts a paradox in the future of separate public systems. First, in the next couple of years, little will seem to change. The combination of uncertainty, phased-in implementation of the federal legislation, and the “boiled frog effect” mean that little will change — or, rather, that few changes are apparent. The second prediction I am pretty certain about is that in 45 years, distinct public mental health systems with state-operated and state-funded specialty services will no longer exist in anything like their current form.

Actually, I think the change will happen more quickly. But it’s been 45 years since Medicaid and Medicare were created, so the frog is a useful analogue. Recall that, when enacted, Medicaid had no specialty mental health benefit, and state (and private) psychiatric hospitals (Institutions for Mental Diseases) weren’t covered. And then consider how things have changed in the past four decades. Acute care was moved to newly covered units in general hospitals, so that there are only a few thousand “state beds” still devoted to acute care in the entire country. Nursing homes were covered for intermediate care, whereas state hospitals were not, so by the mid 1980s several hundred thousand older patients (and some not so old — in an unfortunate lesson about the power of financial incentives) had been moved to nursing homes. By 1985, Gronfein had demonstrated that the Medicaid program’s (indirect) impact on mental health policy was already greater than the impact of the Community Mental Health Centers program. And that was before things really ramped up; you know the rest of the story. Medicaid benefits for community care (clinic, case management, and rehabilitation) were in place. Special services, such as Assertive Community Treatment, were covered. “Medicaid it” became a cry of cash-strapped budget offices and an army of consultants. Today, Medicaid’s funding levels, policy influence, and — in many states — impact on mental healthcare are greater than those of the state mental health agency (if one still exists).

Moreover, the changes since 1965 were not explicitly

called for. Now parity is the law, and the administration proposes rules for parity that do not allow different approaches for managing overall health benefits. So think about it again. Will we need a separate mental health system in the future?

The long term, I admit, is all speculation. The question before us now is what mental health managers, providers, and advocates should be seeking and acting on as we move forward. We know what consumers will be seeking. The evidence is before us, in data showing that behavioral issues are the number one cause of pediatric visits and also that the treated prevalence of depression doubled after the introduction of the selective serotonin reuptake inhibitors — although most care in general medical settings is not up to recommended standards. People want care in the mainstream, for complex reasons that no doubt include stigma, convenience, and coverage.

I believe our challenge is at the heart of healthcare reform. It is also evident in the statistics above. Although people want care in the mainstream, the general health sector, without our help, is incapable of reliably delivering good behavioral healthcare. We see this across the life span in care for depression (a prevalent disorder that is reliably diagnosed and usually well treated by specialists). In the general medical sector, depression is often undiagnosed, and, when diagnosed, it is usually undertreated — from peri- and postnatal depression to adolescence to middle age to late-life chronic illness. Keep in mind that depression is usually simpler to diagnose and treat than other disorders. The research and demonstration programs yield clear results. With a mental health depression specialist on the team — not across town, not in another agency, not available by referral, but on the floor — along with screening, treatment protocols, and measurement, good care can be reliably delivered.

Our mission, in the first few years, is clear. We must lead to achieve integration of care, everywhere. We also have to integrate medical care into our specialty settings, because without it our clients will never get decent medical care, and the rates of premature death will not improve.

In addition, we must work to integrate mental health competencies into all clinical general medical settings

— because emerging standards of care will demand it. We have to help craft health plans that pay attention to behavioral health beyond inadequate measures (e.g., whether a discharged psychiatric patient made a single timely follow-up visit) to fully integrated care expectations and outcomes. At the national level, we need leadership to increase access to appropriate psychotherapies, now that we have overcorrected to a dominance of medication treatment.

I believe that a few entrepreneurial leaders will embrace the challenge of achieving true integration at every level, from policy to plan to practice. These entrepreneurs will also succeed in business, because the game will come to them. Most of us will stumble along the road that we are on. For many, this road will turn out to be a dead end, because someone else got to the integration mandate first. In some circumstances, we will have no leadership and no mission except cost control — which will lead to a kind of deinstitutionalization revisited. In the next round of state budget cuts, in fact, we may see some early evidence of this unfortunate trend.

Other challenges will certainly continue to require state, federal, and local mental health leadership. Key supports such as housing and employment are outside of healthcare. Special responsibilities, such as forensics, are in statute. More must be done to support prevention and early intervention services that now have the force of evidence behind them. But the topic of the day and the biggest area of federal reform are in the area mentioned in our association’s name: health.

What’s your vision of the road ahead? Does it depend on specialty state agency leadership? Does it rely on protected status for particular providers? Or do you have a business plan for success, in an integrated health and behavioral health environment?

Michael Hogan is the New York State Commissioner of Mental Health. His experience in mental health administration and research is unparalleled and includes leadership roles with the President’s New Freedom Commission on Mental Health, the Joint Commission, the National Institute of Mental Health’s National Advisory Mental Health Council, and the National Association of State Mental Health Program Directors. He has coauthored a book and several national reports, written more than 50 journal articles and book chapters, and received numerous awards for his service and leadership.



Capital Perspectives

Mental Health and Addiction Services Leaders Discuss the Opportunities and Threats of Healthcare Reform

Robert Bernstein, PhD, Executive Director, Judge David L. Bazelon Center for Mental Health Law

“The new national health reform law is a considerable achievement for our community. In addition to significantly reducing the number of uninsured people in the nation, the law signals that mental health is properly considered part of overall health. For people with serious mental illnesses, this is an important message, because it challenges the notion that they – and their disabilities – are ‘different.’ But whether the expanded coverage and inclusive messaging will actually move these people and the community behavioral health systems that serve them into the mainstream is an unanswered question.

Too often, community behavioral healthcare has offered bare-bones services to people with serious mental illnesses who lack insurance, with very poor outcomes. Expanded Medicaid eligibility will provide some relief, but I doubt that the new coverage

Community behavioral health must also practice what it preaches about inclusion, expanding its visibility so it is viewed as more than a last-resort safety net and establishing itself as one of many specialty services now integrated within mainstream healthcare.

(whether private or benchmarked) will include the essential services that are now part of the Rehabilitation Option. Similarly, without strong advocacy to demonstrate the importance and cost-effectiveness (relative to institutional care) of ACT, therapeutic foster care, and other crucial services tailored to serious mental disabilities, it is unlikely that these services will be offered to people who purchase commercial insurance through an exchange.

Community behavioral health plays a critical role in helping patients recover from a serious mental illness and in realizing the social inclusion ensured by *Olmstead v. L.C.* To carry out this role meaning-

fully, community behavioral health must take full advantage of the opportunities offered by health reform – for instance, advocating for regulations that maximally benefit the people most in need of its services. Community behavioral health must also practice what it preaches about inclusion, expanding its visibility so it is viewed as more than a last-resort safety net and establishing itself as one of many specialty services now integrated within mainstream healthcare. ‘Tough-time’ arguments notwithstanding, such integration requires that community behavioral health rekindle the activism embedded in its roots.”

Mark Covall, President and CEO, National Association of Psychiatric Health Systems

“Mind and body are one, and federal law now helps us implement this reality. Not only does the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 put behavioral health benefits on par with medical and surgical benefits, but important behavioral health provisions are contained within the healthcare reform laws passed in 2010.

With these new laws, mental health and substance use disorders will no longer be separate and unequal. They need to be viewed like any other disorders, and reform builds on the momentum generated by the new federal parity law. Many more Americans will have access to mental health and substance use benefits under parity and reform. That is the good news.

Nevertheless, the elevation of mental health and substance use disorders so that they are on par with all other disorders means that providers need to step forward and be held more accountable. We need to show that placing mental health and substance use on par with overall medicine adds value. We need to improve our measurement of quality and become more transparent. We need to be cost-effective, and we need to measure outcomes; comparative effectiveness is a good tool for these purposes. We need to partner with others in medicine outside the mental health and substance use community.

We cannot say we should be “equal but different.” We are like any other medical specialty. We

have unique features and different treatments, but we should be held to the same standards as our other colleagues in medicine.

Reform will play out over the next several years, and we need to be in it for the long haul. We must be actively engaged in the implementation of reform. Mental health and substance use coverage and services are on the national agenda, so we must be ready for any opportunity to solidify our role in overall healthcare. Let’s embrace this challenge so that future generations of Americans will not view mental health and substance use disorders as separate from other medical disorders but as—in truth—no different from any other disorder.”

John Draper, PhD, Director, National Suicide Prevention Lifeline

“Reducing ‘avoidable inpatient readmissions’ is a major target of the healthcare legislation aimed at cutting costs. **The legislation seeks to foster incentives for hospitals and outpatient providers to collaborate toward closing aftercare gaps for discharged patients.** One primary cost-saving model that has been consistently promoted is “follow-up care,” which begins at the point of discharge or within 7 days after. Given that approximately 40 percent of annual hospitalizations for mental disorders in the United States are readmissions, and because research indicates that nearly half of the annual \$6 billion in hospital costs for treating suicide attempts relates to readmissions, the need for follow-up care

among discharged patients with mental health problems is clear.

Other evidence shows that follow-up care can not only save money but also save lives. Studies have indicated that the risk of suicide is more than 100 times greater for people in the first week after inpatient discharge than for the general population, and the vast majority of suicide attempters – the group with the highest risk of suicide – never attend their first appointment or maintain treatment for more than a few sessions. Follow-up care for attempt survivors, often provided by telephone, has been shown to reduce suicide rates, as noted in a 2008 study performed by the World Health Organization.

Although the Substance Abuse and Mental Health Services Administration has recently made follow-up care a priority (and funded pilot projects among Lifeline crisis centers to do so), follow-up care is not routinely practiced in most community behavioral healthcare systems. Whether through pilot programs funded by public health authorities or through interagency cooperative agreements, community mental health services – particularly those with crisis hotlines and mobile outreach services – will likely be accorded many more opportunities and financial incentives under healthcare reform to partner with hospitals and to provide follow-up care for discharged patients with mental illnesses.”

Daniel Fisher, MD, PhD, Executive Director, National Empowerment Center

“The biggest threat of healthcare reform to people with mental illness is the increased medicalization of the mental health field. During the last 20 years, consumers, families, and advocates have moved the mental health field toward a recovery- and wellness-based approach. This approach is focused on the importance of broadening funding to facilitate community integration, not just symptom reduction. The central principle is self-determination. This recovery approach was recommended by the New Freedom Commission Report. Furthermore, the report called for this transformation of the mental health system to be consumer and family driven.

At the individual level, the mental health field has started to embrace person-centered planning, which means that consumers drive their own treatment plan. Also, in the mental health field increasing value is being placed on people telling their stories of recovery and on peers working in the field. The field has also started to accept the validity of qualitative research in measuring outcomes.

Unfortunately, the medical field has not kept up with these developments. **Medicine, with a few exceptions, such as Dr. Ornish’s approach to heart disease, remains narrowly focused on symptom**

reduction and professionally directed care. Peers have a minor role in healthcare delivery, and research still insists that double-blind, randomized, controlled research is the most valued. Broad outcomes, such as recovery, wellness, and community integration, cannot be measured in that fashion.

My hope is that through the integration of medical and mental healthcare, the advances in consumer involvement in all levels of advocacy and service delivery will influence the medical system to adopt these values.”

Michael Fitzpatrick, MSW, Executive Director, National Alliance for Mental Illness

“The enactment of healthcare reform, coupled with the landmark Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, has great potential to very positively change the system of care for people living with mental illness in America.

Extending parity to all health plans offered through the new state-based exchanges, expanding Medicaid coverage to all people at 133 percent or less of the Federal Poverty Level, eliminating preexisting condition exclusions, and moving toward better integration of mental health and primary care are all tremendous steps forward. The real impact of these changes is yet

to be determined, however.

Consider, for example, the Medicaid expansion. Although the federal government will initially help subsidize the costs of expansion, states will increasingly incur costs over time. Will they respond by cutting vital but optional services in Medicaid? That would be a step in the wrong direction.

Moreover, other significant problems remain to be addressed. Examples include closing broad gaps between research and practice, improving data collection and outcomes measurement, and addressing the serious workforce shortages that continue to bevil the mental health field, perhaps even more than

other healthcare disciplines. In addition, the National Alliance for Mental Illness’s most recent Grading the States report revealed that progress in the adoption of evidence-based and promising practices is slow or even nonexistent in some states.

Much work needs to be done. **It is essential that advocates and the provider community work together to ensure that the exciting opportunities offered by healthcare reform become reality.** The power of our voices in advocating together for change cannot be underestimated.”

Robert Glover, PhD, Executive Director, National Association of State Mental Health Program Directors

“A great period of transformation for mental health and addiction treatment and prevention is now in motion, with the passage of health reform and the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Leaders in mental health and substance use fields must step up to the challenge and join the larger health community to enact the change that we need to succeed in reforming the healthcare system. Change within our separate silos or around the margins is unacceptable.

The framework that has been established in the new health reform law has huge implications for our field. As Congressman Patrick Kennedy (D-RI) says, the

health reform statute is, in fact, the biggest mental health law passed in history. With mental health and substance use benefits required in both public and private insurance plans, people with these disorders are now part of mainstream healthcare, with all of its glorious qualities and unacceptable shortcomings. **The foundation for a reformed system has been established, but all of the challenges to ensure access, reduce cost, and improve quality remain.** We must demonstrate our expertise in what works in behavioral health and make it integral to general healthcare, not an isolated “specialty” service accessed on an as-needed basis. We need to

build a skilled and adequate workforce that can join the integrated teams to deliver care in a retooled, primary-care-oriented system. We must ensure that behavioral health is included in all electronic medical and health records. And we need to be certain that the clients and families who depend on our systems also understand the changes underway. These are just a few of the many opportunities and challenges that lie ahead.

Although we may feel that we have earned a place at the table, we will not be heard unless our voices are clear, convincing, united — and loud when necessary.”

Carol D. Goodheart, EdD, President, American Psychological Association

“The Patient Protection and Affordable Care Act will extend health coverage to tens of millions of uninsured people, reduce healthcare costs, and end discriminatory insurance practices. As psychologists and community mental health and addictions providers, we know that mental and behavioral health are essential for overall health and that an integrated healthcare model that includes mental and behavioral health services will help to transform our nation’s healthcare system. **The new law offers promising opportunities for psychologists and community mental health and addictions orga-**

nizations to work together through integrated treatment models to address pressing health-care needs.

The new law authorizes, for example, a grant program to establish community-based, interdisciplinary health teams that include mental and behavioral health providers to support primary care practices and another program to colocate primary and specialty care in community-based mental health settings. Psychologists and other mental and behavioral health professionals on these teams may work with community-based mental health and

addictions providers to address the needs of the whole person. Additionally, a new state Medicaid option will allow for the creation of health homes, where psychologists and other community mental health and addictions providers will work together to address chronic conditions, including mental health and substance use disorders.

We must advocate for adequate federal appropriations for these and other integrated initiatives in the new law, if we are to provide better coordinated care for the people we serve.”

Pamela S. Hyde, JD, Administrator, Substance Abuse and Mental Health Services Administration

“The passage of the Patient Protection and Affordable Care Act represents a historic victory for American families, for seniors, for workers, and for small businesses. It holds insurance companies accountable for keeping premiums down and preventing denials of care and coverage, including for pre-existing conditions. As a result, an additional 32 million Americans will have health insurance coverage.

People with mental and substance use disorders will greatly benefit from the new health reform law. A disproportionate share of people with mental and substance use disorders are currently uninsured: an estimated one-fifth to one-third of the uninsured

population have mental and substance use disorders. First with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and now with the Affordable Care Act, we are finally in a real way moving toward equality in coverage and treatment for behavioral health conditions. In recognition that behavioral health is essential to overall health, the Affordable Care Act makes the prevention and treatment of mental and substance use disorders part of the essential benefits package, and no longer can insurance companies use substance abuse or mental illness to deny coverage for a preexisting condition.

Increased access to and demand for prevention, early intervention, treatment, and recovery support services provide an unprecedented opportunity and challenge for the behavioral health community. Although many of the provisions of the law do not go into effect until 2014, we must move quickly to develop capacity. Our success requires that we work in concert with, not independently of, the general healthcare system. By leveraging healthcare financing mechanisms and service delivery capacity, we can achieve the promise of prevention and treatment services

“People with mental and substance use disorders will greatly benefit from the new health reform law.”

SAMHSA Administrator Pamela Hyde

and supports that are high quality, based on modern standards, and recovery focused. To realize the potential of the new law, we need the infrastructure, including health information technology, to adapt to the new healthcare environment. Integration with primary care, new payers, billing rules, and different reimbursement strategies will require additional training, real-time information sharing, functional information systems, and accountability.

The Substance Abuse and Mental Health Services Administration is excited about the possibilities that the Affordable Care Act brings to individuals, families, communities, and providers. Our continued collaboration with the National Council for Community Behavioral Healthcare and other organizations is critical to ensuring the successful implementation of health reform and to reducing the impact of substance abuse and mental illness on America's communities.”

Ron Manderscheid, PhD, Executive Director, National Association of County Behavioral Health and Developmental Disability Directors and Johns Hopkins School of Public Health

“We embrace our future with great enthusiasm and some worry.

A century of dreams has been fulfilled through the passage of national health reform. Theodore Roosevelt fostered the vision, and Franklin Roosevelt expanded the ideal to good health as a basic human right. Lyndon Johnson delivered personal health insurance to the elderly and the poor, and Bill Clinton reinvigorated the vision. Now, after more than three score years, Barack Obama has taken a giant step toward fulfilling Franklin Roosevelt's ideal. In the short term, every American will be able to have coverage through personal health insurance, to have access to appropriate prevention and care, and to have confidence that care received is of high quality. Mental health and substance use care will become essential benefits. The changes being wrought are of historic dimensions. Each is clearly a cause for celebration!

Yet, we frequently worry when we experience the unknown, like a first date or a new job. National health reform is no different. But our worry should be a goad to action. We can prepare for this new unknown by becoming well informed; by engaging in careful, deliberate planning; and by reaching out and forming necessary new alliances. As with all changes of historic dimensions, we must leave some of the old behind, and we must embrace some of the new. Good preparation will do much to dissolve our worry.

You and I are no different. Like you, I have great enthusiasm and some worry. Now, I am preparing myself and NACBHDD for the changes that I know soon will arrive.

Tomorrow will be different than today. We can and will succeed!”

Harold A. Graham, MA, MA, QMRP, Chief Executive Officer and President, Graham Behavioral Services, Augusta, ME

“Where does it start? Services – whether social, mental health, or nursing – start with the persons implementing the ‘face-to-face’ and ‘hands-on’ contact with genuine compassion. Service is only as good as the ‘employee’ providing. Sure, insurance (not meaning assurance) has to accommodate for services for children and adults. However, how does healthcare reform ‘transform’ business to empower employees to enjoy what they do and assure quality? There are a number of business performance models that have validity. National healthcare reform must start with the individual elements that exemplify the extraordinary service that so many of us deliver. If the impetus of reform misses the individuality of people, then it will fail in bureaucracy and exhibited counter-intuitive behavior. It is management that is the key, a balance of support for employees, not necessarily in increased regulations.”

William Bieri, President & CEO, The Nord Center, Lorain, OH

“I am guarded in any sense of pure optimism about the recent healthcare reform legislation. My review of various trend data on broader economic fronts and then specifically community behavioral healthcare and state budgets signal continuing crisis in our field with a widening of the gap between evolving demand for our services and service capacity. More immediately, I see commercial insurance premiums to employers rising, aggressive reimbursement rate negotiations to reduce provider reimbursement, and probably aggressive management of specialists on provider panels if not a reduction in their representation. This will happen sooner than later as insurers hedge against uncertain claims payments with the inclusion of pre-existing conditions and continued management of sicker patients.

I wouldn't be surprised if we see mergers and acquisitions among commercial insurance companies with some in Washington becoming nervous about anti-trust/anti-monopoly issues creating an even more challenging business environment. The Kaiser Commission report on “Medicaid and the Uninsured” paints a cautious picture among state Medicaid executive directors and state budgets and the affordability of states to support increases in Medicaid covered lives and covered services. This will force states to make difficult decisions about services. We're already seeing this change with Arizona eliminating the state's CHIP Plan.

This healthcare reform will slow recovery from the recession and unemployment will remain uncomfortably high. Access to capital for community behavioral healthcare providers will be difficult and more providers will struggle financially for the next three to four years under the current trends and scenarios. I think we all understand that having health insurance is not the same as having access to healthcare services. As behavioral healthcare providers, we need to continue to assert responsible healthcare reform and reduce the historical marginalization of behavioral healthcare in national healthcare reform.”

Clarke Ross, DPA, CEO, Children and Adults With Attention-Deficit/Hyperactivity Disorder

“Children and Adults With Attention-Deficit/Hyperactivity Disorder fully supports enactment of the health reform law, although some of our members are very upset with the financing elements and federal-state government roles. On August 13, 2009, CHADD issued 13 principles to consider in health reform. The enacted health reform law makes significant progress with all 13 of these principles:

1. Provide healthcare coverage for all Americans: The Congressional Budget Office estimates that health reform will cover 32 million currently uninsured Americans by 2019 but 23 million Americans will remain uninsured at that time.

2. Require parity for mental health assessment and treatment, including prohibiting discrimination between health conditions: Health reform extends the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 protections to all health plans in the exchanges as well as all commercial plans currently covered.

3. Prohibit discrimination on the basis of preexisting conditions: Health reform requires that for plan years beginning 6 months from enactment or after, health plans may not discriminate on the basis of preexisting conditions for children. In 2014, all preexisting condition exclusions will be prohibited.

4. Prohibit health plans from terminating coverage when people become seriously ill or when they are treated for long-term, chronic conditions, and eliminate lifetime maximums: Rescissions (the practice of terminating health plan coverage) and lifetime

limits are prohibited, effective for plan years beginning 6 months from enactment or after.

5. Prohibit exorbitant out-of-pocket deductibles and copays: This goal is difficult to define and subject to lots of debate.

6. Allow young adults to stay covered on their parents' plan until 26 years old: Effective for plan years beginning six months from enactment or after, health reform requires insurers to allow young people to stay on their parents' policies through age 26.

7. Target specific coverage of young adults, particularly those with special healthcare needs: The health reform law does not specifically address this principle, but it provides for a new long-term care program, the Community Living Assistance Services and Supports Act, to be created by 2014.

8. Target specific coverage of children, particularly those with special healthcare needs: The health reform law does not specifically address this principle, although the CLASS Act might include provisions for children.

9. Require continued affordable coverage when people lose or change jobs: Health reform mandates guaranteed issue and renewal, effective 2014.

10. Include wellness and prevention services: Health reform creates a Prevention and Public Health Fund,

which will provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth of private and public-sector healthcare costs.

11. Promote integrated primary care with specialty services, including the “medical home” concept and consumer-oriented and meaningful use of electronic medical records and personal health records: Health reform creates state grants for community-based health teams to support implementation of patient-centered medical homes (i.e., healthcare homes) and allocates funds to state Medicaid programs to implement such medical homes.

12. Allow consumers a choice of health plans: Health reform establishes state-based health insurance exchanges for individuals and small businesses by 2014.

13. Include culturally and linguistically appropriate programs that affirmatively address racial and ethnic disparities, including the recognition of disability-based health disparities: Federally conducted and supported healthcare programs must collect data on race, ethnicity, sex, primary language, and disability status. Health plans and health providers are then required, albeit with federal financial assistance, to address these disparities.”

14. Include culturally and linguistically appropriate programs that affirmatively address racial and ethnic disparities, including the recognition of disability-based health disparities: Federally conducted and supported healthcare programs must collect data on race, ethnicity, sex, primary language, and disability status. Health plans and health providers are then required, albeit with federal financial assistance, to address these disparities.”

15. Include culturally and linguistically appropriate programs that affirmatively address racial and ethnic disparities, including the recognition of disability-based health disparities: Federally conducted and supported healthcare programs must collect data on race, ethnicity, sex, primary language, and disability status. Health plans and health providers are then required, albeit with federal financial assistance, to address these disparities.”

16. Include culturally and linguistically appropriate programs that affirmatively address racial and ethnic disparities, including the recognition of disability-based health disparities: Federally conducted and supported healthcare programs must collect data on race, ethnicity, sex, primary language, and disability status. Health plans and health providers are then required, albeit with federal financial assistance, to address these disparities.”

Becky Vaughn, CEO, State Associations of Addiction Services

“The passage of the Patient Protection and Affordable Care Act created an historic event after more than 17 years of effort to recognize addiction and other diseases of the brain as a chronic illness and deserving of services in line with other diseases of the body. SAAS applauds the work of President Obama and the Congress in persisting to create a system ensuring that virtually all Americans will have access to healthcare including essential benefits for substance use disorders and mental illness.

Just as impressive is the successful collaboration that created the advocacy to secure the inclusion of

these benefits. Under the leadership of The Legal Action Center, national groups from substance abuse prevention, addiction and mental health treatment, and recovery support services came together and focused on the essential legislative language. SAAS is proud to have participated in this epic process and of its state provider associations and their members for their efforts to educate their senators and house members on the importance of prevention and treatment benefits in any new healthcare design. We are particularly grateful to Carol McDaid with Capitol Decisions for her leadership and unending work to secure parity and healthcare reform.

The overwhelming work of implementation is moving at record speed requiring providers to quickly prepare for increased capacity with new business models and practices. Continued state and national advocacy in many arenas is required for meaningful input into future regulations, community education on the new rights and benefits, and monitoring for compliance. The exciting goal of serving thousands more individuals and families in need of services is about to take a giant step forward. This is awesome!”

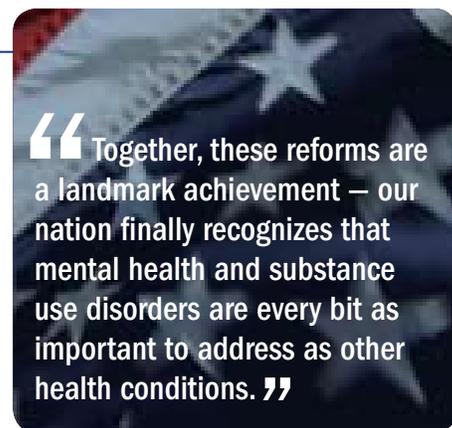
Paul N. Samuels, JD, Director and President, Legal Action Center

“The passage of healthcare reform is a tremendous victory for all who care about eradicating substance use disorders and mental illness. Effective and unified advocacy by our field, which built on the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, championed by Rep. Patrick Kennedy (D-RI) and Rep. Jim Ramstad (R-MN), forged strong, bipartisan support from Congress and President Obama for the full inclusion of mental health and addiction.

The new law includes many remarkably strong provisions to improve coverage of mental health and addiction care for the tens of millions of Americans who do not now receive it. The 29 million people who receive insurance through the exchanges and the 16 million

who are newly eligible for Medicaid will have coverage for mental health and addiction-related services, at parity with medical and surgical services. The law includes mental illness and substance use disorders in wellness and chronic disease prevention, workforce, medical home, and other initiatives. Together, these reforms are a landmark achievement – our nation finally recognizes that mental health and substance use disorders are every bit as important to address as other health conditions.

Even as we celebrate this enormous victory, we must prepare for the challenges ahead. The law provides the framework, but without strong regulations, we will not realize the full potential of reform for people with, in recovery from, or at risk of substance use disorders



and mental illness. We must advocate together for the strongest possible federal and state rules to implement the law's excellent provisions. Only then will it be possible for every American to lead a healthy life.”

Notes from Netherlands

Klaas Schilder, Director, GGzE, Eindhoven, the Netherlands

As the United States moves forward to implement healthcare reform, what should you expect in behavioral health? What barriers and dangers should you prepare for? One way of answering these questions is by looking at what has and has not worked in the Netherlands, a country with decades of experience in universal healthcare. What advice do the Dutch have for our counterparts in the United States?

Historically, the United States and the Netherlands have approached healthcare from starkly different philosophical positions. In the Netherlands, universal healthcare coverage has been a societal cornerstone for the past 60 years. The United States, of course, has largely seen healthcare as a commodity to be purchased, not a right for all. The systems in both countries are in a time of change, however. Whereas the United States is now set to accomplish a degree of universal healthcare, the Netherlands seeks to infuse competitive market principles into its healthcare system. Therefore, two systems that started from opposite poles are now moving toward each other.

The recent modifications in the Dutch system point to one sure consequence as the United States moves toward universal healthcare. The debate, analysis, and retooling of the system never end. Sometimes the discussion is about the types of services that need

to be covered, and other times it's about the role of each of the players involved (providers, governmental administrators, insurance companies, and patients). Often the question is the cost of services and who will pay for them. In fact, the issues that drove healthcare reform at the outset will still be debated years later. If you expect that implementation of the U.S. health reform bill will produce a more tranquil national conversation, you will be disappointed.

You will find that changing the healthcare system is not solely about adopting one fixed model or another. It is about providing quality care in a way that allows for innovation and efficiency. The system also has to respond to changes in a country's values and beliefs. For example, citizens in the Netherlands right now seem to want less government involvement in healthcare and larger roles for consumers and insurance companies. At the same time, citizens demand increased government regulation of salaries paid to executives and more oversight of large provider networks and mergers between providers and between insurance companies.

Another lesson we have learned is that dangers exist from tilting too far either in the direction of governmental control and insurance company mandates or in the direction of provider autonomy. In the Neth-

erlands, periods when we had too much government involvement led to a planned, Soviet-style healthcare system in which care in one part of the country could only be delivered if that same care (and same quality) was available to everyone in the country. The time it took to accomplish new care initiatives plus the rigidity in that system made for an overly bureaucratic and inefficient operation.

The bottom line is that delivering and establishing care on the basis of national consensus can take years and can stifle innovation or limit the hopes and dreams of consumers in behavioral health. **So even though consensus building around universal coverage might drive your agenda for health reform, be cognizant of the trap called consensus building when it comes to delivering services. Also, the system tends to fail when one player, be it government, consumer group, insurance company, or provider, achieves a dominant position.** So when the implementation of healthcare reform moves forward, understand the balance (of power) among all of the players involved. A healthy balance must be achieved, and that takes hard work and continuous effort.

State Views

State Mental Health and Addiction Services Leaders from three National Council Association Members Discuss the Impact of Federal Healthcare Reform



NEW YORK — CHILDREN

Andrea Smyth, Executive Director, New York State Coalition for Children's Mental Health Services

Youth hold so much promise, but with the complexities that come their way, today's children need tremendous resiliency, self-esteem, and assistance to navigate their way to adulthood. That is why the children's mental health advocates must act on the opportunities contained in the federal healthcare reform law.

The New York State Coalition for Children's Mental Health Services is serious about taking advantage of the opportunities presented by the delivery system redesign provisions that the Patient Protection and Affordable Care Act offers. Thankfully, we have a blueprint for establishing a "comprehensive, coordinated children's system" in the state based upon a 2006 legislative initiative, "The Children's Mental Health Act of 2006."

Subsequently, nine commissioners from child-serving state agencies signed off on the Children's Plan, a blueprint for how to improve the social and emotional development of children and their families regardless of where they might access services. The plan was built on the premise that the promotion and maintenance of mental health is a universal concern and directly linked to physical health.

Taken in conjunction with the provisions in PPACA that support system redesign, New York is well posi-

tioned to move forward on the goals of the New York State Children's Plan, including:

- >> Engaging children and their families in services early.
- >> Ensuring systems are collaborating to meet the service needs of children and families.
- >> Building upon the strengths and abilities of children and their families.

Initially the Coalition plans to strongly pursue expansion of home visiting programs in the state. With the addition of \$1.5 billion over five years through the Maternal and Child Health Block Grant (FFY 2010-14), this system redesign is supported as an evidence-base beyond question. Recently, a federally funded study that has been tracking more than 1,300 children since 1991, found that behavioral and academic problems among children who received low quality care during their first four and a half years of life persisted through their 15th birthday. We hope federal healthcare reform will be the catalyst for supporting children's behavioral health by ensuring strong child development skills are present in homes from birth.

Subsequently, the Coalition will continue its examination of the newly expanded ability to grow Home and Community Based Waiver, 1915 (i) programs,

that target beneficiaries by certain characteristics. In New York, we are already discussing the promise of a "Mega Waiver" for children's ambulatory mental health services and now federal healthcare reform encourages the expansion of waiver services.

Next, the law provides \$75 million between 2010-2014 for personal responsibility education programs, to support adolescent development among at-risk populations and persons ages 10-20. Our hope is to target 16 to 20 year old youth who do not fit neatly into either the children's mental health, foster care, nor the adult mental health or public assistance systems of care. Seeking funding for services for this transitional age population has been a priority of the Coalition's for over five years.

Healthcare reform legislation includes authorizing language for the SAMHSA Primary Care-Behavioral Health Co-Location Grant Program and expands appropriations from \$14 million to \$50 million for the program. The Coalition believes that to meet the collaboration of services goal set forth in the New York State Children's Plan, we have to stop talking about the barriers to co-location and integrate service delivery to ease the demands on already stressed families.

According to Courtney Burke of the Rockefeller Institute in Albany, NY, "Successful implementation of any national reform depends heavily on state choices and management." We already have a very narrow directive from the Children's Plan, "Make certain that every children's service opportunity is grounded in support for each child's emotional and physical development." Now we also have a blossoming garden of opportunities in the federal healthcare reform package to support that directive. We can envision children realizing their full potential.

We hope federal healthcare reform will be the catalyst for supporting children's behavioral health by ensuring strong child development skills are present in homes from birth.



CALIFORNIA

Rusty Selix, Executive Director, California Council of Community Mental Health Agencies

The first step in responding to the new healthcare reform is appreciating the enormity of this change and the opportunities it will present starting in January 2014. Understanding those opportunities is difficult for agencies that are focused on a struggle for survival. When I started explaining what can be achieved in a few years, the first response of our executive directors was along the lines of “That’s nice, but I don’t know if we will still be in business, unless something happens soon to reverse the cuts we are now experiencing.”

Accordingly, behavioral healthcare providers’ first priority is to stabilize what we now have and to view the increased coverage and funding under federal healthcare reform — especially the Medicaid expansion — as a way to justify expanded funding between now and then.

The California Council of Community Mental Health Agencies is working with the state on a Medicaid 1115 Waiver that will include expansion of so-called coverage initiatives, which allow the state to access federal matching funds for indigent adults who are not eligible for Medicaid but who use hospital services in disproportionate share and increase the costs for those hospitals. Many people with severe mental illnesses are in that category, and we are working to include them. This waiver will also include mental health, substance abuse, and physical health integration pilot projects, which we hope will provide increased funding.

We are concerned about the disparity between full coverage for indigent adults and the continued state share of costs for people with disabilities who are already eligible for Medicaid. We are cautious about counting on private insurers to assume much of the responsibility, and we must determine what our funding needs will be in 2014 for the services and populations not covered by Medicaid or private insurance.

Beyond these short-term objectives we see enormous potential.

With healthcare reform, we may eventually achieve the goals of our ballot measure and generally provide just about everyone with the right services at the right place and the right time. We especially see opportunities for people to be discharged from jails and prisons and to broaden criminal justice diversion programs.

We also see challenges, however. We are concerned about the disparity between full coverage for indigent adults and the continued state share of costs for people with disabilities who are already eligible for Medicaid. We are cautious about counting on private insurers to assume much of the responsibility, and we must determine what our funding needs will be in 2014 for the services and populations not covered by Medicaid or private insurance.

Our big focus will be on seeing how we can use other savings for the state to solidify our funding. We already know that California counties will realize enormous savings in expenditures for physical healthcare to indigent people. Although mental healthcare will also see savings, the structure of mental health funding that existed before our Proposition 63 ballot measure and tax in 2004 has shrunk in value to about half of what it was when we wrote the initiative in 2003. As astounding as that seems, the \$800 million we get from this measure to provide community mental healthcare to adults with severe mental illness is about all we have, given the demands for other services from the preexisting funds that have declined.

When we wrote the measure in 2003, we thought we could serve about half of the people who need care, and now we are serving only about a quarter. We believe that we need that funding restructured to at least keep pace with inflation and also to repay the mental health system for funds diverted to balance state budgets the last few years. We see the new savings for physical healthcare as a one-time opportunity to solve this problem.



NEW JERSEY

Debra L. Wentz, PhD, Chief Executive Officer, New Jersey Association of Mental Health and Addiction Agencies

NJAMHAA has high hopes and concerns regarding healthcare reform. Clearly, there is great hope that with improved access to insurance, the millions of New Jersey residents with mental illnesses, behavioral and addiction disorders — and the accompanying physical conditions — will seek out and obtain the treatment they need. By also prohibiting the denial of insurance for pre-existing conditions, the reform tackles a critical issue for those with chronic psychiatric disorders. As employers, NJAMHAA’s members warily hope that reform will slow the astronomical increases they face in health insurance premiums.

However, a major concern is the potential cost. Will payments to healthcare providers be sufficient to ensure access or will this exacerbate the current situation whereby extremely low Medicaid rates limit the number of participating providers and force long waits for treatment? Another concern is that the true cost will not go down for small businesses or the middle class, which would take on most of the burden of funding reform.

We welcome the focus on integrated physical and behavioral healthcare, but believe mental healthcare facilities should be able to serve as medical homes, enabling consumers to access preventive primary care services in a familiar setting.

In preparation for reform, NJAMHAA is continuing to advocate for increased Medicaid rates to ensure adequate access to services.

Additionally, NJAMHAA is educating members and examining critical issues. For example, we recently proposed to the state a pilot model for integrating physical and mental healthcare services. We also plan to do presentations on the impact on providers as small businesses.

Finishing the Unfinished Business of Healthcare Reform

Charles Ingoglia, MSW, Vice President, Public Policy, National Council for Community Behavioral Healthcare

As described throughout this issue of the National Council Magazine and in the National Council's 2009 Annual Report, the healthcare reform process has resulted in many significant victories for the behavioral healthcare sector. Indeed, our long-desired goal has been achieved – behavioral healthcare is seen by policy makers as fundamental to overall health and wellness.

We find evidence of this achievement throughout the healthcare reform law – mental health and substance use services must be provided by all plans that participate in the new exchanges, and these benefits must be offered at parity. Healthcare home and Accountable Care Organization pilots must address substance use and mental health disorders. Additionally, the law includes a number of provisions specific to mental health and sub-

stance use, including authorization for new grants to colocate services as well as new workforce development grants.

Even with all the progress we have made, many areas of policy and payment need to be improved for the behavioral health sector to fulfill its intended role in a reformed healthcare system. The National Council is committed to advancing the following issues:

» **Extension of the temporary Federal Medicaid Assistance Percentage increase.** As part of the American Recovery and Reinvestment Act, Congress provided a temporary increase to the Federal Medicaid Assistance Percentage to help cash-strapped states meet their Medicaid obligations. As of this writing, Congress is expected to vote on a 6-month extension of this important provision, extending federal assistance until June 2010. This action is critical, and given the combination of state revenue projections and Medicaid growth, Congress may need to provide additional relief to states beyond June 2010.

» **Federal policy and payment equity for behavioral health organizations.** In recognition of the healthcare access and use challenges confronting communities that are low income or have high rates of illness and few medical providers, Congress has enacted a number of policy and payment preferences for “safety net” providers, including enhanced reimbursement under Medicaid, federal funding to provide care to uninsured people, loan guarantees, and access to federally subsidized malpractice insurance. Unfortunately, the safety net does not offer equity. To correct this situation, the National Council, working with other national organizations, is advancing the notion of Federally Qualified Behavioral Health Centers. This effort includes establishing national treatment and reporting standards for organizations that choose to obtain this designation as well as a proposed reimbursement model that more accurately reflects the costs of providing services.

“Unfortunately, the safety net does not offer equity. To correct this situation, the National Council is advancing the notion of Federally Qualified Behavioral Health Centers to establish national treatment and reporting standards and a proposed reimbursement model that more accurately reflects the costs of providing services.”



>> **Health information technology funding fix.** For healthcare reform to be successful, all medical providers need to share information to better coordinate care, reduce inefficiencies, and improve client outcomes. Behavioral healthcare providers need access to federal funding for the meaningful use of health information technology. The National Council has been working with Rep. Patrick Kennedy (D-RI) and others for the introduction of HR 5040, the Health Information Technology Extension for Behavioral Health Services Act of 2010, which would extend Medicare and Medicaid facility payments to community mental health and addiction organizations as well as private and public psychiatric hospitals.

>> **Medicare parity implementation.** In June 2008, Congress enacted payment parity in Medicare's Part B benefit, which will provide copayment equity for mental health and addiction services. Although this is an important step, much more needs to be done in Medicare for there to be true parity. First, the types of outpatient mental health interventions paid for by Medicare need to be extended to include, for example, case management, psychiatric rehabilitation, and other intensive community-based interventions. Medicare also must recognize mental health counselors and marriage and family therapists as independent practitioners.

You can be assured that the National Council will devote its resources and creativity to the accomplishment of these goals. Our success requires the active involvement of all of our members in the public policy process.

Concern is widespread across the country about the size of the federal deficit, and the administration and Congress are responding with proposed discretionary spending caps, the imposition of "pay as you go" policies, creation of a Federal Debt Commission, and other mechanisms meant to reduce federal spending. This combination of events will make passage of large or expensive pieces of legislation very difficult in the years to come.

Your relationships with members of Congress will be key going forward – only you can educate your representatives about how proposed policies or programs will benefit your community, which they need to know to make informed decisions.

The policy successes of the last few years would not have been possible without your active involvement. Passage of healthcare reform is only the first of many steps necessary to improve the lives of people with addiction disorders and mental illness. We look forward to your active involvement in the years to come as we work to bring our unfinished business to completion.

To learn more about the National Council's policy agenda, go to www.thenationalcouncil.org/cs/our_legislative_initiatives

Charles Ingoglia is vice president of public policy for the National Council for Community Behavioral Healthcare. He directs the federal affairs function of the National Council and oversees policy and advocacy outreach to more than 1,700 member organizations across the nation. He also serves as adjunct faculty at the George Washington University Graduate School of Political Management. Prior to joining the National Council, Ingoglia provided policy and program design guidance, including the review of state Medicaid waiver applications and other health and human services regulations, to the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration.

Do you need capital to buy, build or renovate a facility, update your IT systems, or refinance existing debt?

CHFF CAN HELP!

We are a non-profit loan fund that provides capital to non-profit behavioral healthcare organizations nationwide.

- ❑ Aggressive interest rates
- ❑ Flexible terms and structures
- ❑ Gap and subordinate financing
 - ❑ Loans from \$150,000
- ❑ Participation with other lenders
- ❑ Strategic financial planning services

The Community Health Facilities Fund is pleased to have provided financial advisory services and/or direct loans to the following organizations in 2009:

Ability Beyond Disability
Bethel, CT

Alternatives Unlimited
Whitinsville, MA

Cache Employment and Training Center
Logan, UT

Community Housing Associates
Baltimore, MD



For more information contact,
Chris Conley | **Dean Adams**
 203-273-4200 | 812-273-5198
cconley@chffloan.org | dadams@chffloan.org

www.chffloan.org ♦ info@chffloan.org

Community Health Facilities Fund
 6 Landmark Square, 4th Floor, Stamford, CT 06901

Substance Abuse Treatment — Can Reform Close the Gap?

Robert Morrison, Executive Director; Kara Mandell, Senior Research Analyst; and Rick Harwood, Director of Research and Program Applications — National Association of State Alcohol and Drug Abuse Directors

In Maine, Massachusetts, and Vermont, the public treatment systems served many more patients as a result of the expansions in health insurance coverage realized through comprehensive healthcare reform. If the experiences of these three states hold, the public substance abuse treatment system will undergo a major transformation in the next several years as federal healthcare reform is implemented across the country. And we have much to learn from the experiences of these states.

Staff of the National Association of State Alcohol and Drug Abuse Directors, with support from the Substance Abuse and Mental Health Services Administration, conducted case studies to understand how the recent federal legislation might affect the field.

The most important finding from these studies is that each state was able to increase access to substance abuse treatment through its public system. In Maine, the number of clients admitted to publicly funded substance abuse treatment providers increased by 45% between 1999 and 2008. In Massachusetts, admissions to public substance abuse treatment rose nearly 20% in only 2 years, between 2006 and 2008. Vermont saw the number of people treated in its public substance abuse treatment system double between 1998 and 2007. To achieve these increases, states used a combination of Medicaid expansions (particularly the coverage of non-disabled childless adults ages 21 to 64); increases in the Social Security Administration's budget from state general appropriations; process improvement initiatives; and the creation of publicly subsidized private insurance plans.

A variety of funding sources helped pay for healthcare reform, including state general appropriations, increased tobacco and liquor taxes, federal matching funds from Medicaid, "fair share" employer contributions, and individual insurance premiums (from mandated policies in Massachusetts as well as graduated premiums from "lower" income subsidized policies).

Public substance use treatment providers in Maine, Massachusetts, and Vermont still have more treatment requests from uninsured patients than they have funding for, even as the proportion of state residents who are insured rises. Other challenges have included enforcing parity laws, addressing workforce shortages, and adapting to changing business practices

In each of these states, healthcare reform has realized some cost savings through a decrease in use of emergency services and a reduction in uncompensated costs for care of the uninsured. Medicaid administrative services organizations have reduced the costs of substance abuse treatment by decreasing the lengths of stay in residential treatment in Massachusetts and Maine, although the impact of administrative services organizations on the quality and outcomes of treatment is not known.

The Substance Abuse Prevention and Treatment Block Grant, state general appropriations, and the Social Security Administration continue to play important roles in ensuring that uninsured people with substance use disorders have access to high-quality services, particularly prevention services and "non-medical" services.

Even after implementation of healthcare reform in the three New England states, the field faces continuing challenges. Public substance use treatment providers still have more treatment requests from uninsured patients than they have funding for, even as the proportion of state residents who are insured rises. Other challenges have included enforcing parity laws, addressing workforce shortages, and adapting to changing business practices (e.g., increased Medicaid and insurance reimbursement of care in the public provider system).

Despite expansions in coverage, there continues to be a need for free and subsidized care in Maine, Massachusetts, and Vermont. Although the uninsured rate in Massachusetts was estimated to be only 2.6% of the population in 2009, more than 20% of clients admitted to substance abuse

Components of healthcare reform in MA, ME, and VT

- >> Maintenance of private and employer insurance as the core.
- >> Subsidized, basic health insurance plan for low-income residents, and coverage of substance abuse services.
- >> Expansion of the substance abuse services covered by Medicaid, and coverage of low-income childless adults.
- >> Integration of primary care, chronic care, and prevention.
- >> Treatment process improvement initiatives.
- >> Substance abuse treatment workforce training initiatives.
- >> Implementation of managed care for Medicaid.
- >> Passage of parity legislation and mandates for both substance abuse and mental health.
- >> Performance contracting and pay for performance.



treatment facilities in that year were not enrolled in a health insurance program. In 2007, 10% of Maine residents were uninsured, but more than 31% of clients admitted to public substance abuse treatment facilities had no insurance. Serving the remaining uninsured population continues to be the central role of the publicly funded substance abuse treatment systems and of the Social Security Administration.

All three of these states have enacted laws that mandate private insurance coverage for substance abuse and mental health services, as well as parity laws. Simply enacting mandates and parity laws has not been a panacea, however. Even when insurers comply with parity regulations, copays and deductibles can restrict access to substance use disorder services, particularly for very low-income beneficiaries.

In all three states, treatment providers perceive that private insurance plans have been slow to fully implement parity in coverage for substance abuse and mental health services. Moreover, insurance plans generally do not reimburse providers for the full continuum of care: Residential treatment and social model detoxification are often not covered by private plans, Medicaid, or Medicare, and the burden to fund these services falls on the Social Security Administration. Deciding which services to cover with limited safety net funds is a major challenge to the Social Security Administrations in Maine, Massachusetts, and Vermont.

Moreover, the Social Security Administrations and public substance abuse treatment providers relate that even when subsidized or free plans are provided to the low-income population, people with substance use disorders often remain uninsured. This may be because getting enrolled in and maintaining eligibility requires effort and follow-through, which people with substance use and mental disorders are often unable to do.

In Vermont and rural Maine, providers have continuing difficulty recruiting substance abuse treatment professionals with credentials and certifications that match insurance companies' requirements for reimbursement. As substance abuse treatment is integrated with primary healthcare, recruiting doctors and nurses with appropriate experience and skill in treatment of substance use disorders is also a challenge.

Community-based treatment providers also face new challenges in working with private insurance and Medicaid plans – particularly managed care plans.

The Vital Role of the Substance Abuse Prevention and Treatment Block Grant

Although Maine, Massachusetts, and Vermont each undertook major healthcare reform initiatives to expand both private insurance and Medicaid coverage, there continue to be vital roles for the Social Security Administration and block grant dollars. These states use their block grant funds to

- >> Pay for medically necessary services that are not covered by other payers, particularly residential treatment.
- >> Pay for “nonmedical” services not covered by public or private health insurers, including case management, other recovery support services, housing, child care, transportation, and employment counseling.
- >> Negotiate relationships with other systems, particularly the criminal justice system and the welfare system.
- >> Address new challenges.
- >> Implement innovative services, including medication-assisted therapies.
- >> Fund substance abuse prevention services.

Many insurance plans have networks of preferred providers, which providers need to become qualified to join – often a time-consuming and complex process. In addition, billing practices are different across insurers, so provider staff must spend time learning about the requirements of each insurer to ensure that the proper procedures are followed. The resulting administrative costs represent a significant increase in provider costs. Working with these new partners requires a change in business practices.

Finally, insurance plans generally do not reimburse the costs incurred in helping patients access and interact with other critical, nonmedical services and systems in the state (e.g., the criminal justice, welfare, child and family services, and housing systems).

Massachusetts, Vermont, and Maine each offer valuable lessons about what healthcare reform will bring to public treatment systems. From these case studies, it is clear that public substance abuse treatment providers continue to treat large numbers of uninsured clients, even as the proportion of state residents who are insured rises. Parity legislation and mandates do not guarantee that all needed substance abuse and mental health services will be covered by private health insurance companies. In Massachusetts, providers and Social Security Administration staff have related that even when substance use disorder services are covered, the out-of-pocket costs (copays and deductibles) can be prohibitive.

Even after healthcare reform, there will continue to be vital roles for the Social Security Administration and a

need for Substance Abuse Prevention and Treatment Block Grant dollars.

To learn more about the effects of healthcare reform on the specialty substance abuse treatment system in Maine, Massachusetts, and Vermont or to read the entire study, please visit the National Association of State Alcohol and Drug Abuse Directors' website at www.nasadad.org.

Robert Morrison returned to NASADAD in 2001 as director of public policy, after serving as the organization's public policy associate from 1997 to 1999. In the interim, he was associate director of government relations at Smith, Bucklin and Associates, where he directed government affairs programs for a variety of healthcare clients, including the American Psychiatric Nurses Association. He was appointed deputy executive director of NASADAD in December 2006, chosen to serve as interim executive director in December 2008, and selected as executive director in December 2009.

Kara Mandell is a senior research analyst and Women's Services Network liaison at the National Association of State Alcohol and Drug Abuse Directors, Inc., where she has written reports about the effects of healthcare reform on the specialty substance abuse treatment system in Maine, Massachusetts, and Vermont; the substance abuse service needs of returning veterans; and the integration of tobacco cessation services into addiction treatment services.

Rick Harwood has served as the director of research and program applications at NASADAD since July 2008. He has more than 30 years of experience examining the economic costs of health disorders and doing economic analysis of the effectiveness and financing of healthcare, with a concentration in behavioral health. Harwood has provided consultation and expert advice to the Center on Mental Health Services, the National Institute on Mental Health, the Center on Substance Abuse Treatment, the Center on Substance Abuse Prevention, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the General Accounting Office of U.S. Congress, and staff of the U.S. Congress.



Advocacy Works! Parity Tills the Soil for Healthcare Reform Harvest

Carol McDaid, Principal, Capitol Decisions, Inc.

The first mental health parity bill was introduced in Congress in 1992. A limited – but groundbreaking for its time – mental health parity law was enacted in 1996. For the next decade, the National Council for Community Behavioral Healthcare and its allies advocated for passage of a more comprehensive mental health and addiction parity bill that would prohibit financial and treatment limitations on mental health and substance use disorder benefits that were not imposed on medical and surgical benefits.

The political timing was finally right in 2007, which marked the beginning of a 3-year period when the National Council and a coalition of its allies in Washington successfully implemented parity and healthcare reform key parts of the mental health and substance use disorder advocacy agenda. Parity came first. Although House and Senate champions took slightly different approaches in drafting their versions of parity legislation, the National Council worked with both sides until a compromise version was passed by both chambers and signed into law in October 2008 as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.

By the time parity became law, mental health and substance use services advocates had made personal visits, in Washington and back home, to the offices of all 535 representatives in the House and Senate, along with call-in days, letters, lobby days,

walks and rallies in communities, editorials, blogs, newscasts, and advertisements.

ELEMENTS OF SUCCESS

The mental health and addiction advocacy communities unified meaningfully for the first time for the parity effort. United, we succeeded in a way we had not before. Consumers got involved in unprecedented numbers. Success bred a thousand fathers, and everyone wanted to capture the glory of the win once they could feel momentum toward passage of parity.

After the enactment of MHPAEA, the National Council and about a dozen other groups hosted a celebration honoring our Capitol Hill champions, thanking them for their efforts, and allowing all of our hard-working advocates to savor their success. It was an important moment for our field, but at the event, I was already booking a time to discuss the parity implementation strategy with the National Council's lobbyist Al Guida, president of Guide Consulting Services. There was no time to waste, and we knew it.

PARITY IMPLEMENTATION COALITION

Passing a law is only part of the hard work of accomplishing things in Washington. Regulations to implement the law are where the rubber meets the road. Al was intimately involved in the regulatory process for the 1996 Mental Health Parity Act, whereas I was not. I knew that process had been controversial

and expected the present effort to be even more so. I also sensed that our field had “parity fatigue” right when we needed to gear up for a substantial regulatory battle. Al and I sketched out the plan we needed a joint coalition of mental health and addiction consumer and provider organizations that would advocate for regulations that reflected congressional intent. We would enlist congressional champions as needed and engage a law firm to first clarify what congressional intent was and make sure we were on a solid legal footing. We agreed to talk to respective organizations to garner interest. We wrote out lists; we were off and running.

We executed the plan in 2009. The National Council was one of 10 organizations that joined the Parity Implementation Coalition. The Coalition retained Patton Boggs, a well-known law and lobbying firm in Washington, DC, to clarify congressional intent of the regulations. We also engaged Milliman, an actuarial and benefit firm, to analyze reimbursement patterns of our field versus medical and surgical providers. The Coalition used these analyses to educate influential people on Capitol Hill and as a basis for filing a response to the Request for Information in May 2009 with the Departments of Labor, Health and Human Services, and Treasury.

SIMULTANEOUS ADVOCACY CAMPAIGNS

We did not have the luxury of working on parity implementation alone in 2009. Major healthcare re-



form legislation was being considered simultaneously. Many of the congressional champions we sought to engage were totally engrossed in the healthcare debate. We found ourselves embroiled in both advocacy efforts at the same time. Suffice it to say that the hours were very long, but we were surrounded by scores of people in DC who were also working night and day.

As a result of all the work we did on parity, Capitol Hill showed amazing support for our healthcare reform agenda's inclusion of mental health and substance use disorders in the essential benefit package and its application of parity to the small-group and individual plans. This was an entirely different experience than the cold shoulders we got during the 1993-1994 healthcare reform effort.

The National Council was instrumental in advocating with Sen. Stabenow's (D-MI) office to get parity included in the Senate bill as a requirement for all plans sold in the exchanges; this was a huge win for our field. It complemented the victory we had achieved in MHPAEA, given that small-group and individual plans were exempt from that law. We achieved many other gains in the healthcare reform law, too, including but not limited to expansion of Medicaid to 133 percent of the Federal Poverty Level, inclusion of behavioral health organizations and people with mental illnesses in the new Medicaid medical home state option, and authorization of and increased funding for the Substance Abuse and Mental Health Services Administration grants to colocate mental health treatment and primary care.

NEED FOR ADVOCACY CAPACITY

By the beginning of 2010, the combination of the ongoing healthcare reform and parity efforts began to underscore the limited advocacy capacity in our field. During the healthcare reform debate and parity implementation, with five congressional healthcare committees and three federal agencies to cover, it became obvious that our field has more congressional offices and agency staff to call on than we have trained advocates. Burnout is a real issue. Assumptions that a few of the larger organizations will do all of the advocacy work are an even bigger problem.

This problem will only accelerate as the healthcare reform implementation effort moves forward; this undertaking will require a sustained advocacy effort for a minimum of 5 years. Field leaders need to view this

As a result of all the work we did on parity, Capitol Hill showed amazing support for our healthcare reform agenda's inclusion of mental health and substance use disorders in the essential benefit package... As healthcare reform implementation moves forward, we will need a sustained advocacy effort for a minimum of 5 years. Field leaders need to view this as a strategic capacity issue, just as they see workforce and funding shortfalls, or we will not be able to sustain the significant gains we have made.

as a strategic capacity issue, just as they see workforce and funding shortfalls, or we will not be able to sustain the significant gains we have made. The work requires the voices of many, not just a few.

INTERIM FINAL REGULATIONS IN FEB. 2010

The Departments of Labor, Health and Human Services, and Treasury issued their long-awaited MHPAEA Interim Final Regulations in February 2010. It was clear that the regulators took to heart many of the key concepts in the Coalition's Request for Information comments, including the assertion that the regulations needed to include the following provisions, among others:

- >> Parity in medical management, including in provider reimbursement rates.
- >> Parity in reimbursement rates.
- >> One combined medical and MH/SUD deductible, not "separate but equal" mental health and medical deductibles.

On April 30, the Coalition submitted regulatory comments on the Interim Final Regulations to the appropriate departments. The comments are posted at www.thenationalcouncil.org/cs/public_policy/resources_and_issues/parity#implementation.

The next phase of our work includes providing templates to assist Coalition members in filing appeals for denied claims.

The Coalition's 2010 plan calls for us to supply detailed regulatory comments in May 2010 and provide templates and tactics on six of the most commonly denied claims to help Coalition members effectively appeal these denials. We must also continue work with our congressional champions and keep Coalition members informed of the latest regulatory develop-

ments. The Coalition will work with agency officials on enforcement activities and keep them abreast of plans that are not in compliance. The National Council is interested in hearing from members who experience problems with MHPAEA compliance. If you believe a plan is not compliant, please visit the parity page of our website under Policy Issues and Resources at www.TheNationalCouncil.org to file an official complaint with the federal government and share your concerns with us.

Most recently, the Coalition has been monitoring the action in a recent lawsuit: *the Coalition for Parity, Inc. v. the Department of Health and Human Services et al.* Three behavioral managed care companies sued the federal agencies responsible for implementing parity in an effort to delay or stop MHPAEA's implementation. The Coalition is closely following the activity in this case and will keep National Council members apprised of developments. Efforts to achieve a temporary restraining order failed; the Coalition for Parity, Inc., has to file a response to the government's brief responding to the motion for summary judgment by May 7, and a ruling from the judge will follow shortly after that filing.

Please keep us abreast of how you see parity being implemented in your community so we can make the most of our hard-won effort.

Carol McDaid is a co-founder and Principal of Capitol Decisions Inc., which has a special focus of national alcohol and drug treatment policy. With nearly 25 years of federal legislative, McDaid provides her clients with legislative and public affairs consulting on issues that span the breadth of healthcare, including Medicare, Medicaid, private sector reimbursement issues, and comparative effectiveness research. For more than 15 years, she has worked with leading non-profit drug and alcohol treatment centers, addiction physicians, and other prevention and consumer organizations to refine public policy addressing alcohol and other drug addictions.

The Parity In Healthcare Reform

Pamela Greenberg, MPP, President and CEO, Association for Behavioral Health and Wellness

On October 3, 2008, President Bush signed the Emergency Economic Stabilization Act of 2008, which included the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. After more than 12 years of lobbying for a broader parity law, passage of MHPAEA was a huge success for the addiction and mental health field.

The parity law applies to employers with more than 50 employees, Medicaid managed care plans, state children's health insurance programs, and nonfederal governmental plans. Employers with more than 50 employees who offer insurance coverage for mental health and addiction are now required by law to provide that coverage on par with medical and surgical coverage. In particular, the law mandates that any financial requirements (e.g., copayments,

deductibles, coinsurance) be the same for behavioral and medical-surgical healthcare. In addition, the law requires parity in treatment limitations (e.g., day and visit limits). Parity, as defined by the law, is "no more restrictive than the predominant financial or treatment limitation applied to substantially all medical and surgical benefits." The law also requires employers to include an out-of-network benefit for behavioral healthcare if one is included for medical and surgical care. Stronger state laws are not preempted by MHPAEA.

MHPAEA went in to effect for plan years beginning October 3, 2009, or soon thereafter. The Interim Final Rules that gave guidance on how to implement MHPAEA were issued on February 2, 2010, and take effect for plan years beginning July 1, 2010, or later. Interim Final Rules are intended to give further di-

rection on how the intent of the law should be implemented. The parity rules articulate a new category in which parity should apply: nonquantitative treatment limitations. A few examples of NQTLs are the management of the benefit, formulary design, and standards for provider admission to participate in networks. According to the Interim Final Rules, these standards or processes must be applied no more stringently than they are to medical and surgical benefits. Additionally, the rules establish six classifications of benefits (inpatient in network, inpatient out of network, outpatient in network, outpatient out of network, emergency care, and prescription drugs). If care is provided in one of these classifications for mental health and addiction and is provided in all or additional classifications for medical and surgical care, then the mental health and addiction benefits must also be provided for in those classifications offered to medical and surgical care.

Members of the insurance industry, the business community, and managed behavioral healthcare organizations believe that the Interim Final Rules issued by the Departments of Labor, Health and Human Services, and Treasury go beyond the intent of the law and are currently seeking changes to the rules.

Less than 6 months after passage of MHPAEA, President Obama signed into law comprehensive health reform – the Patient Protection and Affordable Care Act. This legislation, like MHPAEA, took more than 12 years to become law. The law addresses issues related to coverage, healthcare costs, and the healthcare delivery system. As it pertains to parity, the law continues the MHPAEA provisions mentioned above and extends them to people who obtain health insurance coverage through health insurance exchanges. Healthcare reform created state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges through which individuals and small businesses with up to 100 employees can purchase qualified coverage. These exchanges must offer "essential health benefits" that include coverage for mental health and addiction; the MHPAEA provisions apply to that coverage.

An immense amount of change has occurred in the area of mental health and addiction benefits over a short period of time. The full impact of parity is unknown, and additional uncertainty will be added over the next several years as the healthcare reform provisions are incorporated into the mix.





An immense amount of change has occurred in the area of mental health and addiction benefits over a short period of time. The full impact of parity is unknown, and additional uncertainty will be added over the next several years as the healthcare reform provisions are incorporated into the mix.

As implementation of parity and healthcare reform gets underway, a few facts remain unknown. For the most part, we know what the parity law and rules require, although there are still gray areas in the interpretation of the rule, and more guidance is needed. We know that healthcare reform, among other things, expands the parity law to people covered by a health insurance exchange and significantly increases the number of people who will be eligible for Medicaid. This expansion will most likely mean more Medicaid recipients covered by Medicaid managed care plans and therefore parity for more people. We also know that healthcare reform creates an essential benefits package that will include some level of services for

mental health and addiction; the exact benefit has not yet been determined. The healthcare reform law includes a prohibition on annual and lifetime limits on the dollar value of coverage, which presumably nullifies the need for the Mental Health Parity Act of 1996 (which requires parity for annual and lifetime limits).

At this point, it is fair to say that we have more questions than answers. We don't know how benefit packages will change as a result of healthcare reform or parity. Will more or fewer services be covered? Will cost sharing change? What impact will reform and parity have on premiums? How will purchasers react? Will states be able to afford the richer benefit package? Will consumers be positively or negatively affected by having a single deductible? Will more people seek or receive services? Do we have the workforce needed to handle these new laws? This is just a sampling of the questions that only time and experience will be able to answer.

Over the next several years, it will be critical to monitor how both parity and healthcare reform play out for the addiction and mental health benefit. After 12 years or more of lobbying for both parity and healthcare reform, it seems like the work may be completed, but in reality it has just begun. Ensuring proper interpretation and implementation of these laws and monitoring their impact may take the next 12 years.

Pamela Greenberg is the president and chief executive officer of the Association for Behavioral Health and Wellness. ABHW members provide an array of services related to mental health, substance use, employee assistance, disease management, and other health and wellness programs to more than 147 million people in both the public and the private sectors. Pamela is president of the American College of Mental Health Administration. She was the chair of the Coalition for Fairness in Mental Illness Coverage, one of the leading coalitions that helped develop, advocate for, and pass the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Prior to joining ABHW, Pamela was the deputy director of federal affairs for America's Health Insurance Plans.

“Rose Hill is real proof of how much people with mental illness can accomplish if they are given a chance.”

Dan & Rosemary Kelly, Founders

Our Focus is Recovery

Continuum of Care

We offer a full continuum of programs to support the needs of each patient. Within our Residential, Transitional, and Community Support Programs, patients gain insights, learn to manage medications, and develop coping skills to regain and maintain psychiatric stability.

Dedicated, expert staff

Teams of dedicated professionals are the heart of Rose Hill Center, working together with one goal in mind – helping each patient achieve his or her highest level of independence.

Individualized treatment plans

Carefully developed Individual Treatment Plans allow patients to move at their own pace toward greater independence and recovery.

Medication management

Patients learn the importance of taking medication. In our residential setting we can focus the time and attention on finding the most effective medication and dosage for each individual.

Rose Hill Center offers comprehensive, residential psychiatric treatment and rehabilitation services for adults with mental illness.



rosehillcenter.org
866.504.2259

Treatment. Growth. Recovery.

Guess Who's at the Core of Your Workforce?

John Morris, Executive Director, Annapolis Coalition on the Behavioral Health Workforce; **Michael Flaherty, PhD**, Director, Institute for Research, Education and Training in Addictions

Federal healthcare reform legislation will usher in an unprecedented period of change for the American healthcare system. Although some of the impact is predictable (eg. much greater access to insurance for millions of citizens), a host of other changes are coming whose dimensions we can only glimpse and probably a few that we cannot imagine until the legislation fully rolls out in the coming years.

At the Annapolis Coalition on the Behavioral Health Workforce (www.annapoliscoalition.org), we have been arguing for years that no sustainable reform can take place in our field without concerted, focused attention on workforce issues. Whether the issue is the implementation of evidence-based practices; reductions in disparities regarding access and quality; or diversion of people with mental and substance use conditions from inappropriate settings such as prisons or jails, the essential ingredient for success is the competence of the person providing the intervention. From our perspective, this is also true for people who have achieved sustained recovery, because they are the de facto core of the workforce, endowed with the knowledge, skills, and experience they attained in their personal journey to recovery.

The dramatic increase in demand for healthcare services, including behavioral healthcare services and supports, will exacerbate preexisting shortages of healthcare providers, and the healthcare reform law does include strategies to ameliorate some of this increased pressure. The National Council for Community Behavioral Healthcare has done an excellent job of summarizing all of the workforce legislation passed this year (see www.thenationalcouncil.org/galleries/policy-file/BH%20Workforce%20Legislation%20Fact%20Sheet%204-7-10.pdf), of special note are the provisions of the Patient Protection and Affordable Care Act (PL 111-148) and the Health Care and Education Reconciliation Act of 2010 (PL 111-152). The relevant sections address

>> Grants for enhancing education in social work,

graduate psychology, and child and adolescent mental health.

- >> Loan repayment for pediatric behavioral health specialists in underserved areas.
- >> Training opportunities for direct care workers in long-term care settings, including home- and community-based alternatives.
- >> Recruitment and retention of allied health professionals (not including medicine, social work, psychology, and counseling) in health shortage areas.
- >> Education of primary care providers about behavioral health issues.
- >> Expansion of the National Health Service Corps.

In addition to these provisions of relevance to providers, the bills allow for a new federal Workforce Commission whose mission includes a focus on behavioral health, with expanded curricula that encompass behavioral health and recognize that behavioral health is an integral part of a true public health model.

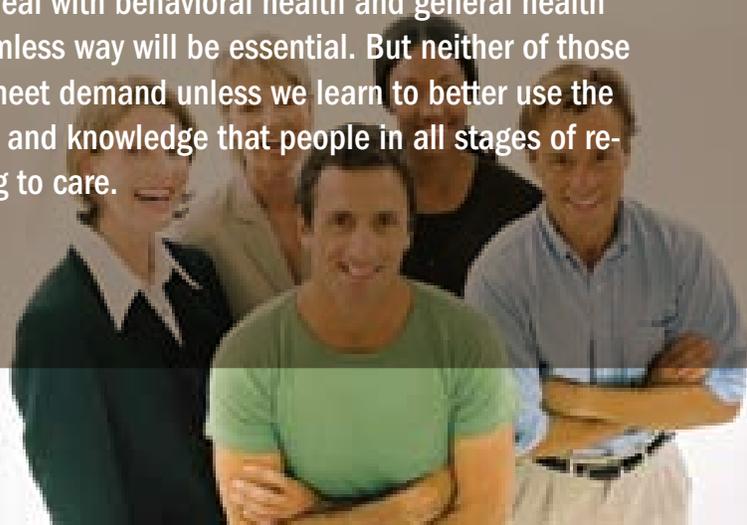
So what does all this legislation mean for National Council members? At a minimum, it means engaging your leadership team, your key constituents, and your community partners in some focused strategic planning about how you can increase not only the

number of staff members to meet the rising demand but also the competence of your workforce. That's the essential first step. But beyond creating a workforce plan (which includes some tough assessments of reimbursement mechanisms, credentialing and licensure standards, recruitment, and retention strategies), change may also involve rethinking how services are organized and delivered.

Workers are always linked to an organizational structure, and it is clear that we will increasingly face demand for skilled integrated care environments: primary care infused into a traditional behavioral health setting, behavioral health competencies infused into primary care settings, and likely some hybrid environments that may not resemble traditional healthcare delivery systems but incorporate e-health, alternative approaches, and much more robust peer-operated services than the field has historically seen.

We think that the single most challenging – and most promising – opportunity in the current climate of change is the need to devise a strategy to ensure the role of people in recovery and their families in reshaping how supports and services are delivered across the spectrum of primary and behavioral healthcare. The Institute of Medicine has been promoting person-centered and client-driven

Increasing the number of doctors, nurses, psychologists, social workers, and counselors is important. Increasing the competence of all to deal with behavioral health and general health issues in a seamless way will be essential. But neither of those strategies will meet demand unless we learn to better use the wealth of talent and knowledge that people in all stages of recovery can bring to care.





care for years, yet the impact on practice has been modest. The addictions treatment field has grown out of deep roots in self-help and today has an increasing synergy with the mental health field as a place where concepts of recovery are being operationalized, measured, and translated into action. Coupled with the workforce demands of healthcare reform, these new realities point our field toward a fresh emphasis on the role of people in recovery and the voices of their families.

So the core message is simple: an environmental scan, followed by a specific plan to address workforce issues. The tough part will be thinking creatively about how to do business in new ways that might actually bridge a portion of the treatment gap that yawns right in front of us. Increasing the number of doctors, nurses, psychologists, social workers, and counselors is important. Increasing the competence of all workers (including the nondegreed, direct care workforce) to deal with behavioral health and general health issues in a seamless way will be essential. But neither of those strategies will meet demand unless we learn

to better use the wealth of talent and knowledge that people in all stages of recovery can bring to bear on their own care and on the care of others who experience similar challenges.

The most successful providers will be those who can aggressively pursue enhancements to the traditional disciplines and workforce and who can expand their vision of workforce to include a wider range of workers to achieve genuine recovery and resilience in a vastly expanded client base.

Note: As this article went to press, the newsletter *Alcoholism and Drug Abuse Weekly* (May 10, 2010, issue) reported that the Health Resources and Services Administration had budgeted \$25 million to add new qualified and trained behavioral health counselors in federally supported community health centers. Under this proposal, HRSA would collaborate with the Substance Abuse and Mental Health Services Administration for technical assistance. HRSA would train counselors and addiction specialists to perform screening, brief intervention, and referral to treatment. This kind

of change presents opportunities for providers who are poised to move quickly to expand and enhance services.

John Morris is director of the human services practice of the Technical Assistance Collaborative, Inc., a national not-for-profit consulting group based in Boston, MA. He is also executive director of the Annapolis Coalition on the Behavioral Health Workforce, which has just published a national action plan for workforce development in partnership with the Substance Abuse and Mental Health Services Administration. He is currently chair of the board of directors of Mental Health America. Morris is a past president of the American College of Mental Health Administration and of the ACMHA Foundation, and in 2006 he was awarded the Saul Feldman Lifetime Achievement Award, ACMHA's highest honor.

Michael Flaherty, PhD, is a clinical psychologist (certified in addictions by the American Psychological Association) with more than 30 years of daily clinical and administrative experience in mental health and the addictions. He is the executive director of the Institute for Research, Education and Training in Addictions as well as the principal investigator of the Northeast Addiction Technology Transfer Center, which serves New York and Pennsylvania. IRETA is a nonprofit institute dedicated to aligning science, service, and policy research and practice in addiction prevention, intervention, treatment, recovery, and research. He also sits on the board of directors for the Annapolis Coalition.



Your Partner in Mental Wellness

Working together to achieve mental wellness through total care

- inspiring stories and practical tips for everyday living
- treatment options and guidelines for managing positive and negative symptoms
- breaking industry news and genetic research

Subscribe Today

1-866-672-3038

www.szmagazine.com

Reform a Game Changer — Only if YOU Create a New Game

Brad Zimmerman, Managing Director, Personal Mastery Programs

It has never been more apparent that “the only constant is change.” Behavioral health organizations have been complying with required changes for years, but now, with healthcare reform, it has become critical that they generate change, creating new and innovated approaches. With Medicaid expansion and private insurance parity, an estimated 45 million new consumers will have the opportunity to purchase behavioral health services. Extreme opportunity requires extreme change and if we are to realize this opportunity, we must “change the game.” The public, who are our new consumers, must now see behavioral health as another required component of a healthy lifestyle. Caring for one’s mental attitude, outlook, and well-being can now

Linda Rosenberg, President and CEO of the National Council for Community Behavioral Healthcare notes that “Simply put, we must be ready to play in a new game, in a world where increasing numbers of individuals by virtue of Medicaid expansion, the emerging Health Insurance Exchanges, and parity regulations will have access to behavioral health services.”

staff, management, and boards into cohesive teams that are committed to this reality. These challenges would be considerable for any service sector to overcome. Behavioral healthcare carries an added cultural burden — a long history of services structured to support compliance mandates, typically from external funding and accreditation agencies, has left us with organizational cultures driven by compliance. This compliance culture is a tremendous barrier to the creativity and unification the current game change requires.

An organizational culture driven by compliance mandates puts management in the position of working with staff around what is required, not what is possible. Management is bound by inflexible state requirements, and staff must implement these requirements into a workflow that provides consumers with (sometimes compromised) care. In many cases, creative staff are stifled and required to continue practices that they and consumers know are inefficient or ineffective. This does not need to happen more than a few times for both clinical and management staff to give up thinking they can change “the system.” An unintended rift grows between management and staff, the culture begins to stagnate, and people just comply with the way things have always been done; the commitment to working together creatively is lost.

We must shift this culture of compliance to a culture rooted in personal commitment — a “personal growth culture.” An organization, by nature, is a group of people organized to fulfill a common purpose. Therefore, any effort to expand an organization’s ability to excel must focus on personal growth for each person. In an organization with a personal growth culture, the energizing force that motivates people to perform well and launch new initiatives is their personal aspiration; leadership exists at all levels.

- >> People accept that they must confront difficult issues to produce forward movement and do so in a manner that strengthens relationships.
- >> Accountability exists throughout the organization

and is supportive of people, not punitive.

- >> People seek different opinions and perspectives to enhance their abilities; coaching is the norm in relationships.

All of which combine to unleash innovative approaches to the challenges and opportunities we are all facing.

The shift to a personal growth culture requires strong leadership. Most leaders of our organizations have devoted their lives to helping people less fortunate than themselves. After working the front lines with extensive training and experience as behavioral health professionals, they moved into administration because they were willing to take on a leadership role, but they often find themselves ill equipped to change the culture from which they came. The leader of a personal growth culture must develop certain tools:

- >> The ability to inspire people to change.
- >> The ability to support people by holding them accountable.
- >> The ability to be effective coaches, helping people generate new methods that may be outside their comfort zone.

This is the personal growth that leaders need to be effective initiators of change.

Behavioral health leaders must dedicate the time and resources needed to develop their change leadership skills. They need courage to overcome the discomfort and disbelief in the possibility for real change, especially in light of the current economic reality. If we do not rise to the challenge right now, however, someone else will. The potential payoff to our organizations and our communities is great but only if we create a whole new culture in which commitment to creativity and change are the hallmarks.

Brad Zimmerman is the managing director of Personal Mastery Programs, a Change Leadership Coaching firm that provides services to behavioral health and primary care organizations nationwide. Brad also provides change leadership support to the National Council for Community Behavioral Healthcare’s Integrated Health Learning Communities.

“Imagine the day when seeing a mental health practitioner will be as common as going to a personal trainer! Rising to this opportunity will require tremendous creativity. We must become masters of change, able not merely to accept change but to initiate it. We must shift from a culture of compliance to a personal growth culture.”

become a daily routine, like eating a healthy diet and exercising. If providers are going to take advantage of this chance to serve the broader community, they must craft a whole new “mental model.”

Because human nature resists change, leaders of behavioral health organizations must be catalysts for change, transforming behavioral health from merely treating disorders to supporting wellness and personal growth. If the provider community is to be successful, we must learn to actively promote this new view. Imagine the day when seeing a mental health practitioner will be as common as going to a personal trainer. Consumers will participate in their mental health as fully they do in their physical health. Parity and healthcare reform make this possible, but we must re-envision our entire approach, positioning our organizations to make this possibility a reality.

Rising to this opportunity will require tremendous creativity. We must become masters of change, able not merely to accept change but to initiate it. Accordingly, the leaders of our organizations must learn to unify



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

41st National Mental Health and Addictions Conference & Expo

May 2-4, 2011, San Diego, CA



San Diego: There's no better place to be!

www.TheNationalCouncil.org/Conference 202.684.7457

Rush Hour on the Reform Timeline – Management Matters

Patrick Gauthier, Director and Kathryn Alexandrei, Assistant Director – AHP Healthcare Solutions, Advocates for Human Potential

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010 represent monumental reforms to the behavioral healthcare system, offering promise and risk in equal measure. Stakeholders in the behavioral health field have worked tirelessly to achieve these reforms. Now that change is upon us, how do we gather and align the right mix of vision, leadership, resources, and expertise to navigate risks and collect on the promise of reform?

Change of this magnitude will require a revolution in the management practices of our field. Business acumen has never been more important. To successfully ride the waves of coming changes, we need to place value on management skills in our organizations, import appropriate business practices from the private sector, and refine our management skills internally. The bureaucracies that legislate, regulate, design, finance, allocate human resources, and manage change on this scale must embody and promote a new management approach, rapidly disseminate new tools, and establish revolutionary expectations if we're going to be successful in the coming years.

The behavioral healthcare field has never seen such a momentous time as this, ripe as it is for innovation and business opportunities. Consumers immediately begin benefiting from free preventive care, reforms that ban annual and lifetime maximum benefits, and those that make it illegal to rescind coverage for any reason, including preexisting conditions. Community health centers receive huge increases in funding. Those provisions alone make an enormous difference in the lives of the people we serve. Many more positive changes will occur, however. Medicaid will grow by millions of new members, children can stay on their parents' insurance through college and beyond, and parity wends its way to people enrolled in small-group and individual plans.

That said, it is rush hour on the reform timeline—MHPAEA, healthcare reform, the National Health Information Network, and the 10th edition of the *International Classification of Diseases* are all slated to manifest in the same 4–5-year period. With deadlines such as these and management challenges rooted deeply in the culture of our field, we will be tested to act decisively, wisely, and in an entirely coordinated fashion that will prove unforgiving for those who buck the tide. Never before has so much been asked of us, and never before has so much been at stake.

To be successful, we must acknowledge and overcome our own tendency to resist change, and we need to accelerate our pace when we accept that we must change. We must also examine the degree to which our field has been underresourced and underfunded when required to change. With the right resources and demands on us for accelerated change processes, we can, in fact, deliver in the fast lane. We can't afford a repeat of the Health Information Technology for Economic and Clinical Health Act under the American Recovery and Reinvestment Act of 2009, which overlooked the technology needs of our field while allocating billions for physician, clinic, and hospital electronic medical record systems.

THE IMPETUS FOR VERTICAL AND HORIZONTAL COLLABORATION

If parity has taught us anything, it is that regulations and stakeholders' responses to them can be difficult to predict. Consequently, new and perhaps anxious conversations need to begin taking place among interdependent stakeholders that haven't historically found it necessary to collaborate very closely. On the vertical, that means federal, state, county, health plan-issuer, and provider organizations must work together in the pursuit of alignment. On the horizontal, agencies such as Medicaid and state departments of insurance, mental health, substance abuse, family and children's services, and

The behavioral healthcare field has never seen such a momentous time as this, ripe as it is for innovation and business opportunities. To successfully ride the wave of change, we need to place value on management skills in our organizations, import appropriate business practices from the private sector, and refine our management skills internally.



juvenile justice will be called on to collaborate. Hospitals, primary care providers, and employers play vital roles in this horizontal collaboration as well. Each has an important part in the emerging paradigm.

In the case of parity, for example, states must first conduct a “crosswalk” that compares and contrasts state and federal regulations. The resulting regulatory guidance must make its way to local health plans and managed care organizations, which then need to communicate new benefits and processes to their brokers, customers, employers, providers, and plan members.

Ours is a system with many moving parts (see figure 1), and each has to be accounted for in our planning and execution. The field depends on the direction, planning, and resources that radiate out from federal, state, and county agencies, whose internal “revolution” in change management is absolutely essential to the field. The manner in which Medicaid and Medicaid managed care plans, as well as Section 1115 waivers, are dealt with both vertically and horizontally is a good example of the communication challenge and procedural complexity ahead.

PRIORITIES

The most pressing needs right now are organizational and procedural, centered around ensuring the vision

and intent of lawmakers. Those priorities include the following:

- >> Convening stakeholders from federal, state, and county mental health and substance use disorder programs to develop new relationships, a shared vision, a robust communication plan, and comprehensive plans of action.
- >> Providing leadership regarding the impact of parity and healthcare reform on state plans, Section 1115 waivers (among others), the continuity of the safety net, and the purpose of block grants in the future.
- >> Delivering technical assistance concerning the impact of parity and healthcare reform on prevention, treatment, and benefit coverage for mental health and substance use disorders.
- >> Comparing and contrasting state and federal laws and regulations to provide adequate guidance to the state insurance commissioners and the health plans they regulate.
- >> Disseminating similar guidance to self-insured employers (Employee Retirement Income Security Act of 1974 groups) and their plan administrators.
- >> Standardizing and normalizing terms; data defi-

nitions; data collection practices; screening and assessment tools; treatment planning; patient placement criteria; and billing, claiming, and coding and reporting everything from encounters to outcomes.

- >> Accelerating procurement processes to enable federal, state, and county agencies to more swiftly execute their action plans.
- >> Properly defining comparative effectiveness, quality, and value initiatives in the reformed paradigm, and planning to build capacity and competency for each.
- >> Realigning financial incentives between payers and providers in public and private sectors while fashioning innovative reimbursement reforms that lead rapidly to the formation of accountable care organizations and the creation of bona fide value.
- >> Adequately financing the infrastructure and capacity required by reforms, including professional project management resources, workforce, and business architecture dimensions. Financing must address serious gaps in workforce and technology.

Federal departments understand that they are responsible for providing the field with guidance through the change process. All of these reforms require clear regulations and the tools to make them part of procedures.

Parity and healthcare reform represent ideals and intentions for health and behavioral health that will require sacrifice, prioritization, joint agreements, planning, and — above all — action. What we need now are vision, leadership, and management resources.

Patrick Gauthier consults on behavioral healthcare with policymakers, insurers, managed care organizations, and provider associations across the country. He consults with organizations that are responsible for the implementation of policy reforms as well as those that seek efficiency, quality, and service expansion through innovation. He was a member of the National Association of Health Underwriters for more than a decade and led a national managed behavioral healthcare organization during a period of significant expansion in managed behavioral healthcare.

Kathryn Alexandrei is a consultant to the behavioral healthcare and benefits management fields and her practice emphasizes infrastructure and organizational development, business process management, performance management, and behavioral health market research, planning, and social media. Formerly, she served as CEO of an international non-governmental organization dedicated to the prevention of trafficking and exploitation of women and children, and addressing the health and behavioral health needs of survivors.



MH = mental health; SUD = substance use disorder; VA = Veterans Administration; CHAMPUS = Civilian Health and Medical Program of the Uniformed Services; SA = substance abuse; NCQA = National Committee for Quality Assurance; URAC = Utilization Review Accreditation Commission; CARF = Commission on Accreditation and Rehabilitation Facilities.

ADVERTORIAL



Building a Recovery-Focused System: How Managed Care Organizations Can Help

James G. Gavin, President and CEO, Community Care

The focus on creating a recovery oriented system in behavioral health has resulted in new ideas about how to plan, coordinate and deliver services. In general, recovery focused care is defined as supporting healing and transformation that enables a person to live a meaningful life. In other words, a recovery focus to treatment is a conversation *with* a consumer and *not about* a consumer.

While a great deal has been written about how providers of services can transform what they do to embrace these concepts of recovery, there has been little discussion about how payers can support service transformation. This paper is about one managed care company, Community Care Behavioral Health Organization of UPMC (Community Care) and its support of, payment for, and focus on, recovery.

Community Care is a 501(c)(3) company incorporated in 1996 as a non-profit alternative in behavioral health managed care. Currently Community Care, NCQA accredited, manages behavioral health services for over 600,000 persons with Medicaid in the Commonwealth of Pennsylvania and is working with the City and the State of New York on a care monitoring initiative.

The mission of Community Care is to improve the health and well-being of the community through the delivery of effective, cost-efficient, and accessible behavioral health services. Through low administrative costs and sound, clinically driven, fiscal practices, Community Care has demonstrated that there is room in the public managed care market for this different type of managed care company. Under Community Care's leadership, the Pennsylvania program has demonstrated increased access and increased service options for consumers while freeing up resources to be used to support individuals in their journey to recovery.

Community Care includes consumer and advocacy representatives in governance and program development at all levels of the company. Each program

includes a Consumer/Member Advisory Committee and there is always a consumer representative on the Board of Directors. In addition, Community Care hires consumers to work within the company in many different areas.

To promote recovery principles, Community Care issued an invitation to all network providers to participate in a Learning Collaborative focused on implementing, sustaining, and spreading the recovery principles. The Learning Collaborative has grown to approximately 60 agencies in 35 Pennsylvania counties. Each agency is committed to changing and transforming services toward recovery-oriented practices. The goal of the Learning Collaborative is for all participating provider organizations to make the following vision statement a reality within their organization:

Every single consumer serviced by our agency will have the opportunity to become activated and empowered to participate in shared decision making related to the use of psychiatric medication in their recovery process.

Community Care has been creating toolkits for providers and consumers which incorporate the Recovery Institute concepts. Community Care has provided every interested provider in its network with copies of the toolkit and created models for assisting with implementation.

Five guiding principles underscore the clinical work of Community Care. These are:

1. A focus on recovery in care management activities. Care managers routinely ask about recovery goals during their work and they prompt providers to develop recovery plans.
2. Use of programs that directly support consumers in their recovery efforts. Community Care has developed NCQA-certified Disease Management Programs for members with major depression

and schizophrenia that help identify their recovery goals and access necessary resources.

3. Expansion of the provider network to include programs, such as psychiatric rehabilitation and peer services that can effectively support consumers' recovery.
4. Quality programs that support the implementation of best practice guidelines and evidence-based practices. Community Care actively encourages providers to assess the impact of treatment of recovery and design clinical services to support members' recovery and physical health needs.
5. Programmatic Initiatives that support new ways of delivering services. These initiatives have grown from our Recovery Institute, initiated in 2005 with consultation from Pat Deegan, Ph.D. The Recovery Institute is designed to assist providers in system transformation to recovery-oriented services and to create tools that members can use directly.

Community Care has established itself as a recognized leader and innovator in the promotion of recovery-oriented services for adults and resiliency focused services for children in Pennsylvania. We actively engage in facilitating the evolution of the behavioral health system toward one that promotes a journey of healing and transformation, enabling individuals with behavioral health problems to live meaningful lives in the communities of their choosing, while striving to achieve personal goals.

Community Care has demonstrated that a payer can successfully transform its own work as well as the services that it supports to better support consumers' recovery.

For additional information about Community Care or about recovery programs, please contact Jim Gavin at gavinjg@cdbh.com or 412.454.2146

No Health Without Health IT

Dennis Morrison, PhD, CEO, Centerstone Research Institute

If you have a clinical background, this story will seem familiar – at least at first. A relative calls and says her daughter, who is deaf, is experiencing auditory hallucinations, and she wonders whether this is “normal.” The girl – we’ll call her Laura – is in late adolescence, an age when symptoms of schizophrenia often start presenting. I am worried but don’t want to alarm my relative. Then the girl’s mother casually mentions, “By the way, she only hears the voices when she’s having her period.” Now this is odd. I’ve never heard of such a connection.

Laura is hospitalized on a psychiatric unit, and I go into full research mode. Because I work in clinical research, I access my online and personal connections. I find a handful of case studies describing a syndrome called menstrual psychosis, so rare that there is no controlled research on the topic, only case studies as far back as the 1930s. What’s more surprising is that the preferred treatment is simply to place the young woman on oral contraceptives; the hallucinations will disappear. Antipsychotic agents have no effect. I contact the attending psychiatrist on the unit where Laura has been admitted and confess to some concern about meddling in his treatment but – despite the admonitions we’ve all heard about looking for horses, not zebras, when we hear hoofbeats – I tell the psychiatrist, “You’ve got a zebra here,” and forward all the research I’ve found about this syndrome. Unfortunately, Laura has been started on a low dose of olanzapine. Within a few days, she is already experiencing significant weight gain. Only after she is discharged and sees her gynecologist does she start on the contraceptives and discontinue taking olanzapine. She has been symptom free since.

Because of my access to health information technology, Laura received patient-centered, research-based care and experienced a total recovery. If I hadn’t been in this particular story, I’m too aware that Laura might have celebrated her 21st birthday with Type II diabetes and struggled with the stigma of an incorrect diagnosis and the side effects of the wrong medication. She would likely have become obese, developed a tobacco addiction, and experienced struggles with employment. And her parents would most likely have outlived her.

What would have happened if the attending physicians had immediate access to an electronic health record with integrated clinical decision support technology, so that when Laura’s symptoms were entered, it presented the very same research I was able to find, but in real

Electronic health records can and should do things that a paper record cannot – such as offering research data and contextual cues to help clinicians provide better care. The ultimate arbiters of treatment are the patient and the provider. The health IT system is an aid in this process. It’s Clinical Decision Support, not Clinical Decision Making.

time when she was admitted to the psychiatric unit? Such a system could have alerted the admitting physician that Laura’s was an atypical psychosis, and it could have presented the same case studies I found with the same suggestions for treatment. This is the promise of health information technology.

The current reality is quite different. According to RAND and the Institute of Medicine, our patients have between 20–30% likelihood of getting the correct treatment for their conditions. What’s worse is that it need not be that way. Mental health providers have very effective treatments for the problems we see. We know that most people with chronic conditions, such as schizophrenia and bipolar disorder, can experience significant symptom relief and improved quality of life with treatment – especially if that treatment is given early on. Few clinicians are well versed in treatment efficacy, however.

There are several reasons for clinicians’ lack of knowledge about appropriate treatments. Data exists but is not accessible. Research has offered a wealth of knowledge about clinical effectiveness in behavioral healthcare. As in all of healthcare, it has become physically impossible for any clinician to stay ahead of the curve regarding his or her knowledge about treatment effectiveness. As happens with our medical counterparts, organizational cultures, guild issues, and individual inertia contribute to the resistance to implementing research-based treatments. Add these to ever escalating productivity expectations, and changing practice becomes nearly impossible.

There is no single solution to this problem, but health IT can help – considerably. Electronic health records can and should do things that a paper record cannot. One of those things is to make suggestions to help clinicians provide better care. As described above, providing contextually appropriate cues to clinicians about the patient in front of them is the goal. The ultimate arbiters of treatment are the patient and the provider.

The health IT system is an aid in this process. That’s why it is called Clinical Decision Support, not Clinical Decision Making.

So what’s keeping us from this future? In a word – money. We know that the penetration of EHRs in behavioral health settings is low, as it is in general healthcare, largely because of the cost to implement such systems. The American Recovery and Reinvestment Act of 2009 allotted funding to stimulate the use of EHRs, but behavioral healthcare was not included in those incentives. That may change as a result of some work several of us have done to get that legislation amended. Rep. Patrick Kennedy has sponsored legislation (HR 5040) that will allow behavioral healthcare providers access to the same incentives that our medical counterparts have. I believe this is critical so we do not get electronically orphaned in the new age of interoperable healthcare.

If we want to have any hope of improving the healthcare system so we can start providing the correct care and avoid what happened to Laura, we have to get on the health IT bandwagon. We need electronic records that (a) are interoperable; (b) engage patients and families in their healthcare; and (c) provide real-time, research-based information to providers and patients. Without such a system, behavioral health providers will, at best, be marginalized in the healthcare system and, at worst, be eliminated.

Dennis Morrison is CEO of Centerstone Research Institute and has worked in the behavioral health field since 1969. He holds masters degrees in psychology and exercise physiology and a doctorate in counseling psychology from Ball State University. From 1995 - May 2008, Morrison served as the CEO of the Center for Behavioral Health in Bloomington, Ind. In May 2008, CBH affiliated with Quinco Behavioral Health Systems and Centerstone, creating a \$110 million multistate community-based provider organization serving 69,000 consumers each year. In order to integrate and manage the research and information technology services of the new organization, Centerstone Research Institute was formed, and Morrison was named CEO.

What Is Meaningful About “Meaningful Use” for Behavioral Health IT?

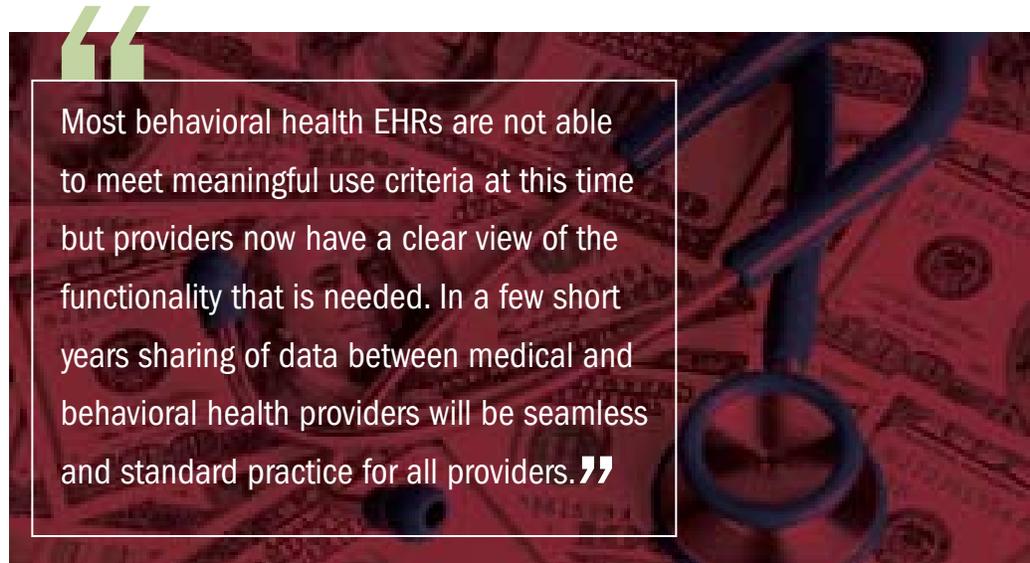
Michael R. Lardiere, LCSW, Director of Health Information Technology and Senior Advisor on Behavioral Health, National Association of Community Health Centers

All of the talk about “meaningful use” of health information technology has stirred up questions as to just what it means for behavioral health providers. Under the American Recovery and Reinvestment Act of 2009, behavioral health providers do not receive any incentive payments for meaningful use of HIT. Psychiatrists have access to Medicare or Medicaid Incentive Payments, and nurse practitioners may have access to Medicaid Incentive Payments; however, psychologists, social workers, other mental health providers and outpatient substance abuse providers do not. So why should behavioral health providers be concerned about meaningful use of HIT?

Although ARRA and, in particular, the Health Information Technology for Economic and Clinical Health Act of 2009 set the path to expand the use of technology to improve healthcare in the United States, HITECH was not all encompassing and did not include all providers. In testimony I provided to the HIT Policy Committee, I identified this deficit in HITECH and encouraged the committee to include behavioral health providers and provide the financial resources for behavioral health providers to participate in the goals of HITECH. Behavioral health and primary care providers must share data if we are to provide comprehensive, high-quality care to the patients we serve.

What promise does HIT hold for healthcare? It allows for a number of important improvements that are not available in paper-based systems:

- >> Information that can follow the patient; is timely, accessible, and complete; and enables patient-centered, integrated care across all settings.
- >> Evidence-based decision support at point of care for practitioners of all disciplines to ensure consistent, high-quality care.
- >> Access to decision support and tools for managing health by and for patients.
- >> Availability of population-based data to



Most behavioral health EHRs are not able to meet meaningful use criteria at this time but providers now have a clear view of the functionality that is needed. In a few short years sharing of data between medical and behavioral health providers will be seamless and standard practice for all providers.”

- advance medical knowledge.
- understand factors that influence health practice and status.
- drive improvements in care.
- >> Transparency of quality information to incentivize quality rather than cost and profit.
- >> Engage patients and families.
- >> Improve care coordination.
- >> Improve population and public health.
- >> Ensure adequate privacy and security protections for personal health information.

The statutory definition of meaningful use includes the use of an electronic health record that is “connected in a manner” that provides for the electronic exchange of health information to improve the quality of healthcare, such as promoting care coordination (in accordance with law and standards applicable to the exchange of information). In my mind, this is one of the most compelling arguments for behavioral health providers to be aware of and interested in meaningful use of HIT. Providers of all kinds need to share information to coordinate care if we are going to improve the quality of healthcare for our patients.

The HIT Policy Committee identified five domains that serve as the roadmap for meaningful use of HIT:

- >> Improve quality, safety, and efficiency and reduce health disparities.

As a behavioral health clinician, I would not want to exclude any of these domains in providing improved care to my patients.

The final rules on meaningful use criteria are currently being considered by the Centers for Medicare and Medicaid Services and the Office of the National Coordinator as they comb through more than 2,000 comments that were provided by healthcare providers across the nation. The final rule is expected to be published around June 2010.

The HIT Policy Committee has proposed a roadmap that will allow EHRs and other technologies to evolve over time to gain the full benefit of meaningful use. 2011 is the first year in which a provider can qualify for Meaningful Use Incentive Payments. The table on the page 37 identifies how the criteria are expected to evolve and functionalities become broader over time.

GOALS	2011	2013	2015
Improve quality, safety, and efficiency	<ul style="list-style-type: none"> > Document and capture encoded data > Use CPOE for all order types > Manage populations 	<ul style="list-style-type: none"> > Use evidence-based order sets > Include CDS at point of care > Manage chronic conditions through CDS 	<ul style="list-style-type: none"> > Achieve minimum levels for quality, safety, and efficiency measures > Include CDS for national high-priority conditions > Achieve medical device interoperability and multimedia support (e.g., x-rays)
Engage patients and families	<ul style="list-style-type: none"> > Provide electronic copy of or electronic access to clinical information for patients > Offer patient-specific educational resources > Provide clinical summaries for each patient encounter 	<ul style="list-style-type: none"> > Offer secure patient-provider messaging > Record patient preferences > Document family medical history > Upload data from monitoring devices 	<ul style="list-style-type: none"> > Provide access for all patients to their own health records, populated with real-time EHR data > Provide patient access to self-management tools > Complete electronic reporting on experience of care
Improve coordination of care	<ul style="list-style-type: none"> > Exchange key clinical information among providers of care (in any format) > Perform medication reconciliation at relevant encounters 	<ul style="list-style-type: none"> > Achieve medication reconciliation and electronic summary of care at each transition of care > Receive and act on prescription fill information 	<ul style="list-style-type: none"> > Access comprehensive patient data from all available sources
Improve population and public health	<ul style="list-style-type: none"> > Submit electronic data to immunization registries > Submit reportable lab results to public health agencies > Submit surveillance data to public health agencies on the basis of applicable law and practice 	<ul style="list-style-type: none"> > Receive immunization information from registries > Receive public health alerts 	<ul style="list-style-type: none"> > Use epidemiologic data derived from EHRs > Automate real-time surveillance > Provide clinical dashboards > Generate dynamic and ad hoc quality reports
Ensure privacy and security protection	<ul style="list-style-type: none"> > Comply with Health Insurance Portability and Accountability Act of 1996 rules and state laws > Comply with fair data-sharing practices set forth in National Privacy and Security Framework 	<ul style="list-style-type: none"> > Use summary or deidentified data when reporting data for population health purposes 	<ul style="list-style-type: none"> > Provide patients with accounting of treatment, payment, and health care operations disclosures > Protect sensitive health information

Note. CPOE = computerized physician order entry; CDS = clinical decision support.

Although not all of the criteria are applicable to stand-alone behavioral health providers, such as reporting electronic data to immunization registries, making this information available through exchange of data with your patient's medical provider is important.

In my work, I have the benefit of flowing between primary care and behavioral health providers quite easily, and in all of my discussions, never has a behavioral health provider stated that he or she did not see the benefits of meaningful use or would not want to coordinate care with a patient's other providers. All of the conversations cluster around two issues: "confidentiality" of data, and financing to support the implementation of EHRs and other technologies to meet meaningful use criteria.

The confidentiality issue is being addressed at several levels that I am aware of. Health Information Exchanges at the state level need to correct this problem. The Office of the Assistant Secretary for Program and Evaluation is currently preparing toolkits for state HIEs to provide guidance on how to address confidentiality. The Certification Commission for Health Information Technology EHR Workgroup has addressed these issues in its Behavioral Health EHR Criteria, and the Office of the National Coordinator for Health Information Technology is beginning to examine the problem at both the National Health Information Network level and the NHIN Direct level. NHIN Direct consists of services, systems, and protocols that allow data exchange at the local level.

Getting to the "granular level" of consent may be difficult in the short term. Granular level consent allows patients to specify at each visit or for each specific piece of data in their electronic record which providers they want or do not want the data to be shared with. I am not a believer in providing this functionality, for a couple of reasons. First, it continues to keep behavioral health and medical data separate, does not provide a comprehensive view of patient treatment concerns, and leads to poorer quality care. It also allows patients to maintain the incorrect view that their medical problems and behavioral health problems are separate and continues the stigma that surrounds behavioral health issues. As providers share data with each other and get used to receiving it, both medical and behavioral health providers will not be able to

recognize what piece of data was left out during the most recent exchange. This can lead to poor treatment decisions and poor-quality care.

I prefer the "opt-in" or "opt-out" approach, whereby patients can identify whether they want to share any data or not. If they do not, then none of their records get transmitted, and the patients remain in complete control. The provider need only alert other providers treating the patient that data are available and that the patient has opted out of sharing any information. This alerts the receiving provider to either request authorization to obtain the data or conduct a more comprehensive evaluation before beginning treatment.

Are most behavioral health EHRs able to meet meaningful use criteria at this time? Unfortunately not; however, the roadmaps are in place, and providers now have a clear view of the functionality that is needed. I believe that we will see many behavioral health EHR vendors provide this functionality; medical EHRs will also begin to incorporate specific behavioral health modules into their programs, and in a few short years sharing of data between medical and behavioral health providers will be seamless and standard practice for all providers.

So, if there is no money for behavioral health providers in ARRA, what is meaningful about meaningful use?

Behavioral health providers should be aware that the states can provide grant and loan programs under ARRA to all providers in the state; however, providers will only receive ARRA funds through these programs if the systems meet meaningful use criteria. Behavioral health providers also may be purchasing or planning to purchase EHR systems now and need to be aware of the requirements that they will need to meet to obtain incentive dollars that are sure to come in the future. Our healthcare system cannot function and meet the promise of using HIT to improve the quality of care we provide to our patients and eventually lead to healthcare savings unless behavioral health providers are fully integrated into the system and are attuned to and achieving meaningful use side by side with their medical provider colleagues.

Michael Lardiere is the director of health information technology at the National Association of Community Health Centers. He is a member of the Board of the National eHealth Collaborative and of the Certification Commission for Health Information Technology EHR Behavioral Health Workgroup.



Q:

How can your employees protect their families?

A: Supplemental Insurance

Benefits Limited offers a discounted insurance program for National Council members for Group Life, AD&D, Group Disability & Voluntary Payroll Deduction Benefits, Cancer, Accident, Disability, etc.

Contact us to learn more & start saving instantly with our application free process without waiting for your next annual enrollment.

For information call 877-896-4189



ADVERTORIAL

Netsmart Technologies Helps Lead Inclusion of Behavioral Health in “Meaningful Use” Funding

In February 2009, Congress passed the American Recovery and Reinvestment Act of 2009 (ARRA), more commonly referred to as the economic stimulus legislation. Specific to healthcare, ARRA included the Health Information Technology for Economic Clinical Health (HITECH) Act.

CURRENT ELIGIBILITY FOR BEHAVIORAL HEALTH

Under the HITECH Act, behavioral health providers are eligible to receive Medicare and/or Medicaid Provider incentives beginning in 2011 based on the number of “eligible professionals” (EPs) in their organization (physicians, nurse practitioners, dentists and certified midwives), assuming the organization meets criteria for “Meaningful Use” (MU) of an EHR. There are also Hospital incentive funds available, but behavioral health facilities and psychiatric hospitals are currently not included in eligibility for Hospital incentive funds, but would be under legislation recently introduced in Congress.

To qualify as a Medicaid EP, a physician, nurse practitioner, dentist or certified midwife must be non-hospital based, do more than 30% Medicaid encounters over a representative 90-day period, and assign their incentives to the organization where they are using an EHR in a “meaningful” way per the MU criteria. The current benefit for Medicaid-eligible professionals is \$21,250 for the first year of MU. In years 2-6 the benefit is \$8,500 per year, for a total benefit of \$63,750 per EP. Medicare-eligible professionals will receive a \$44,000 maximum Medicare Provider incentive amount for the six-year time period.

INDUSTRY LEADERSHIP HELPS GAIN BEHAVIORAL HEALTH INCLUSION

As the technology partner for thousands of community mental health providers across the country, Netsmart Technologies joined The National Council for Community Behavioral Healthcare and other industry organizations in public policy initiatives to expand the incentives for behavioral health providers under ARRA. This effort was key to new legislation being introduced in Congress, and now strong support is needed from the behavioral health community to gain support for passage of the bill.

CORRECTIVE LEGISLATION WOULD FURTHER EXTEND ELIGIBILITY

On April 15, U.S. Rep. Patrick Kennedy (D-RI) and Tim Murphy (R-PA) introduced the Health Information Technology for Behavioral Health Services Act of 2010 (H.R. 5040) in the U.S. House of Representatives. This important legislation would add licensed psychologist and clinical social workers to the list of professionals eligible for provider incentives, thus expanding the amount of incentives behavioral health and substance abuse treatment organizations can receive. In addition, the legislation would expand the definition of eligible facilities for Hospital incentives so behavioral health, mental health and substance treatment facilities can choose to receive organization-level incentives as an alternative to incentives based on the number of EPs. In addition, this expanded definition would make psychiatric hospitals eligible for Hospital incentives.

Netsmart, The National Council for Community Behavioral Healthcare, the National Association of Psychiatric Health Systems, and others are mobilizing behavioral health providers to contact their members of the U.S. House to gain co-sponsorship for H.R. 5040 and support for its passage. As in the past, Netsmart customers and staff are meeting with members of Congress and their staffs as part of The National Council’s Hill Day activities, with H.R. 5040 at the center of that effort.

WHAT IS MEANINGFUL USE CRITERIA?

In order to receive incentives, an organization has to be a “meaningful user” of a certified electronic health record. To be considered as implementing MU, a provider organization must be using an ARRA-certified electronic health record. The organization must also meet the criteria that have been established for Stage 1 Meaningful Use, which generally includes implementing processes and systems that:

- >> Improve quality, safety, efficiency and reduces health disputes
- >> Engage patients and families in their health care
- >> Improve care coordination
- >> Improve population and public health
- >> Ensure adequate privacy and security protections for personal health information

To take full advantage of MU incentive funds, organizations need to prepare now and work with a technology partner with the resources and solutions to help them meet MU criteria.

NETSMART CAN HELP BEHAVIORAL HEALTH PROVIDERS MEET MU CRITERIA

Netsmart has a certification plan for its Avatar and CMHC/MIS enterprise software solutions, and roadmaps showing how each product maps to the Stage 1 Meaningful Use criteria. These roadmaps are designed to give behavioral health providers assurance they can meet MU criteria, a path to get there and planning tools to make the process easy and efficient.

Netsmart provides all the technology needed for MU from one place, reducing risk and helping assure success:

- >> **EHR certification experience**, the resources required for the certification process, and an EHR that can achieve ARRA certification;
- >> **A Consumer Web portal** that meets the requirement of providing consumers with access to their health information;
- >> **Electronic Prescribing**. Netsmart’s InfoScriber e-prescribing service is designed specifically for behavioral health;
- >> **Computerized physician order entry (CPOE)** for outpatient facilities (non-medication) and inpatient (medication and non-medication) orders;
- >> **Health Information Exchange (HIE)** connectivity to meet the Meaningful Use requirement for sharing of clinical information.

To view a one-hour Netsmart Web seminar summarizing the details of Meaningful Use criteria, a Meaningful Use more information, visit www.ntst.com/meaningfuluse

To see the complete text of H.R. 5040 and to learn how you can support this critical legislation, visit www.ntst.com/legislation.

This analysis regarding the possible impact of Meaningful Use is based on information as defined at the time of writing and provided as general information only, and not as legal or financial advice. Organizations should obtain qualified professional legal and financial opinions on the meaning and impact of the policy on their particular organization prior to making any business plans or decisions.

Comprehensive Coverage: The Minnesota Mix

Ron Brand, Executive Director, Minnesota Association of Community Mental Health; Mohini Venkatesh, MPH, Director of Federal and State Policy, National Council for Community Behavioral Healthcare

A June 2008 report from the National Council for Community Behavioral Healthcare and the National Alliance on Mental Illness, “Coverage for All: Inclusion of Mental Illness and Substance Use Disorders in State Healthcare Reform Initiatives (full report at <http://healthcareforuninsured.org/>),” detailed how states have attempted to reform their healthcare systems, the impact on consumers of mental health and addiction services, and lessons learned from states’ experiences. The report featured a case study on Minnesota, a state that has incrementally reformed its healthcare system over the past ten years. With the passage of federal healthcare reform, the Minnesota case study (an updated version of which is presented in this article) offers many lessons.

In 2007, the governor proposed and the legislature passed a Mental Health Initiative. One of the more important components of the initiative was legislation amending Minnesota’s two programs for the uninsured – General Assistance Medical Care and MinnesotaCare – to add to the comprehensive mental health and addictions benefit.

WHO IS COVERED?

GAMC covers those with income at or below 75% of the Federal Poverty Level who meet one or more

of additional criteria known as GAMC qualifiers. Qualifiers include waiting or appealing disability determination by Social Security Administration or state medical review team; or being in a homeless or live in shelter, hotel, or other place of public accommodation.

Minnesota Care covers children and pregnant women, parents, and caretakers up to 275% of the FPL, except that parents and caretakers gross income cannot exceed \$50,000. Single adults without children increased to 200% of FPL by January 1, 2008 and will rise to 215% of FPL by January 1, 2009.

WHAT SERVICES ARE COVERED?

For Minnesota Care, there are limits of \$10,000 on inpatient care for any condition (physical, mental health, or addictions) for parents over 175% of FPL and childless adults. For GAMC, inpatient benefits are fully covered. Both programs cover chemical dependency outpatient services. An intensive array of outpatient and residential mental health services are available.

WHAT IS THE COST?

In Minnesota, the Medicaid Temporary Assistance for Needy Families population, GAMC and MinnesotaCare are enrolled in comprehensive nonprofit health plans that are responsible to deliver and

are at risk for the entire health benefit, including behavioral health. Adding mental health rehabilitative services (including Adult Rehabilitative Mental Health Services individual and group rehabilitation services, Assertive Community Treatment, Intensive Residential Treatment and mobile and residential crisis services) to MinnesotaCare was projected to cost \$3.40 per person per month. For GAMC, which includes a homeless population, the cost was \$7.01 per person per month. The additional targeted case management service was projected to cost \$2.22 per person per month for MinnesotaCare and \$7.66 for GAMC.

The legislature appropriated a total of \$1 million in additional state dollars in FY 2008 and \$ 3.5 million in FY 2009 to add the adult rehabilitative services and case management in MinnesotaCare. State funds previously targeted for case management were moved from the counties to the state in an amount of \$4.4 million in FY 2009.

WHAT LED TO COMPREHENSIVE COVERAGE?

The state collected data on the residents served by MinnesotaCare, GAMC, and Medicaid managed care plans serving non-disabled populations, and discovered that an increasing number of individu-

Minnesota’s mental health agency and other stakeholders desired to move mental illness from its historical treatment as a social disease requiring social services to an illness like any other. They wanted to foster earlier interventions and avoid shifting enrollees among different programs in order to access specific services.

als with serious mental illnesses were in these plans. Several insurance reforms – similar to those included in the national healthcare reform bill – modified the private market, including guaranteed issue in small and large group plans, broader rate bands, parity for mental health and chemical dependency services, medical loss ratios, high risk insurance pool, and others. A lawsuit by the Attorney General called attention to health plan denials of payment for court-ordered treatment, for example for civil commitment or out of home placement for adolescents.

Health plans settled with an agreement that behavioral health benefits would be covered by a health plan if the court based its decision on a diagnostic evaluation and plan of care developed by a qualified professional. In addition to the court-ordered services provision, the state contracts and capitation with pre-paid health programs (MinnesotaCare and GAMC) were amended to align risk and responsibility for services in Institutions for Mental Diseases, 180 days of nursing home or home health, and court-ordered treatment. There were also highly successful experiments reducing costs and improving outcomes for commercial and non-disabled Medicaid clients who were offered a more intensive community based mental health service that improved coordination with and linkages to behavioral healthcare, primary care, and other needed services.

These demonstrations produced a positive return on investment – \$0.38/person/month – and gave the health plans tools to manage the increased risk that resulted from several insurance reforms, including parity, a statutory definition of medical necessity, and the court-ordered treatment provision.

The state supported comprehensive coverage because it sought to bring intensive mental health and addiction services into the mainstream of healthcare. Minnesota’s mental health agency and other stakeholders desired to move mental illness from its historical treatment as a social disease requiring social services to an illness like any other. They wanted to foster earlier interventions and avoid shifting enroll-

ees among different programs in order to access specific services. Operationalizing this change required rethinking medical necessity determinations, provider credentialing, contracting, procedure codes and other processes common to private insurance plans.

HOW DID IT GET THROUGH THE POLITICAL PROCESS?

Three factors significantly contributed to the political viability of a benefit expansion in the MinnesotaCare and GMAC programs:

- >> Governor Tim Pawlenty and members of his administration provided strong leadership. The provisions to expand the mental health benefits in these plans were part of the Governor’s Mental Health Initiative, set forth in advance of the 2007 legislative session.
- >> An extremely strong coalition of stakeholders formed the Minnesota Mental Health Action Group. This group is co-chaired by a representative from the Department of Human Services and included representation from the private insurance industry and organized and knowledgeable advocacy and provider communities.
- >> There was strong support in the legislature for the expansion of benefits in MinnesotaCare and GAMC, including from key legislators such as Mandy Greiling, a member of the Finance Committee in the House, who has a son with schizophrenia. The creation of a mental health division in the Health and Human Services Policy Committee also helped move the policy discussion forward.

WHAT IS THE CURRENT PAYER MIX?

A recent survey of community behavioral health organizations found that on average, 42% of reimbursement for services came from private insurers. While this represents the average, the survey found that there was quite a range in reimbursement sources. For community behavioral health organizations that specialize in services such as Assertive Community Treatment or case management, Medicaid is the predominant reimbursement source, either through fee-

for-service or managed care.

Reimbursement from private insurance and Medicaid managed care is uniformly better than Medicaid fee-for-service. In addition to higher rates, the private insurers and Medicaid managed care organizations have been willing to offer special contracts for packages of services for crisis care and hospital discharge plus aftercare.

CHALLENGES

Continuity of care between the inpatient and outpatient settings continues to be a challenge. Current hospital payments assume that hospitals are actively involved through discharge and the transition to outpatient settings and advocating for payments for outpatient providers to assist in this process is viewed as duplicative. This undermines our ability to smoothly transition clients between service settings.

Meeting the credentialing requirements for program services and mental health professionals has posed new challenges. Community behavioral health organizations employ professionals that may not meet private insurers’ credentialing standards (for example, 3 years of post-licensure experience). Community providers have addressed this through contractual arrangements in which quality assurance and supervision requirements substitute for these credentialing standards. Services are billed under a supervisory protocol in which the supervising professional’s National Provider Identifier is used.

Additionally, some programs offer services that rely on a combination of funding sources such as county, state, and private insurers. In these situations, counties sometimes want to limit private insurance clients’ access to these programs because a portion of the overall program is covered by the county.

IMPACT OF STATE BUDGET CUTS

In a dramatic turnabout that may foreshadow dilemmas faced by other states, effective early 2010, the governor vetoed funding for the GAMC program. The legislature extended the program for several months, as a compromise was negotiated to retain elements of coverage for the GAMC population – a hospital uncompensated care fund, medication/pharmacy, and “Coordinated Care Delivery Systems.” An accountable hospital-centered program paid a fixed amount to cover about 40% of the GAMC population who elect to participate. As there is no reimbursement for outpatient clinic and all non-hospital services, providers



A recent survey of community behavioral health organizations found that on average, 42% of reimbursement for services came from private insurers. Reimbursement from private insurance and Medicaid managed care is uniformly better than Medicaid fee-for-service. In addition to higher rates, the private insurers and Medicaid managed care organizations have been willing to offer special contracts for packages of services for crisis care and hospital discharge plus aftercare.

and consumers are scrambling to seek disability determination or enroll in MinnesotaCare after the six month GAMC enrollment period ends.

While these cuts are only effective as of June 1, 2010, it is expected that they will result in increases to the uncompensated care burden on hospitals and community safety net providers.

HOW DO WE MINIMIZE THE IMPACT OF BUDGET CUTS?

The Minnesota Association of Community Mental Health, a not-for-profit membership organization representing community mental health and other service provider agencies throughout the state, has been working in coalition with the National Alliance on Mental Illness, Mental Health America, and other key stakeholders, on advocacy related to the GAMC program changes. Initially, advocacy efforts were focused on encouraging the state legislature to vote in support of expanding the state Medicaid program early to receive additional federal funding (as provided for in the national healthcare reform bill). Unfortunately, this proved to be politically untenable in the immediate future; however, a measure was passed to allow the governor to use executive authority to expand Medicaid.

While being actively involved in this advocacy process is vitally important to the community behavioral health system, MACMHP members are also evaluating ways in which they can optimize their business practices to meet this changing budgetary reality. Among other strategies, community behavioral health providers are working to develop partnerships with community hospitals to reduce the number of avoidable emergency department admissions and ease the transition from the inpatient to outpatient settings, supporting clients through the disability determinations process so they may become eligible for Medicaid as quickly as possible, and raising funds that will help to cover the cost sharing requirements for MinnesotaCare clients that are unable to pay.

Through this two-pronged approach that includes both advocacy and pragmatic business considerations, it is hoped that the community behavioral health system will be able to develop new cost-effective ways of delivering services that will be well-positioned to withstand funding changes while taking advantage of new opportunities made available through national and state health reform initiatives.

To learn more about Minnesota's healthcare reform efforts, see National Academy of State Health Policy and the Commonwealth Fund's report, "Reforming

Health Care Delivery Through Payment Change and Transparency: Minnesota's Innovations" at <http://www.commonwealthfund.org/>

Ron Brand is executive director of the Minnesota Association of Community Mental Health Programs, Inc., a position that he has held since 1990. He is involved with public policy advocacy, education, and member services. Previously, he worked in a community counseling center, in substance abuse treatment, as a school psychologist, and for a private foundation focused on organizational development and community care. Brand has a masters degree in psychology from the University of Minnesota.

Mohini Venkatesh serves as the staff policy liaison to the National Council for Community Behavioral Healthcare's network of associations throughout the states, conducts federal legislative and policy analysis on an array of issues, and manages political engagement activities including an annual Hill Day in Washington, DC. She received a masters degree in public health from Yale University and a BA in psychology from the University of Massachusetts-Amherst.

JYS Clinical Career Opportunities

Juneau Youth Services

Seeking experienced clinical staff to provide mental health and chemical dependency treatment to Severely Emotionally Disturbed youth in a residential setting.

Candidates must demonstrate awareness and application of:

- developmental theory
- family dynamics
- mental illness/substance abuse
- behavioral principles
- individual therapy
- behavioral assessments

Master's degree in psychology, social work, or closely related field. Salary DOE. Preference to licensed and license-eligible candidates.

Exceptional benefits, including:

- Premium for employee health & dental insurance coverage paid 100% & 50% for spouse/dependent
- Two days of leave per month after six months of employment
- Retirement program with matched contributions up to 9% of annual wage
- Paid holidays
- Licensing supervision, including financial support
- Relocation allowance

Visit www.jys.org or call 907-789-7610 for more information



BETTER BUSINESS PROCESSES... BETTER CLINICAL OUTCOMES...

RESULTS

Community behavioral health organizations have achieved:

- **\$200,000 in annual savings through access efficiencies.**
- **40% reduction in client wait times – with greater engagement and reduced no-shows.**
- **450 hours of additional services, without additional staff.**

To replicate the results in your organization, schedule an SPQM test drive with David Lloyd and his team – contact Jeannie Campbell at 202.684.7457 or JeannieC@thenationalcouncil.org.

STRATEGIES

The SPQM team has implemented winning change concepts in 500+ community behavioral health organizations:

- SPQM Dashboards
- Enhancing Revenue
- Streamlining Documentation
- Improving Access and Retention
- Leadership and Workforce Development
- Clinical Assessment Tools

... A BETTER BOTTOM LINE



The SPQM Services Suite is brought to you by the National Council for Community Behavioral Healthcare and MTM Services







No Reform Without Payment Reform: The Massachusetts Experience

Vic DiGravio, President and CEO and Stephanie Hirst, Senior Director of Policy and Research — Association for Behavioral Healthcare, Massachusetts

Here in Massachusetts, we like to be the best (ask any Boston sports fan), the first (we held the original Thanksgiving in 1621), or unique (we voted for George McGovern and are proud of it). Bay Staters almost never apologize for this; moreover, when it comes to healthcare reform, we like to think we are continuing our tradition of being first and best.

Certainly, the Massachusetts soil in which the seed of healthcare reform was planted was much more fertile than in many other states. Massachusetts's long history of medical innovation and concentration on healthcare coverage gave us a leg up on reform. In 2006, when Massachusetts passed healthcare

reform, 98 percent of employers with more than 100 employees and 65 percent of those with fewer than 100 employees helped provide health coverage for their workers. Massachusetts, moreover, started with a fairly high baseline of coverage: 91 percent of Massachusetts residents already had some form of health insurance. We were not starting from scratch. So healthcare reform in Massachusetts worked; 98 percent of residents now have health insurance coverage. By almost any measure, healthcare reform in Massachusetts has been a success.

But how have behavioral healthcare and behavioral healthcare providers been affected by Massachusetts healthcare reform? Access to behavioral

healthcare is a mandatory component of most of the plans created under the law, including the state's subsidized health insurance plans for people who earn up to 300 percent of the Federal Poverty Level. The benefit package of these subsidized plans is similar to coverage provided under Massachusetts's strong Medicaid program, which includes a wide array of inpatient, outpatient, and prescription drug coverages. Unlike our Medicaid program, however, "reasonable" deductibles and copays are allowed for almost all services, including behavioral healthcare.

As implementation unfolded, the Association for Behavioral Healthcare and our members realized that many of the gains we expected to see from Massachusetts healthcare reform could be jeopardized if the development of regulations and guidelines that shape behavioral health coverage limited access through the imposition of costly copays and deductibles. As we all know, little else in healthcare requires the particular pattern of service use demanded by mental health and substance abuse treatment.

We have succeeded in fixing the access issue, but if we don't fix the cost problem, healthcare reform may all be for naught, both here in Massachusetts and nationally... And healthcare reform has succeeded in expanding coverage for Massachusetts citizens, but has it increased business opportunities for providers?

Copayments for methadone services initially proved to be especially burdensome for patients. As a result, in January 2007, the Commonwealth Health Insurance Connector Authority (the quasi-government agency charged with implementing healthcare reform) agreed to waive “all copayments for all components of methadone treatment for Commonwealth Care enrollees.” This substantive policy change helped ensure that more people across the state were able to access needed treatment and, just as important, signaled a willingness on the part of the Connector to consider the unique nature of mental illness and substance use disorders in formulating and adopting healthcare-reform-related policies.

The Connector reaffirmed its commitment to promoting access to behavioral healthcare in July 2008, when it initiated changes to copayments for state-subsidized plans. For the most part, these changes were in the form of increased copayments. Mental health and substance use disorder services, however, were not subject to increases in copayments. In fact, people who earned between 200 percent and 300 percent of the Federal Poverty Level actually saw a decrease in their mental health and substance abuse outpatient copayments. Before this change, behavioral healthcare services were categorized as specialty services. Copayments for behavioral health outpatient services are now the same as those charged for primary care visits. This change was a significant victory — behavioral healthcare became more accessible, and state policymakers again signaled an understanding of the importance of behavioral healthcare.

Despite these gains, cost sharing remains a concern today. For example, copayments for inpatient mental health and substance use disorder services, including 24-hour detox treatment, range from \$50 to \$250 for people who earn between 100 percent and 300 percent of the Federal Poverty Level and are enrolled in the state-subsidized plans. When consumers cannot afford these copayments, providers are forced to either absorb the costs or deny services. As in most of the country, providers of community mental health and substance abuse services in Massachusetts operate on razor-thin margins. Expensive copays increase financial instability, diminish providers’ ability to provide quality treatment services, and reduce client access.

Although providers in Massachusetts have noted that more people now have insurance, our mem-

At long last, the impossible dream of healthcare for all will finally become a reality in our Commonwealth, and quality care will truly be available and affordable for each and every man, woman, and child in our state...”

Senator Edward M. Kennedy
April 12, 2006

bers still see a large number of uninsured clients in need of services. This is especially true for people in need of substance abuse treatment. According to an October 2009 presentation by Rick Harwood and Kara Mandall of the National Association of State Alcohol/Drug Abuse Directors, 61 percent of people who sought substance abuse treatment in Massachusetts in 2005 were uninsured. This number dropped to 22 percent in 2009. Although such a decrease represents significant progress, it is nowhere near the state’s overall uninsured rate of 2 percent.

Our members have identified an array of barriers to enrollment and coverage, which have resulted in a disproportionate number of people with behavioral health disorders being left without insurance:

- >> People are often only in treatment for a few days, and it is difficult to help them get enrolled during such a short time period, especially given their acuity
- >> It is hard to track clients as they move from one type of service to another (i.e., different providers)
- >> The enrollment process is burdensome
- >> Many people cannot afford even modest copayments or deductibles.

Research conducted by the state has identified similar issues. In particular, a May 2010 study published by the Massachusetts Division of Health Care Finance and Policy found that “almost one-third (32.8 %) of Massachusetts residents with full-year insurance coverage reported some type of problem getting health care in the past 12 months. This included... almost one in five (18.1 %) who reported that they were not able to get health care that they needed because of cost.”

Massachusetts is still working to address these barriers. As federal healthcare reform implementation begins to take shape, consumer education and outreach will be paramount, and policymakers should take care to address affordability issues and to ensure that the enrollment process is as user friendly as possible.

Healthcare reform has succeeded in expanding coverage for Massachusetts citizens, but has it increased business opportunities for providers? We think probably not. Most ABH members have a long history of contracting with third-party payers for both mental health and substance use disorder treatment services. Our members were not expecting, nor did they see, a boom in business.

It is interesting that as implementation unfolded, providers struggled with a series of questions about the impact that the law would have on them as employers. Although Massachusetts health reform includes a mandate that people be responsible for ensuring that they have health coverage, the law is also equally clear that employer-sponsored health insurance is at the heart of our state’s move toward universal coverage. As employers, ABH members continue to struggle with the high cost of insuring their employees. This year, many of our members are facing 25–35 percent increases in premiums for their employees.

These increases aren’t necessarily the result of healthcare reform but are more indicative of the fact that healthcare reform in Massachusetts has not addressed the skyrocketing costs of healthcare. We have succeeded in fixing the access issue, but if we don’t fix the cost problem, healthcare reform may all be for naught, both here in Massachusetts and nationally.

At this point, we consider healthcare reform to be a success. But everyone in Massachusetts understands that cost control is the next great frontier and perhaps our greatest challenge. Will efforts at cost containment succeed? We don’t know, although we’re going to give it our best shot.

Vic DiGravio is president and chief executive officer of the Association for Behavioral Healthcare. Prior to joining ABH, Vic served for 6 years as chief of staff to Massachusetts Senate Majority Leader Frederick Berry. He is a graduate of Connecticut College and Harvard University’s Kennedy School of Government.

Stephanie Hirst is senior director for public policy and research for the Association for Behavioral Healthcare. She is a graduate of Colby College and the McCormack Graduate School of Policy Studies at the University of Massachusetts Boston.

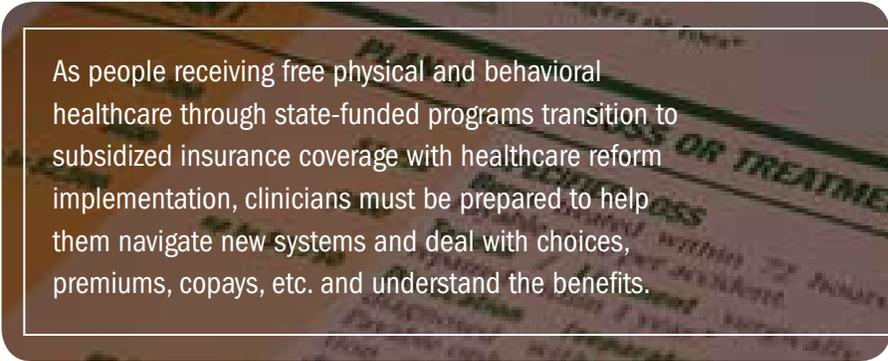
“Why Do I Have to Pay?” Transitioning Patients from Safety Net to Insurance Coverage

Norah Mulvaney-Day, PhD, Research Associate, Center for Multicultural Mental Health Research, Cambridge Health Alliance

In April 2006, Massachusetts passed a historic health insurance reform bill that mandated that every state resident have health insurance or pay a tax penalty. Many components of the health insurance reform currently unfolding nationally, for both physical and behavioral health, are modeled on this law. Accordingly, the experiences in Massachusetts provide a valuable early snapshot of what we can expect for people with behavioral health disorders and how clinicians can best support their patients during this time of policy transition.

Starting in August 2007, my colleagues and I at the Center for Multicultural Mental Health Research began tracking the experiences of 66 clients receiving behavioral healthcare in a safety net institution in Massachusetts. Prior to reform, these people were all uninsured and received physical and behavioral healthcare through a state-funded program that provided healthcare for the uninsured. After reform, many in this population transitioned from the state-funded “free care” program into a government-subsidized insurance mechanism. The big change for this population was the introduction of copayments and monthly premiums. People who make less than 150 percent of the Federal Poverty Level are now charged copayments of \$1 to \$3 for prescription medications, whereas people who make between 150 percent and 300 percent of the FPL must pay both monthly premiums and higher copayments for clinic and hospital visits and prescription medications.

Our project has identified several areas where clinicians can help ease these transitions for patients who do not qualify for Medicaid and fall within these FPL groups. Particularly for near-poor patients, who may be subject to cost sharing and insurance premiums for the first time, close attention to the following issues may be necessary during this time of policy change.



As people receiving free physical and behavioral healthcare through state-funded programs transition to subsidized insurance coverage with healthcare reform implementation, clinicians must be prepared to help them navigate new systems and deal with choices, premiums, copays, etc. and understand the benefits.

GUIDING CHOICES AND PAPERWORK: Clinicians should become as familiar as possible with the requirements of health insurance reform as well as the options for coverage provided under any subsidized insurance exchanges that are set up by their state. Patients will likely require support understanding the components of the health insurance reform, choosing between insurance options, and figuring out their eligibility for the insurance. Clinicians will need to triage these questions to the appropriate administrators, and some patients may need more intensive support filling out forms. Asking patients about their insurance coverage and whether they have questions, understanding the resources available to support patients, and linking them to these resources during their sessions will help the most vulnerable patients make the transition smoothly. In particular, ask whether insurance coverage is a factor if patients suddenly stop coming to care, and help triage those patients to an administrator or case worker who can assist them.

DEALING WITH COPAYS: Clinicians should closely monitor patients with multiple co-occurring physical and behavioral health conditions who transition to a health insurance mechanism with cost sharing (eg. copayments for visits) to ensure that they are not self-rationing needed psychiatric medications or behavioral health visits because of difficulties managing the cost of copayments. For patients with

multiple health and mental health concerns who are on many medications, the copayments can quickly add up. Many states will likely implement an annual ceiling on copayment amounts per person. Patients may not know about the ceiling, however, and even if they do, they may not know the best way to keep track of their copayment costs. Check into the rules in your state regarding ceilings on copayments. Help your clients develop strategies to keep track of copayment receipts so they can avoid disruptions in necessary mental healthcare.

MAINTAINING SUBSIDIZED HEALTH INSURANCE: Clinics should consider providing training on the process of obtaining and maintaining subsidized health insurance, particularly the need for monthly premiums, the need to reapply every year, and factors that could require redetermination of eligibility. Of the people we are following in our study, most who lost insurance coverage did so because they did not understand the administrative requirements of the subsidized insurance policy. Some patients missed premium payments and lost coverage, some did not understand that they had to reapply every year, and some did not realize that a change in their life circumstances (e.g., getting married, getting a new job) required redetermination of eligibility for subsidized insurance coverage. Often, these patients were forced to pay out of pocket during insurance gaps while their eligibility was being reas-



essed, which led them to cut back on needed medications and care.

DEALING WITH “WHY PAY FOR INSURANCE:” Clinics should be prepared to support patients who are opposed to the health insurance reform and feel that paying for insurance is not fair. Particularly in settings where patients have received robust community-based health services without charge, patients who are near-poor but do not qualify for fully subsidized insurance may initially be resistant to the change. Patients also may not understand why they need to pay for health insurance even when they are not sick. Efforts to explain the benefits of regular insurance may be necessary. For example, some patients who have transitioned into subsidized insurance in our setting appreciate that they can get their medications at their local pharmacy rather than coming to the hospital, are very pleased with increased access to specialists, and feel more entitled to receive healthcare because they pay regularly for insurance. Reminding patients of the benefits of insurance in your state may eventually help overcome initial resistance to the change.

TRANSLATIONS AND SUPPORT: Clinicians who treat patients with limited English proficiency should be aware of potential language issues in the implementation of the reform. Look for translated materials that explain the insurance reform. If letters and updates on patients’ insurance coverage are not translated into the languages of the patient population you serve, talk with your clinic administrators about other options for translation. Remember that even when the information is translated into a patient’s first language, he or she may require help understanding the insurance package, choosing among the options available, and navigating the new system of care.

CLEARING MISCONCEPTIONS: Depending on how care for the uninsured is structured in your state, clinics should help patients who choose not to get insurance understand clearly whether they will be subject to the individual mandate. Particularly if the prior government-run program included an identification card of some kind, patients may be mistakenly under the impression that they already have insurance and will not be subjected to the mandate. Clearly disseminating information about the penalty for not getting

insurance and information about who is subject to this penalty will help allay anxiety for many patients during the process of the health insurance reform.

Health insurance reform provides enormous opportunity to increase access to healthcare for many people. For patients with behavioral health disorders who do not have Medicaid and are being seen in safety net settings, clinicians can play an important role in navigating the challenges that may occur during the implementation process. Attention to these issues can help ensure that all patients benefit from the increased access to health insurance made possible by healthcare reform.

Norah Mulvaney-Day is a mental health services researcher and social policy analyst at the Center for Multicultural Mental Health Research at the Cambridge Health Alliance. She has a background in community-based research, participatory research, and healthcare systems analysis. Her research at the Center has included pilot testing a cultural competency assessment tool at different levels of the hospital system and implementing a participatory systems enhancement project to improve special education services for disruptive children in a public school setting. She received her doctorate in mental health policy from Brandeis University.

Every software vendor makes promises.

Better clinical, better billing, better results.

What good are promises if your vendor can't deliver?

Qualifacts has built our reputation on fast, successful implementations and happy customers. Across 26 successful go-lives last year, our average project, from kick-off to go-live, was only five and half months.

5.5 – No other vendor is even close.

So when you are ready to use an EHR, not just buy one, give us a call.

Find Success With Qualifacts.

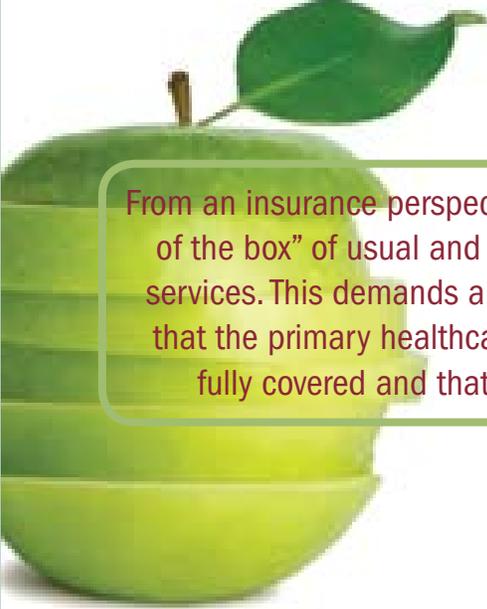
www.qualifacts.com | (866) 386-6755

qualifacts

5.5

Health Integration – Are You Covered?

Nicholas L. Bozzo, Managing Director, Negley Associates and President, Mental Health Risk Retention Group.



From an insurance perspective, primary healthcare is “outside of the box” of usual and customary behavioral healthcare services. This demands a customized approach to assuring that the primary healthcare activities being performed are fully covered and that the organization is protected.

The landscape of service delivery for behavioral healthcare organizations has probably changed forever with the passage of the Patient Protection and Affordable Care Act. Now we need to be sure that insurance products reflect the new world order.

Discussions and initiatives that promote the integration of behavioral and primary healthcare will accelerate as all Americans have health insurance coverage and attention turns to bending the cost curve. The new reform legislation authorizes an array of pilots designed to manage a person’s overall health care and health expenditures. As increasing numbers of behavioral health organizations directly deliver or partner to deliver primary as well as mental health and addictions treatment, it is imperative that the organizations revisit their liability coverage – assuring that the organization is insured against the risks associated with expanded scope of service.

From an insurance perspective, primary healthcare is “outside of the box” of usual and customary behavioral healthcare services. This demands a customized approach to assuring that the primary healthcare activities being performed are fully covered and that the organization is protected.

Don Thacker, CEO of Shawnee Mental Health Center in Portsmouth, Ohio, discussed his experience with primary healthcare integration at his center says.

He says when he was first considering behavioral and primary care integration, his action list involved looking at:

- >> What kind of primary care services to provide.
- >> To whom should services be offered (Shawnee provides services to the severely mentally disabled adult clients).
- >> To partner or go it alone (Shawnee decided to do it alone).
- >> Was there a need to add liability coverage (Shawnee checked with their carrier, the Mental Health Risk Retention Group, which provides coverage for the primary care delivered in behavioral health settings).

Shawnee said that one of the biggest fears is about financial sustainability.

Another challenge is to be able to achieve a marriage of two different worlds, primary healthcare and behavioral healthcare, to provide the best outcome for those served. He also added that it was important for his center to try to establish a person-centered treatment model where consumers would feel comfortable receiving their primary healthcare and behavioral healthcare services at the same location.

Behavioral health organizations, along with insurance brokers, need to consider the following in determining increased exposures due to integration:

- >> Identify specific areas that need to be covered:
 - Are you partnering with a primary care provider?

- Are you hiring primary care professionals?
- Are you providing primary care to those you treat for mental illnesses and addiction disorders?

- >> Is your insurance carrier experienced in primary medical malpractice claims?
- >> If you are partnering with a primary care provider, have you eliminated the coverage gaps between your and your partner’s general and professional liability policies?
- >> Have appropriate endorsements been written to affirmatively provide the coverage necessary to protect you?
- >> Have you identified the limitations and dangers of relying solely on the protection afforded by the Federal Tort Claims Act, which only protects doctors and not your organization and does not provide any coverage for sexual misconduct exposures?

The goal is that an organization should not have to pay for a loss that could have been covered by insurance. The integration of behavioral and primary care is expected to improve general good health; but one should not lose sight of one of the most important corporate assets that help you provide your services and protects your balance sheet – insurance protection.

Nicholas Bozzo has 21 years experience in insurance starting with underwriting at Chubb, Kemper, and Axis and rising to head the Mental Health Risk Retention Group and Negley Associates. He says his proudest achievement is “Taking on the leadership role of an organization with a 20-year track record of success – that’s considered by many to be the gold standard of risk retention groups – and continuing to maintain the success without missing a beat.” He was named “CEO of the Month” in November 2008 by Risk Retention Reporter. Just before joining Negley, he gained senior management experience as founder and head of the Specialty Lines Business at Beazley, PLC.

ADVERTORIAL



Support the Health Information Technology Extension for Behavioral Health Services Act

Joseph Rocks, Chairman and CEO, NHS Human Services

Throughout the healthcare industry there is a general sense of excitement about the shift toward increased utilization of technology. In addition to the efficiencies that technology affords, the financial encouragement created by the American Recovery and Reinvestment Act (ARRA) of 2009 is a great incentive. This legislation has made more than two (2) billion dollars available to create a system for the usage of a certified Electronic Health Record (EHR) and Health Information Exchange (HIE). While this is an opportunity for the primary health care sector, once again the behavioral health providers have been excluded from this bill. This inequity has created both ethical and treatment dilemmas and is unfortunately another example of the stigmatization of the people we work with and serve.

NHS Human Services is a provider of Adult Behavioral Health, I/DD and Children's Services to approximately 50,000 individuals in seven (7) states. We have made a commitment to implementing an EHR and are looking for opportunities to integrate primary care and behavioral health throughout our entire service area. Due to our size and geographical footprint, we are perhaps more aware than others of the negative impact the ARRA bill will have on our programs and consumers. In order for the healthcare industry to realize the maximum positive results from these types of opportunities, all treatment segments must be more equally included.

As the Chairman and CEO of NHS Human Services (NHS), I take my responsibility to lead seriously. My background as a former Senator in the Commonwealth of Pennsylvania has provided me with much experience in this area and has given me the life experience of advocating for individuals with special needs and being a change agent on their behalf. Once again, it is time for a change. It is time for our consumers to be treated as equals in the healthcare arena. It is time for them to be afforded the same access to care and financial resources as others with physical health needs. It is time for them to be treated holistically and recognize that the body and mind are linked.

Most states are facing budget deficits and proposing legislation that does not treat behavioral health and community mental health centers the same as primary care providers. Our ability to provide care to some of the most vulnerable people in our population is severely impeded by this kind of legislation and bureaucratic shortsightedness.

The National Institute of Mental Health recognizes mental disorders as the leading cause of disability in the United States and Canada for adults ages 15-44, yet the federal government has not included us in the stimulus package which is designed to improve the provision of health care and outcomes for our consumers.

It is up to us as leaders in this field to make sure that funds are available to in-

It is up to us as leaders in this field to make sure that funds are available to increase the quality of life for individuals diagnosed with a mental illness or who are living with developmental and intellectual disabilities. It is time for a change.

crease the quality of life for individuals diagnosed with a mental illness or who are living with developmental and intellectual disabilities. It is time for a change.

We must fight for EHR funding and increased collaborations with primary care providers. We must continue to fight to create a system that treats both the physical health and behavioral health needs of individuals in a comprehensive way.

While we rely on the leadership and advocacy efforts of our national partners at the National Council, it is imperative now for all of us to secure sponsorship for the independent legislation which will improve access to technology for those that receive behavioral health services. NHS, along with our IT partner Netsmart, is proud to be part of this battle. As most are aware, recently, Reps. Patrick Kennedy (D-RI), Tim Murphy (R-PA), Gene Green (D-TX), Alcee Hastings (D-FL), and Chris Murphy (D-CT) introduced the Health Information Technology Extension for Behavioral Health Services Act of 2010 (H.R. 5040). This legislation would create more equality in the healthcare industry. The legislation would ensure that behavioral and mental health professionals, psychiatric hospitals, behavioral, mental health and substance abuse treatment facilities are eligible for the incentive payments in relation to an EHR as established under the ARRA in 2009.

It is my goal to be in the forefront during this time of historic change. Please join me, the National Council and our supporters like Netsmart to create opportunities that will revolutionize the behavioral healthcare industry. In doing so, we will create a better quality of life and outcomes for those that we serve each day. It is time for a change that will support millions of people everyday on their journey to recovery.

The Honorable M. Joseph Rocks, former Senator of Pennsylvania, is the Chairman and CEO of NHS Human Services, headquartered in Lafayette Hill, PA, which currently provides services in seven states.

Contracting With Managed Care Organizations

Julianna S. Gonen, Esq., JD, PhD, Feldesman Tucker Leifer Fidell LLP

“The managed care organizations you contract with are business partners, referral sources, and revenue sources. Entering into contractual relationships with them also entails obligations that can affect how your agency operates and is paid.”

Note: This article offers general guidance on the contracting process; it does not replace and is not a substitute for legal advice from qualified counsel.

Managed care is a dominant model for the organization, delivery, and payment for healthcare services, both in the private market and in public programs such as Medicare and Medicaid. Accordingly, healthcare providers must often decide whether to become part of one or more managed care organizations. This article provides an overview of typical MCO contract provisions and some tips on how to position your agency in negotiating with an MCO over a new or existing participating provider agreement.

GENERAL CONTRACT CONSIDERATIONS

Usually, the starting point of a contractual arrangement between an MCO and a provider is the MCO's standard participating provider agreement. In addition to the specific elements of the contract pertaining to the services that the provider will render to the MCO's members and the reimbursement to be paid to the provider for those services, most agreements include numerous general contract terms. Because the contract was prepared by the MCO, there is a high likelihood that many of the terms will impose obligations on the provider that are not reciprocally imposed on the MCO. To the extent possible, you should seek to make these general rights and obligations – such as the ability to amend and the duty to indemnify – mutual.

Contracts vary with respect to the initial term (the time period during which the contract is effective) and renewal provisions. Pay attention to whether the contract will automatically renew at the end of the initial term. If a contract is “evergreen” – that is, if it renews automatically – you might seek to include an automatic annual rate increase. Whether an agreement ends because of expiration or termination for another reason, be cognizant of your obligations to continue providing services to the MCO's enrollees after termination of the agreement. State law often governs this to some extent, but you might be able to negotiate for a reversion to reimbursement on the basis of charges after a certain length of time after termination.

PROVIDER RIGHTS AND RESPONSIBILITIES

The centerpiece of the provider responsibilities section is the enumeration of the services to be delivered to the MCO's enrollees. Carefully review this list to ensure that it includes all services that your agency provides; MCOs sometimes enter into agreements with specialty vendors for certain services and carve them out of agreements with other providers. Conversely, check to make sure that the contract does not require you to perform services beyond your scope.

Although all MCO participating provider agreements prohibit the provider from seeking payment from enrollees for covered services (except for applicable cost-sharing amounts, e.g., copayments), the agreement should specify that the provider may bill patients for non-covered services.

Many MCO contracts incorporate by reference policies and procedures to which the provider must adhere; these are enumerated in separate documents.

If the contract obligates your agency to comply with the MCO's utilization management and utilization review program or any other policies and procedures not set forth in the main contract, be sure to obtain current copies of any such program documents before signing the agreement.

MCO RIGHTS AND RESPONSIBILITIES

The main focus of the MCO rights and responsibilities section is, of course, the payment terms. Make sure that if the payment schedule is set forth in an attachment, it is expressly incorporated by reference in the main agreement. If the contract provides for a risk-based payment method, rather than simply discounted fee for service, make sure that you have thoroughly evaluated the financial implications of the proposed method.

Carefully review the requirements for claim submission (e.g., paper vs. electronic), the time frame for submission, and whether late submission automatically precludes reimbursement. Most states have statutes that govern the timeliness of the MCO's payment of claims to providers, but they often only apply to insured plans. Include a requirement that the MCO pay all claims within a certain time frame, with a specified rate of interest to be applied to late payments.

Standard MCO agreements typically allow the MCO to offset a past overpayment against future claim payments. You should try to avoid agreeing to such provisions and instead agree to a recoupment procedure that is separate from future claims payments. This allows you greater control over the recovery and creates less accounting confusion. The agreement should set a limit to how far back an MCO can go in seeking to recover overpayments.

Providers should seek assurances in their MCO agreements that the network the provider is joining will not be "rented" or "leased" to additional payers without the provider's knowledge and opportunity to object. This ensures some level of predictability in terms of the number of patients the provider is expected to serve at the discounted rates under the contract.

MEDICAID MCOS

With dramatic increases in Medicaid expenditures, many states have implemented a variety of managed care models for their Medicaid programs. States with Medicaid managed care programs must adhere to various federal guidelines in designing and implementing those programs. Some states prescribe a nonnegotiable Medicaid addendum form to be included in an MCO-provider contract, whereas other states use a checklist of terms that need to be included in any contract between a Medicaid MCO and a provider. Thus, a Medicaid MCO has limited flexibility to negotiate or alter certain terms of its agreements with its participating providers, who serve Medicaid beneficiaries.

ANTITRUST ISSUES

Providers often feel as though they are at a strategic disadvantage when negotiating contracts with MCOs. Particularly in a market that has a high concentration of

similar providers, a provider might feel a lack of sufficient leverage to gain favorable terms, including reimbursement rates, from the MCO. Because of this, providers sometimes seek to collaborate with one another in the negotiation process to increase their bargaining strength. Note, however, that when entities with no prior clinical or financial affiliation team up to negotiate with MCOs, particularly over payment rates, they run a high risk of committing antitrust violations. To pass antitrust muster, a group of providers is generally required to show that they are economically integrated, either through financial risk-sharing arrangements or through clinical integration, to justify contracting with MCOs on a collective basis.

Managed care contracting should be viewed as part of your agency's business plan. The MCOs you contract with are business partners, referral sources, and revenue sources. Entering into contractual relationships with them also entails obligations that can affect how your agency operates. Always be mindful of the risks attendant to any substantial contractual arrangement, and be sure to vet potential contracts with an attorney.

Juliana Gonen is counsel at the firm of Feldesman Tucker Leifer Fidell LLP in Washington, DC. Her experience includes class action litigation at the federal and state levels involving health plan reimbursement practices; litigation over the usual, customary, and reasonable payment rates of health plans; review of numerous health-plan-participating provider agreements; and drafting of compliance programs for a Medicaid HMO. Prior to entering the practice of law, Gonen spent 10 years working in various health policy organizations in Washington, DC, including the American Managed Care and Review Association, the American Association of Health Plans, the Jacobs Institute of Women's Health, and the Washington Business Group on Health.



SKYLAND TRAIL
Offering hope, changing lives

Nationally recognized center of excellence
in adult psychiatric treatment
offering high quality, individualized care.

Buckhead, Atlanta • Three campuses
Insurance accepted

www.skylandtrail.org • 404.315.8333



Healthcare Reform Toughens Up On Compliance

Mary Thornton, BSRN, MBA, President, Mary Thornton & Associates, Inc.

Federal healthcare reform is a large, complex piece of legislation that tries to balance increased healthcare spending by the federal government with a much-expanded effort to reduce fraud, abuse, and waste to protect the taxpayers' investment. Providers who intend to continue billing Medicaid and Medicare must understand the level of regulatory compliance expected and adequately fund and staff their compliance efforts. Do not wait for final regulation — begin the design and implementation of a robust compliance program now.



Speaking at the National Council for Community Behavioral Healthcare's 40th annual conference in Orlando, FL in March 2010, Howard Dean, former presidential candidate, head of the Democratic National Committee and a physician, complimented federal healthcare reform legislation for its fraud-, abuse-, and waste-fighting provisions. These provisions are, in fact, quite formidable and far reaching, reflecting the administration's desire that additional government investment in healthcare services over the next several years be protected from people who are unwilling or unable to follow the rules.

The additional provisions are funded by more than \$300 million in investments by the administration in fraud- and abuse-fighting consultants, regulators, investigators, and software that will be made available over the next 10 years, with front-end boosts in 2010 and 2011. The tools available to these overseers have been greatly enhanced by the Patient Protection and Affordable Care Act and include redundancies to catch people who are not sophisticated and careful. Providers who intend to continue billing Medicaid and Medicare must understand the level of regulatory compliance expected and be willing and able to adequately fund their compliance efforts. The additional actions mandated by the PPACA break down into the following categories:

- >> Changes to existing laws that target fraud, abuse, and waste and potentially increase provider liability, coupled with expanded power to enforcement and oversight agencies to impose penalties and remove unwanted providers from the government's healthcare network.
- >> Greater provider responsibilities, including mandatory compliance programs and repayment provisions for overpayments or improper payments that link directly to the federal False Claims Act and require swift action once the overpayment or improper payment has been identified.
- >> Greater transparency on the part of physicians, pharmaceutical companies, medical equipment suppliers, and others. These provisions, based on legislation that was introduced but not passed several years ago, are intended to disclose, expose, and discourage certain types of professional relationships and potential conflicts of interest that could increase healthcare costs without balancing benefits.
- >> Front-end enrollment and screening activities (paid for with additional provider enrollment fees) that are intended to prevent people who are excluded and those who might engage in fraud, abuse, and waste from being enrolled in the federal healthcare programs.



Many of the provisions of the PPACA became effective on enactment; others wait for rules and regulations to be issued. Richard Kusserow, a former inspector general for the Department of Health and Human Services, estimated that it might take as many as 50,000 pages of regulation to fully implement the law. In any case, providers – unless they are quite large, with considerable resources – are unlikely to manage compliance efforts on their own. Attorneys and consultants who can help to uncover and weigh risk, direct and advise on disclosures and paybacks, and assist in redeveloping operational compliance are going to be necessary in this new environment.

A summary of the compliance-related provisions of the PPACA that may be of particular interest to behavioral health providers follows.

MANDATORY COMPLIANCE PROGRAMS

The Office of Inspector General has for many years encouraged providers to develop and implement effective, active, and visible compliance programs. Its website contains many guidance documents, discussions, and roundtable reports that suggest that the prudent provider take compliance seriously and formally. In the PPACA, the encouragement is not a suggestion but a requirement. In addition, providers will be expected to certify that a plan exists and that it meets regulatory expectations. At this time, experts believe the process will be quite similar to the certification now required of many Medicaid providers in New York State, but with the caveat that the regulation will require the certifier to be a part of the leadership team, not the

compliance officer. In addition, the PPACA requires that Recovery Audit Contractors, now expanded into Medicaid, not only verify that Medicaid providers have antifraud plans but also evaluate the plans' effectiveness.

Providers should anticipate these requirements. Do not wait for final regulation. Go to the OIG's website, look at the current guidance documents, and begin the design and implementation of a robust compliance program. Most important is the location of the compliance officer in the organizational structure. He or she should report directly to the chief executive officer or board of directors and, if the former, should have regular, direct access to the board.

DISCLOSURE AND REPAYMENT

The PPACA now makes disclosure and repayment the law. Providers are required to disclose and repay any overpayment they have received within 60 days of the date the overpayment was identified. The overpayment not only must be returned to the appropriate party but also must be accompanied by a written explanation of the reasons for it (rules about specific content have yet to be written).

Any overpayments held beyond 60 days become fodder for a false claims action. Civil monetary penalties, as well as exclusion, may also be imposed. At the Health Care Compliance Association meeting in April 2010, many experts cautioned providers to make sure that they had a highly structured methodology – including findings from any internal medical records reviews or audits – for identifying over-

payments so that paybacks will be swift and continuously tracked.

Left unclear by the PPACA is how a provider organization should behave if it is already under a federal review or audit and finds unrelated overpayments. In most cases, providers are cautioned not to make paybacks during these periods. Because of the potential liability, however, providers should consult with the investigating agency on how to proceed.

RECOVERY AUDIT CONTRACTORS AND MEDICAID

Recovery Audit Contractors have been the subject of much discussion among Medicare providers. These are essentially “bounty hunters”² who are paid a contingency fee based on overpayments or improper payments identified. They are private contractors, usually with exceptional data-mining abilities, who focus on potential areas of abuse and then identify providers that might fit their profile. Some of their early activity was roundly criticized, and additional controls were put in place to rein in what some saw as RACs’ abuse of their responsibilities. These controls have been successful. As evidence of this success, many hospitals have set up RAC committees to understand the latest focus areas of the RACs, reduce potential risk prior to any audit, and anticipate findings and self-disclose or report potential problems.

RACs will now be incorporated into the Medicaid program. Many questions are still unanswered about how they will operate, who will control their activities, and how they will avoid duplicating the efforts of what sometimes seem to be a legion of other auditors looking at Medicaid providers as well. The PPACA requires that each state identify at least one RAC auditor by the end of 2010.

CHANGES TO THE FEDERAL FALSE CLAIMS ACT, ANTIKICKBACK STATUTE, AND STARK LAWS

The federal civil False Claims Act, generally known for its lower level of intent (in general, the government does not need to prove intent to defraud if it can prove recklessness and/or deliberate ignorance on the part of the provider submitting claims) and its whistleblower (called “relators” in the law, these individuals can file False Claims Suits against providers and will collect a portion of the recovery if the suit is successful) provisions, was expanded dramatically under the Fraud Enforcement and Recovery Act. Of particular note was the expansion of the “reverse false claims” definition, which imposed a potential false claims liability on any provider who “knowingly conceals” or knowingly avoids or decreases an “obligation to pay or transmit money or property to the government.” The Act expands on this wording by defining obligation and by imposing a time frame after the obligation is identified for disclosure and repayment by the provider. Enough ambiguity remains that it will take years and many court actions before it is clear what identified means in terms of providers’ awareness of an overpayment. But the general expectation is that providers can expect great federal enthusiasm for uncovering those test cases in the coming years. For now, providers should assume that they have a 60-day window in which to repay identified overpayments or credit balances.

The False Claims Act was also expanded under the Act through changes to both the definition of original source and prior public disclosure exemptions for whistleblower suits. These changes are complicated but allow for an expanded pool of whistleblowers, especially those who can add materially to the facts.

The Antikickback Statute, which forbids payment for making or receiving referrals of federally insured beneficiaries, is a criminal statute and can subject the provider to fines, jail, and exclusion. Prior to the Act, prosecutors had to prove criminal intent that is, prove that the person knew the AKS prohibits certain conduct and engaged in prohibited content, thereby knowingly disobeying the law. The Act’s revised definition of intent eliminates the need to prove that the person acted knowingly or with specific intent to violate the law. Years of carefully constructed case law are no longer applicable.

In addition to changing the level of intent, the Act also links the AKS to the False Claims Act. In the past, providers could argue that claims resulting from violations of the AKS were not subject to a false claims action. The Act now specifically states that violations of the AKS are “false or fraudulent for purposes of the False Claims Act.”

The Stark Law, which prohibits physicians from making referrals to designated health services in which they have a financial interest, was also changed in three important ways. First, the Department of Health and Human Services must come up with a self-referral disclosure protocol. The ability of providers to self disclose and who they should disclose to have been confusing and confounding. Until the rules are written, providers will not know the extent of the disclosure needed, time frames, possible mitigation, and other provisions, but these rules will likely follow those included in the current Office of Inspector General self-disclosure (as opposed to self-referral disclosure) protocol that is currently available to providers.

In addition to the requirement for an SRDP, the PPACA also lowers the penalties for Stark violations, which is expected to encourage providers to more readily consider self-disclosure.

Finally, one of the major exceptions to physician self-referral was changed. The exception, called In-Office Ancillary Services, allows physicians to provide lab testing and other services in their offices (for which they benefit financially) without violating the self-referral law. The PPACA now requires that before providing such services, the physician must tell his or her patients that they can get the services from other providers, including those who are not a part of the physician’s group practice or under the supervision of the provider, and they must give the patient a list of alternative providers for the service being offered.

CHANGES TO HEALTHCARE FRAUD OFFENSES AND EXPANSION OF CIVIL AND OTHER MONETARY PENALTIES

The changes in this category include a lowered level of intent, similar to the AKS intent changes discussed above, for healthcare fraud offenses developed under the Health Information Portability and Accountability Act in 1996. These offenses include a mixture of various schemes and activities, and case law continues to develop. The changes under the PPACA make it easier to prosecute healthcare fraud offenses, and some experts believe that the use of this prosecutorial tool will increase substantially. Violations are subject to various sanctions, including incarceration. In addition, now included among the offenses that can be categorized as healthcare fraud are violations of the AKS and other laws, such as the Employee Retirement Income Security Act of 1974.

Civil monetary penalties have been substantially enhanced in an effort to gain

the cooperation of providers in enforcement actions and to deter certain activities. The penalty for failing to provide timely access by the OIG to your facilities and records for purposes of oversight can result in a fine of \$15,000 per day. Knowingly making a false statement or omitting information from your application for enrollment can result in a fine of up to \$50,000 for each false statement. The potential stakes for providers that allow people who are excluded from participating in the federal healthcare programs to order services or prescribe medications can be fines of up to \$50,000 per order or script. Clearly, providers are on notice that internal controls to prevent these types of activities must be reexamined, strengthened, and regularly tested.

INCREASED TRANSPARENCY

The PPACA requires a number of new disclosures from manufacturers and distributors of drugs, biological agents, medical equipment, and medical supplies. Additional disclosures are also required of physicians and nursing facilities. Some of these disclosures are intended to make public certain relationships physicians and teaching facilities have with designated manufacturers and distributors. Others are intended to help the Centers for Medicare and Medicaid Services understand how these relationships are structured, the networks they provide, and how they might affect the cost of healthcare.

Behavioral healthcare providers should be aware of any relationships between their physicians and drug manufacturers, in particular. In addition, once the Secretary of DHHS begins the public disclosure process, providers should make sure the information is accurate. The blame for failure to report generally falls on the manufacturers and distributors, and penalties are quite high.

In addition, the PPACA requires disclosure of all drug samples requested and distributed; some information from health benefit plans and prescription drug plans about generic dispensing rates and certain other costs; and additional, detailed information about nursing facility ownership and management. Also, as discussed above with respect to AKS changes, physicians who provide certain ancillary services in their offices are now required to make disclosures about choice to their patients, not to the federal government.

Providers in states that have their own disclosure laws should consult with their attorney before making disclosures. They should seek legal advice as to preemption, especially where the state law has more rigorous disclosure requirements.

CHANGES TO PROVIDER SCREENING

CMS is attempting to prevent people and organizations that should not be providers of government-funded healthcare from getting enrolled in the first place. The PPACA requires that DHHS develop additional screening procedures to weed out potentially weak or dishonest providers and suppliers.

These provisions are expected to include, for example, checks on licensure and criminal background. Many of these screening activities were formerly the responsibility of the provider organizations themselves. DHHS is also trying to use enrollment and reenrollment at regular intervals to root out providers they did not catch at first or those who have since become of interest to enforcement or oversight agencies. The PPACA allows CMS to stop enrolling providers for a period of time if this might be effective in stopping certain types of fraud. For example, when the government understood the magnitude of the compliance problems associated with partial hospital programs, it could have shut down enrollment of Community Mental Health Centers and others to prevent future fraud or abuse.

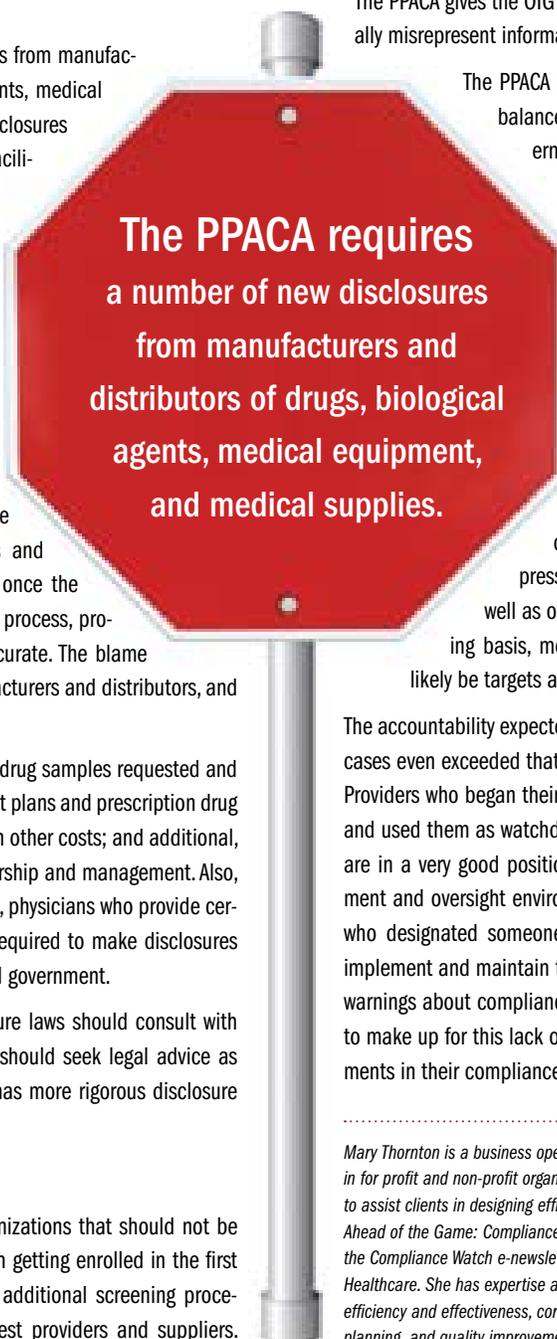
The PPACA gives the OIG permissive exclusion rights for providers who materially misrepresent information on an enrollment application.

The PPACA is a large, complex piece of legislation that tries to balance increased healthcare spending by the federal government with a much-expanded effort to reduce fraud, abuse, and waste to protect the taxpayers' investment. The increased enforcement and oversight efforts were already underway through regulation and other activities on the part of the administration. The PPACA, however, gave the administration a bigger field on which to play – and it did.

The activities add greatly to the complexity of the federal healthcare programs. And it is time for providers to examine the sophistication of their current compliance efforts and the resources dedicated to their compliance program. With the pressure on the Department of Justice and the OIG, as well as others, to reduce fraud, abuse, and waste on an ongoing basis, more marginal cases and even smaller providers will likely be targets as well.

The accountability expected of Medicaid providers has now reached or in some cases even exceeded that expected of Medicare providers 10 to 20 years ago. Providers who began their compliance programs years ago, kept them funded, and used them as watchdogs not only of risk but also of potential opportunity are in a very good position to withstand the current changes in the enforcement and oversight environment. Those who only gave compliance lip service, who designated someone with relatively little power in the organization to implement and maintain the program, and who have regularly ignored internal warnings about compliance risk will have to hope that they are given the time to make up for this lack of urgency and begin robust and continuous improvements in their compliance program's visibility and activity.

Mary Thornton is a business operations specialist with 20 years experience as a senior manager in for profit and non-profit organizations. She combines a bachelor's in Nursing with an MBA to assist clients in designing efficient, high quality services and programs. She is the author of Ahead of the Game: Compliance Strategies for the Behavioral Health Care Industry and editor of the Compliance Watch e-newsletter published by the National Council for Community Behavioral Healthcare. She has expertise and extensive experience in providing consultation on operational efficiency and effectiveness, corporate compliance, program development, marketing, strategic planning, and quality improvement.



Be Prepared or Be Trampled: The Next 36 Months

Monica E. Oss, Chief Executive Officer, OPEN MINDS

Over the past 24 months, we have seen major changes in the economy, in policy, and in legislation completely reshape the financing of the health and human services – and the behavioral health and social service niche within it. The tumultuous events of the past two years brings to mind the African proverb, “When elephants fight, it is the grass that suffers.” I think healthcare consumers did well with parity and healthcare reform. But provider organizations are the proverbial grass on the political playing field of elephants.

Sorting through the multi-faceted changes facing healthcare over the next three years, it is a challenge to come up with the specific factors that must guide organizational development. My colleagues and I have completed extensive analysis and modeling of the healthcare reform legislation and have identified four key strategic implications for behavioral health provider organizations over the next 36 months:

- >> Most behavioral health dollars will flow through health plans.
- >> Changes in finance and technology will increase preparation of behavioral health services provided via “primary care.”
- >> Health plan-based financing will draw clear lines between ‘health’ services and ‘social’ services.
- >> Comparative effectiveness initiatives will increase the private pay market in behavioral health.

FUNDING THROUGH HEALTH PLANS

With a combination of parity and a greatly reduced uninsured population, most behavioral health treatment will be funded by health plans (private, Medicaid, Medicare, etc.). Federal grants and state program dollars that make up traditional ‘safety net’ funding for behavioral health will diminish – both because of lack of decreased consumer need and increased demand for funding for new ‘entitlements.’ The management implications of this shift are many – a few key considerations are:

- >> Successful provider organizations need an expert process to work with third-party payors.
- >> Financing of delayed cash flow will be a growing issue.
- >> One key focus of marketing efforts will be optimization of Fee for Service reimbursement in health plans.

BEHAVIORAL HEALTH SERVICES VIA “PRIMARY CARE”

Parity provides equal coverage of behavioral health services, and the healthcare reform legislation encourages integration of primary care with all specialty care. The synchronistic combination of these factors – along with new service delivery technologies and new clinical interventions based on brain science – will encourage an increase in the preparation of behavioral health services delivered in primary care settings. These services will not be the services for 20% of consumers who have disabilities and complex conditions. Rather, they will be “standard” behavioral health services for the other 80% of the population.

Primary care settings shouldn’t be confused with primary care physicians. While PCPs will certainly be providing more behavioral health services in their office settings, the largest expansion of behavioral health services will be in retail clinics delivered online in consumers’ homes, and inserted in health clinics via e-health technologies.

What will remain for behavioral health services outside of primary care settings? The answer is clinical services for consumers with chronic and complex behavioral health conditions. And, it is likely that the services for these consumers will be channeled to highly specialized organizations with the ability to provide a wide array of services to this specific population using some type of risk-based financing. For executives of behavioral health provider organizations, this is a call for new strategy – deciding whether integrated service models or

“When elephants fight, it is the grass that suffers.”

I think healthcare consumers did well with parity and healthcare reform. But provider organizations are the proverbial grass on the political playing field of elephants.”

disease management models are the direction for their organization.

CLEAR LINES BETWEEN ‘HEALTH’ AND ‘SOCIAL’ SERVICES

One clear effect of increased financing of health benefits through health plans (and the very likely increase in the use of managed care financing models) is that there will be a clear definition of what constitutes ‘healthcare’ services. We’ll see more medical necessity criteria used for standard behavioral healthcare for the majority of consumers.

Services that are considered “social supports” (services not meeting medical necessity criteria) will be available only for consumers with chronic and complex behavioral health conditions – and likely only under risk-based financing. For most behavioral health provider organizations, this likely situation demands a scenario-based analysis of your current consumer base and service array. How many of them will meet the chronic/complex case



definition? What preparation of services delivered by your organization will clearly meet the 'medical necessity' test? Of the services, how would their utilization change in a capitated finance environment? What will risk-based financing models (case rate, episodic payments, etc.) for these services look like?

COMPARATIVE EFFECTIVENESS INITIATIVES

With healthcare reform, the use of comparative effectiveness analysis will increase the promotion of behavioral health funding from private pay. Comparative effectiveness analysis, which is essentially a disease-state-specific meta-analysis of evidence-based practices – “recommends” clinical protocols based on outcome and cost. There are two groups of services that will likely be in the private pay domain. The first group includes more expensive treatment approaches that do not have good cost-offset data and are likely to not be “recommended” competitive effectiveness analysis. The second group is new treatment technologies that are not included in the competi-

tive effectiveness evaluation process. As a result, the private pay market will change dramatically – it will likely include many ‘traditional’ therapies preferred by consumers and emerging technologies. To address this increase in private pay, many provider organizations will need enhanced intake billing and market functions.

The magnitude of the market impact of these four factors is unknown right now. While we have the legislation, the regulations are being crafted at this very moment. And, in the case of healthcare reform (and parity), the devil is, literally, in the details. Measuring how beneficial this legislation is for the consumers we serve – and the implications for behavioral health professions and provider organizations – will be a function of these regulations.

Right now, policymakers are sorting through the meaning of parity – the issue of combined consumer out-of-pocket limits, of quantitative benefit equality, and of equity in non-quantitative benefit manage-

ment. The battle with health insurers over transparency and minimum requirements for medical loss ratios are pending. It is critical to both advocate for consumer-centric regulations and, when the regulatory dust settles, understand the implications and opportunities – to get your organization’s management team on board for the changes in the road ahead.

Just one word of advice for your management team during this time of gigantic change – “When eating an elephant, take one bite at a time.”

Monica Oss is the founder of OPEN MINDS. For the past two decades, she has led the OPEN MINDS team and its research on health and human service market trends and its national consulting practice. Oss is well known for her numerous books and articles focused on the strategic and marketing implications of the evolving health and human service field. She has unique expertise in payer financing models, provider rate setting, and service pricing. She has led numerous engagements with state Medicaid plans, county governments, private insurers, managed care programs, service provider organizations, technology vendors, neurotechnology and pharmaceutical organizations, and investment banking firms – with a focus on the implications of financing changes on delivery system design.

Compliance Watch

A BEHAVIORAL HEALTH EXCLUSIVE

QUARTERLY NEWSLETTER

EDITORIAL BOARD

Executive Editor: Mary Thornton, BSBA, MBA, Mary Thornton and Associates, Health Care Strategies

Managing Editor: Chuck Ingoglia, MSW, Vice President, Public Policy, National Council for Community Behavioral Healthcare

Contributing Editors: John Casardine, Michael Lau, PhD, LCPC, Scott Miggelke, LCSW, ACSW

The Status of U.S. Healthcare Reform

Dale Jarvis, CPA

Federal healthcare reform as contained in the 2,400-page Senate bill and 150-page House-Senate reconciliation bill is now the law of the land. For those of us committed to addressing the needs of persons with mental health and substance use disorders, this event represents the end of the beginning, but the heavy lifting is yet to come. We continue to live in a country where

- 45,000 Americans die each year because they lack health insurance.
- More people die from preventable health conditions (like drug overdoses, smoking-related illness, alcohol, pneumonia, and respiratory illness) than in any of the other 18 industrialized nations examined in a recent study.
- Overuse, misuse, and underuse of clinical services are responsible for 30% of health care costs – approximately \$700 billion per year.

CONTENTS

Status of U.S. Healthcare Reform **1**
Dale Jarvis

The HITECH Act **1**
Jill Benson

Securing Protected Health Information **5**
Tina Williamson

Future of Behavioral Healthcare **6**
Dale Jarvis & Mary Thornton

CPT 90801 **8**
Mary Thornton

Southwood Hospital Settlement **9**
Robyn Johnson & Mary Thornton

Extrapolation & Audit Paybacks **11**
Mary Thornton

State of Your Compliance **12**
John Casardine

Short Subjects **13**

The HITECH Act: The Continued Development of the HIPAA

Jill Benson

Over the past few years, the Health Information Technology, Economic and Clinical Health Act of 2009 (HITECH) amended the American Recovery and Reinvestment Act of 2009 national law to bring changes to the Privacy and Security Rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes, which went into effect on February 18, 2010, affect both Covered Entities (CEs) and Business Associates (BA). Business Associates must also

TIME TO RENEW

Subscriptions are for a calendar year. To continue to receive Compliance Watch in 2010, please renew your subscriptions at National Council Store at <http://store.thenationalcouncil.org>

Need help? Call Nathan Springer at 202.684.3740 or email Communications@thenationalcouncil.org

Complex Medicare reporting requirements... increased scrutiny of Medicaid payments... OIG audits... whistleblower provisions. Now you can be out in front of compliance issues with the industry's only e-newsletter devoted to keeping your organization within the letter of the law. Each quarter, Compliance Watch brings you in-depth articles on compliance challenges and solutions unique to mental health and addictions service provider organizations and is edited by Mary Thornton, the field's foremost compliance expert.

Subscribe at
<https://store.thenationalcouncil.org>

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Payment Reform, Pilot Programs, and the New Alphabet Soup

Dale Jarvis, CPA, Managing Consultant, MCPP Healthcare Consulting



Transforming the American healthcare system is going to require many, many changes to how care is delivered and paid for. The broad consensus is that this change simply has to happen and that health reform efforts at the federal and state levels will not succeed unless quality is improved and costs are contained. The Patient Protection and Affordable Care Act creates tremendous opportunity for numerous payment and service delivery pilot projects with the potential to transform American healthcare.

This work will be led by a new federal entity, the Center for Medicare and Medicaid Innovation, whose purpose is to organize, test, and evaluate innovative payment and service delivery models. The alphabet soup continues with two new acronyms that safety net mental health and substance use providers should add to their vocabulary as they prepare for the new world of healthcare reform – VBP and ACO. This article explores these two additions to the healthcare landscape.

VBP – VALUE-BASED PURCHASING

Value-based purchasing is perhaps the clearest and most revolutionary component of healthcare reform. As the name implies, VBP represents a dramatic shift from paying for the volume of care to paying for the value of care. The many concepts under this umbrella term make up the mechanisms the field needs to accomplish the shift toward essentially paying for outcomes. The following examples illustrate how VBP strategies might be considered the antithesis of fee for service in three key areas: prevention and early intervention, care management, and hospital care.

Prevention and early intervention services funded through VBP will be supported by financial incentives, including case rates to fund additional staff positions, practice incentives, and grants for targeted programs, such as obesity prevention. Capitation payments can also include a prevention and early intervention cost layer to support these initiatives.

Care management services will be supported by case rates to pay for additional staff and longer visits and by bonuses for practices that successfully implement care management systems and can demonstrate improved clinical outcomes and lower total healthcare expenditures. Again, capitation payments can also include a care management cost layer.

Hospital care is moving toward bundled payments that put into an at-risk situation, hospitals and all professionals who participate during and after an episode of inpatient care. High-performing facilities and healthcare teams will earn bonuses for efficient care, reduced error rates, and prevention of readmission. Others teams could have the opposite

“To figure out how to transform medical communities, with all their diversity and complexity, is going to involve trial and error. And this will require pilot programs – a lot of them.”

Atul Gawande, “Testing, Testing.” *The New Yorker*, December 14, 2009

If safety net mental health and substance use providers are not deeply involved in pilot efforts, they will not be able to ensure that healthcare reform truly meets the needs of Americans with mental health and substance use disorders. Two new acronyms that providers should add to their vocabulary as they prepare for the new world of healthcare reform – VBP and ACO.

experience when avoidable complications push the cost of an episode above the bundled payment amount.

These new models consciously break the link between how much service a provider or facility provides and what that provider or facility is paid. A number of these payment designs will include pay-for-performance incentives, which may constitute as much as 30% of the total payment. It is very likely that VBP will see wider use in mental health and substance use treatment as well as general healthcare.

ACOS – ACCOUNTABLE CARE ORGANIZATIONS

The term accountable care organization first emerged in 2006 in a Health Affairs article written by Elliot Fisher of Dartmouth Medical School. Fisher is a thought leader who has been investigating how the many physicians in the United States who work in hospitals and small practices can be better supported to improve quality, manage costs, and participate in the new risk-bearing payment models.

ACOs will likely evolve in many shapes and flavors as states pass laws that mandate their use (including, so far, Minnesota, Colorado, Massachusetts, and Washington). In his handbook *How to Create Accountable Care Organizations* (www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizationsExecutiveSummary.pdf) Harold Miller proposed four levels of ACOs:

- >> Level 1 ACOs will consist of a group of person-centered medical homes that receive capitation or case rate payments for managing the cost and quality of care within their control.
- >> Level 2 ACOs add major specialists, such as cardiologists, orthopedic physicians, and obstetrician-gynecologists, which expands the scope of the risk and reward present in a Level 1 ACO.
- >> Level 3 ACOs add hospitals and other specialists.
- >> Level 4 ACOs add public health and social service agencies to coordinate all health and social services.

Each type of ACO will require a separate set of staff who will be responsible for helping the clinicians manage the clinical, management, and financial aspects of what is, in effect, a mini-managed care company where the quality efforts are embedded in the organization rather than handled through an outside inspector model, as found with traditional managed care companies.

ACO organizing efforts are beginning throughout the United States as hospitals, large group practices, and health plans attempt to be on the leading edge of ACO development. Leaders in the safety net mental health and substance use treatment system need to stand up and take notice. ACO organizing efforts are almost certainly beginning or already underway in your community, so now is the time to begin the

important task of building relationships with the organizers. This work can lead to involvement as a preferred provider in the ACO or, preferably, as a member of the ACO to organize the delivery of mental health and substance use services for patients of the ACO.

VBP and ACOs represent two categories of important service delivery design and payment reform pilots envisioned by Atul Gawande (2009) and carried out by the Center for Medicare and Medicaid Innovation, states, and private health plans. No one knows which pilots will succeed and which will be relegated to the “seemed like a good idea at the time” pile. But we do know that if safety net mental health and substance use providers are not deeply involved in pilot efforts, they will not be able to ensure that healthcare reform truly meets the needs of Americans with mental health and substance use disorders.

Dale Jarvis is a management consultant for MCPP Healthcare Consulting. Mr. Jarvis specializes in payment and reimbursement system redesign, financial modeling, and business systems design for healthcare purchasers and providers. For more than 20 years, as a financial manager and consultant, he has helped healthcare systems identify their strengths and weaknesses, become more efficient, and provide high-quality care to their clients while maintaining financial viability.

Pynn & Associates

**Behavioral Health
Evaluation
602-625-1002**



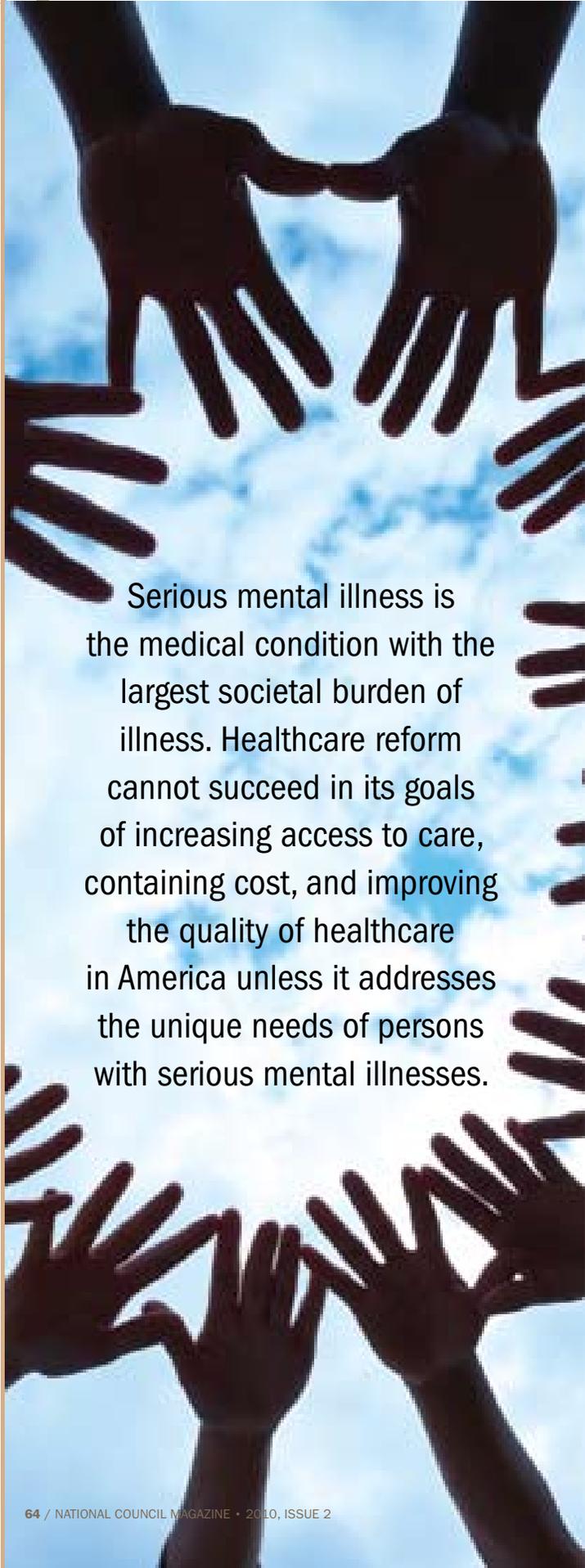
Pynn & Associates is a professional services consulting firm specializing in research and evaluation in the fields of behavioral health and human services. Since 1990 the company has provided survey research and program evaluation to Federal, state and local agencies.

The company provides a variety of research and analysis services to behavioral health clients, such as:

*Survey Design and Implementation
Program Analysis
Process Evaluation*

Clients

*U.S. Department of Defense
Substance Abuse and Mental Health Services Agency
National Institute on Drug Abuse
National Center for Education Statistics
National Center for Health Statistics
United States Department of State*



Serious mental illness is the medical condition with the largest societal burden of illness. Healthcare reform cannot succeed in its goals of increasing access to care, containing cost, and improving the quality of healthcare in America unless it addresses the unique needs of persons with serious mental illnesses.

Fostering System Reform for Adults With Serious Mental Illness

Joseph Parks, MD, Chief Clinical Officer, Missouri Department of Mental Health; **Arthur Evans, PhD**, Director, Philadelphia Department of Behavioral Health and Mental Retardation Services

On November 12 and 13, 2009, representatives of national mental health organizations and experts in mental health services, financing, and policy gathered in Washington, DC, at a meeting supported by Ortho-McNeil Janssen Pharmaceuticals, to develop an agenda for reforms in the provision of services for adults with serious mental illness. The timing, composition, and focus of the meeting reflected a broad understanding in the mental health advocacy community that with mounting scientific advances, recent passage of parity and healthcare reform legislation, and an energetic discussion of national health priorities underway, a rare opportunity had emerged to reshape the nation's approach to mental health service delivery.

Participants in the meeting, including Linda Rosenberg, president and chief executive officer, and Chuck Ingoglia, vice president, public policy, at the National Council for Community Behavioral Healthcare, shared a belief that thoughtful changes in policy, funding, and program design could result in greatly improved outcomes for people with mental illnesses as well as reduced burden, cost savings, and increased efficiency in healthcare and many other areas of American life. In addition, attendees recognized that the opportunity could be lost without development of a targeted action agenda incorporating the community's disparate voices. Recognizing that such opportunities to shape the future of the healthcare system in which we work and of the people it serves come less than once in a generation, the representatives set aside their smaller differences and achieved consensus on the following shared goals.

RECOMMENDATION 1: Design and implement a robust set of performance measures, including consumer outcomes, with risk-adjusted financial incentives.

Challenge/Opportunity: We do not yet have a complete body of empirical data that would enable practitioners and payers to understand which mental health interventions work best for specific people.

Action: Stakeholders must reach agreement on development of a standard set of service definitions that are consistent across states and incorporated into licensing and professional practice standards.

RECOMMENDATION 2: Commit to ensuring that people with chronic mental illness have the same life span as the general population by designating them as a disparities group.

Challenge/Opportunity: Research has consistently found that mental illness results in greater societal costs than all other disabilities. People with mental illnesses face unnecessary and unjust differences in health, risk behaviors, healthcare, and mortality.

Action: Congress should designate people with chronic mental illness a “health disparities population.” This designation would facilitate tracking and measuring of the health disparities experienced by people with chronic mental illnesses and provide the opportunity to focus resources on addressing these disparities.

RECOMMENDATION 3: Encourage the federal government to require and provide incentives for a shared information health record, including behavioral health that:

- >> **Is user and provider friendly.**
- >> **Is interoperable.**
- >> **Supports registries.**
- >> **Prompts shared decision making.**

Challenge/Opportunity: Healthcare providers, including those in primary care and behavioral healthcare, frequently have trouble accessing treatment information they need to coordinate care and meet their patients’ overall healthcare needs. Current policy excludes community behavioral healthcare organizations and nonpsychiatrist behavioral health clinicians from eligibility for health information technology assistance under the Health Information Technology for Economic and Clinical Health Act.

Action: Federal HIT initiatives, including those implemented under the HITECH Act, must have substantial involvement from behavioral health stakeholders to ensure that systems are capable of supporting behavioral health content and operational needs.

RECOMMENDATION 4: Insist that federally sponsored Person-Centered Medical Homes (Health Homes) encompass behavioral health, substance use, and mental health by including them as Federally Qualified Behavioral Health Centers and by prioritizing Community Mental Health Centers for getting new FQHC sites.

Challenge/Opportunity: Demand for behavioral health services has increased rapidly in the past decade, but capacity in both the public mental health system and the general healthcare system to provide behavioral health expertise and treatment has failed to keep pace. As a result, adults with serious mental illnesses have not received adequate healthcare, and the behavioral health needs of other consumers has been unmet.

Action: Person-Centered Health Homes created or supported under federal

programs must include mental health and substance abuse treatment expertise and capabilities. Additionally, the federal government should support creation of Federally Qualified Behavioral Health Centers, which would complement the safety net care already provided by FQHCs.

The coordination and integration of primary care and behavioral healthcare made possible by these actions would result in less fragmentation and duplication of services and improved outcomes for the clients served by Health Homes and FQBHCs.

RECOMMENDATION 5: Align the federal government’s definition of medical necessity with research on the range of services needed by people with serious mental illness.

Challenge/Opportunity: Inconsistent definitions of medical necessity for services typically provided to people with serious mental illnesses result in variations in payment across plans or programs, inequitable patterns of care, and unpredictable outcomes for patients in different service settings.

Action: The Centers for Medicare and Medicaid Services, the principle payer for public mental health services, must provide guidance in the form of a definition of medical necessity that can be applied across jurisdictions and treatment settings that serve people with serious mental illnesses.

The definition for medical necessity set by CMS will provide a standard for other payers to follow in paying for a scope of services that meets the needs of people with mental illnesses, providers of services, and, indeed, payers themselves.

These recommendations call for federal leadership in the development and support of policy that will improve services for adults with serious mental illnesses. With enactment of national health reform legislation, the nation is at a watershed moment in which much of its healthcare system will be realigned. Serious mental illness is the medical condition with the largest societal burden of illness.

Healthcare reform cannot succeed in its goals of increasing access to care, containing cost, and improving the quality of healthcare in America unless it addresses the specific healthcare policy issues outlined above. It is imperative, therefore, that federal leaders act on these recommendations promptly in the health reform implementation process. We ask that National Council members advocate with their legislative representatives for prompt action to implement the recommendations.

Joseph Parks, MD, is the chief clinical officer for the Missouri Department of Mental Health in Jefferson City as well as a clinical assistant professor of psychiatry at the Missouri Institute of Mental Health and University of Missouri in Columbia. He serves as president of the Medical Director’s Council of the National Association of State Mental Health Program Directors. He practices psychiatry on an outpatient basis at Family Health Center, a federally funded community health center established to expand services to uninsured and underinsured patients in the Columbia area. He was awarded the 2006 American Psychiatric Association Bronze Achievement Award for a program that controls pharmacy costs by improving prescribing practices.

Arthur C. Evans Jr., PhD, is the director of Philadelphia’s Department of Behavioral Health and Mental Retardation Services, a \$1 billion healthcare agency. Since Evans’s appointment in November 2004, Philadelphia has begun a transformation of its entire system to focus on recovery for adults, resiliency for children, and self-determination for all people who use mental retardation services. Evans serves as acting commissioner of the Department of Human Services and leads reform efforts for Philadelphia’s child welfare system. He is a clinical and community psychologist. He holds a faculty appointment at the University of Pennsylvania School of Medicine and has served on the faculty at the Yale University School of Medicine and Quinnipiac University.

Patient Centered Medical Homes: Caring for the Whole Person

Barbara J. Mauer, MSW CMC, Managing Consultant, MCPP Healthcare Consulting

With team-based care management as a key component of the Patient Centered Medical Home, behavioral health providers have an opportunity to demonstrate the quality and cost benefit of adding mental health and substance use services to the primary care setting AND, of adding primary care to specialty behavioral health settings.

In 2008, Donald Berwick (then chief executive officer of the Institute for Healthcare Improvement, now nominated as the administrator of the Centers for Medicare and Medicaid Services) described a vision of the “triple aim” of the healthcare system:

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

To accomplish these aims, the general healthcare system must change from a focus on episodic acute care to a focus on managing the health of defined populations, especially those living with chronic health conditions. The patient centered medical home has gained momentum as a way of effectively delivering care in the context of chronic disease. The American Academy of Family Physicians defines the patient-centered medical home as “An approach to providing comprehensive primary care for people of all ages and medical conditions. In a patient-centered medical home, the patient is an active participant in his/her own health and is cared for by a family physician who leads the practice team coordinating all aspects of the patient’s health.”

Recent federal healthcare reform legislation has strengthened the case for healthcare homes with an integral mental health and substance use services component. Sec. 2703 of the Patient Protection and Affordable Care Act provides for a “Medicaid Medical Home Pilot” that gives states the option of enrolling Medicaid beneficiaries with chronic conditions, including serious and persistent mental illness, into a health home. The provisions include community mental health centers as eligible providers. \$25 million will be available to implement these provisions.

The core of the PCMH is team-based care that pro-

vides care management and supports patients in their health goals. A Commonwealth Fund report identified care management as being among the few policy options that hold promise not only for containing costs but also for improving health outcomes for high-risk populations.

In 2006, the Medicare Medical Home Demonstration Project was authorized by Congress. Spurred by that initiative, large health plans and state Medicaid agencies have implemented demonstration projects to test new payment methods and study the quality and cost advantages of the PCMH model.

These projects speak to the shared desire to develop service delivery and payment models that address the shortcomings of the current healthcare system. The payment reform discussion centers around connecting a portion of the PCMH or accountable care organization reimbursement to achievement of quality indicators and to a proven impact on the total healthcare expenditures for a panel of patients.

To support PCMH pilots, the National Committee for Quality Assurance developed standards for medical practices that want to be recognized as PCMHs. The NCQA Physician Practice Connections and Patient-Centered Medical Home materials articulate nine standards that practices must meet, including use of patient self-management support, care management, evidence-based guidelines for chronic conditions, and performance reporting and improvement.

In 2009, national leaders in the PCMH and mental health and substance use treatment fields (assisted by the Carter Center’s Medical Home Summit) began a dialogue regarding the importance of treating mental health and substance use conditions in the PCMH. Subsequently, the PCPCC behavioral health work group submitted recommendations to NCQA regarding future improvements in the certification standards to include reference to mental health and substance use services. The American

Academy of Family Physicians also recommended improvement in the standards, including “very importantly an emphasis on incorporating mental health and behavioral health into the standards, which we believe are conspicuously missing from the current standards.” [Note that NCQA has released a draft revised set of standards that include reference to mental health and substance use services.]

Oregon has recently released standards and measures for PCMHs (which the state has designated as Patient-Centered Primary Care Homes) that include mental health and substance use treatment services. The state established 19 guiding principles for implementation of the PCMH, including the following: “Any clinic that is willing to assume responsibility for providing comprehensive, longitudinal care to a population of patients (eg. a community mental health center) should be eligible to be measured and receive payments as a primary care home.

The core attributes of the PCMH are articulated in person-centered language:

ACCESS TO CARE

Be there when I need you.

ACCOUNTABILITY

Take responsibility for making sure I receive the best possible healthcare.

COMPREHENSIVE WHOLE-PERSON CARE

Provide or help me get the healthcare and services I need.

CONTINUITY

Be my partner over time in caring for my health.

COORDINATION AND INTEGRATION

Help me navigate the healthcare system to get the care I need in a safe and timely way.

PERSON- AND FAMILY-CENTERED CARE

Recognize that I am the most important member of my care team and that I am ultimately responsible for my overall health and wellness.

Within each core attribute, one or more standards are identified that represent particularly important domains of the broad core attribute, as summarized



in the table. Within each standard are specific measures. For example, under care coordination is the measure “When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible, and stay involved when I get care in other places.”

PCMHs and care management (which incorporates care planning and care coordination) are central to healthcare delivery system redesign, which is necessary because 45% of Americans have one or more chronic health conditions, and treatment of these conditions accounts for 75% of direct medical care in the United States. A new research synthesis on care management for patients with complex comorbidities offers important findings for implementation of care management in PCMHs, including the following:

>> Studies of care management in primary care show convincing evidence of improving quality; however,

it takes time to realize these quality outcomes (e.g., 12 months is probably not enough time).

>> Care management studies in primary care are mixed regarding reductions in hospital use and healthcare costs (two promising studies included emphasis on training of the care manager team; care management panel sizes at reasonable levels; close relationships between care managers and primary care physicians; and interactions with patients in the clinic, at home, and by telephone).

With care management as a key component of the PCMH, mental health and substance use providers have an opportunity to become part of bidirectional integration initiatives:

>> Demonstrate the quality and cost benefit of adding mental health and substance use services to the primary care setting, as an additional focus of care management.

>> Demonstrate the quality and cost benefit

of adding primary care to specialty behavioral health settings, with care management focused on health status as well as the mental health and substance use status of patients.

The most succinct description of the rationale for including mental health and substance use services in the PCMH is that articulated by Pamela Hyde, Administrator, Substance Abuse and Mental Health Services Administration:

- >> Behavioral health is part of health.
- >> Prevention works.
- >> Treatment is effective.
- >> People recover.

The transition of primary care practices to a PCMH will be neither fast nor easy. A recent article described the lessons from 36 family practice settings across the country that participated in a two-year PCMH project:

- >> Becoming a PCMH requires transformation.

>> Technology needed for the PCMH is not plug-and-play.

>> Transformation to the PCMH requires personal transformation of physicians.

>> Change fatigue is a serious concern even within capable and highly motivated practices.

>> Transformation to a PCMH is a developmental process.

>> Transformation is a local process.

These findings and the related recommendations are relevant to the bidirectional implementation of integrated care — also a process of transforming personal and organizational practice in the context of local relationships. PCMH and integration initiatives must be woven together, and participating mental health and substance use providers must approach these processes with a commitment to transform services, quality, cost measurement, and, ultimately, their organizations.

Note: The Patient Centered Primary Care Collaborative — coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians, and many others — has focused on developing and advancing the PCMH. In 2009, the PCPCC formed a behavioral health work group to develop more details regarding how mental health and substance use treatments fit within the PCMH. The PCPCC website provides a wide array of detailed materials for readers who want more information about the PCMH model.

Barbara Mauer is a nationally known expert in behavioral health and primary care integration. She has more than 15 years of experience in this field and is a managing consultant for MCPP Healthcare Consulting in Seattle, Washington, and a senior consultant with the National Council for Community Behavioral Healthcare. She offers consulting services to public- and private-sector health and human service organizations on integration as well as strategic planning, quality improvement, and project management. Mauer has authored many papers and presented at national conferences on behavioral health and primary care integration.

Joint Principles of the Patient Centered Medical Home

- ➔ Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- ➔ The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- ➔ The personal physician is responsible for providing for all of the patient's healthcare needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services, and end of life care.
- ➔ Care is coordinated and/or integrated across all elements of the complex healthcare system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- ➔ Quality and safety are hallmarks of the medical home.
- ➔ Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.
- ➔ Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Source: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, 2007

Help Those You Serve.

FREE TO GET.

Together Rx
Access[®]
Prescription Savings Program

FREE TO USE.

00000 0000
MEMBER NAME



What is the Together Rx Access[®] Card?

- A FREE prescription savings program for eligible individuals and families who lack prescription drug coverage and are not eligible for Medicare
- Most cardholders save 25%-40%* on brand-name prescriptions products
- Over 300 brand-name prescription products[†]
- Savings on a wide range of generic products as well
- Instant savings, right at the pharmacy counter

How does someone qualify for the Card?

Individuals and families who meet all of the following requirements are eligible:

- No prescription drug coverage of any kind
- Not eligible for Medicare
- Meets household income limits[‡] (example: not more than \$45,000 for a single person, or \$90,000 for a family of four)

Help them save in less than one hour.

It's fast and easy with the Together Rx Access quick start savings card. Potential enrollees simply call a toll-free number to enroll and activate their card right away.[§]

Order your supply of quick start savings cards. Simply visit
TogetherRxAccessOnline.com/order

Sponsored by many of the nation's leading pharmaceutical companies:



* Each cardholder's savings depend on such factors as the particular drug purchased, amount purchased, and the pharmacy where purchased. Participating companies independently set the level of savings offered and the products included in the Program. Those decisions are subject to change.

† Visit TogetherRxAccess.com for the most current list of brand-name medicines and products.

‡ Please call Together Rx Access at 1-800-250-2839 for more details.

§ The enrollee must meet eligibility requirements. The card is active instantly if the enrollee calls during business hours; at all other times, the card is active within two business days.

©2010 Together Rx Access, LLC. Together Rx Access and the Together Rx Access logo are registered trademarks of Together Rx Access, LLC.

Are Your Full Caseloads Really Full?

Unlock Hidden Capacity and Revenue



David Lloyd, President, MTM Services

Parity and national healthcare reform are opportunities for community behavioral healthcare organizations to provide services to a broader spectrum of residents in their catchment areas. Changes in the national healthcare delivery landscape require community behavioral health organizations to enhance service capacity so they can participate as valuable partners in the integrated healthcare service delivery systems of the future.

Several watershed events in the history of community behavioral healthcare development have had a significant impact on service delivery capacity and processes:

- >> The shifts from contracted capacity-based grant funding to grant and Medicaid fee-for-service performance-based funding in the late 1980s and early 1990s.
- >> The shift in the mid- and late 1990s in some states from true fee-for-service reimbursement to Medicaid carve-out waivers under capitated funding models.
- >> The passage of the 1996 Health Information Portability and Accountability Act and the False Claims Act amendment. Although many in the behavioral health industry understood the portability and privacy-security provision of HIPAA, perhaps very few were aware at the time of the accountability portion of the act and, in particular, the increased qualitatively based audits by the Office of Inspector General for the U.S. Department of Health and Human Services in the late 1990s and 2000s.

Although each of these funding and compliance transitions required community behavioral healthcare organizations to develop new solutions and adapt, perhaps all of these changes combined will not be equal to the challenges these organizations now face with parity and national healthcare reform – both of which require organizations to quickly address access to care and service delivery quality performance standards.

Parity and healthcare reform will move community behavioral health organizations from a primary Medicaid-grant payer mix to a much broader managed payer mix. Third party payers under the parity law, insurance exchanges, co-ops, accountable care organizations, and expansion of Medicaid managed care will dramatically shift the financing of uninsured populations to public-private partnerships that build on commercial-like insurance products.

The opportunity to shift to a more integrated payer mix can be stymied by several operational challenges. For example, 42% of a sample of 600+ behavioral providers reported 20–39% cancellations and no-shows in one quarter for intake and assessment appointments alone. And 49% of the same sample reported 20–39% cancellations and no-shows in one quarter for individual therapy appointments.

These operational challenges were reflected in survey responses from 600+ behavioral health providers that attended two parity and healthcare reform webinars hosted by the National Council for Community Behavioral Healthcare in December 2009 and January 2010 (responses are indicated in terms of percentage of attendees):

1. From the clinicians' perspective, are the caseloads in your organization "full" at this time?
i. Yes = 74% No = 26%
2. Do you know the cost and days of wait for your organization's first call to treatment plan completion process?
i. Yes = 41% No = 59%
3. Indicate the no show/cancellation percentage last quarter in your organization for the intake/assessment appointments:
i. 0 to 19% = 20%
ii. 20 to 39% = 42%
iii. 40 to 59% = 16%
iv. Not aware of percentage = 22%
4. Indicate the no show/cancellation percentage last quarter in your organization for individual therapy appointments:
a. 0 to 19% = 26%
b. 20 to 39% = 49%
c. Not aware of percentage = 25%

In my experience in consulting with community behavioral health organizations nationally during the past 15 years, the concept of clinicians' caseloads being full poses a significant challenge to efforts to improve access to treatment for consumers waiting for services.

Historically, a "full caseload" might be defined as 65 cases for child and adolescent therapists and 80 cases for adult therapists. It is difficult to understand how caseloads can be full, given the percentages of no-show and canceled activity for both initial assessment and ongoing therapy appointments in questions 3 and 4 of the survey above. The conclusion might be that caseloads are full at the beginning of each clinic day on the basis of schedule rates; however, at the end of the day, the services have not been delivered, given the percentage of time allotted to no shows and cancellations.

Another factor defining "full caseload" seems to be a holdover from the grant-funding era that requires therapists to carry cases so that the clients can see the physician or advanced practice nurse for medications. This protocol has resulted in a significant challenge for therapists in several areas.

At numerous community behavioral health organizations, therapists report that they have two types of caseloads – active cases that are engaged and receiving therapy, and inactive "active" cases that the therapist is carrying so that the client can see the doctor, advanced practice nurse, or nurse practitioner for medications. The real challenge is that many of the "medications-only" consumers are not in active treatment with the therapist, on the basis of extremely high no-show and cancellation levels, and the therapist must write progress notes documenting the no-show activity.

In our compliance and risk management consultation assessments, many therapists review treatment plans for the medication-only cases on the basis of the frequency required by each state (i.e., every 90 days), noting the progress the inactive "active" consumer has achieved even though the therapist has not seen him or her in the 90-day period. When asked how they assess progress or lack of progress in the review process,

therapists have said, for example, that they:

- >> Called the client to ask whether he or she was doing okay.
- >> Read the physician's or nurse's progress notes to confirm the client's status.
- >> Assumed that because the consumer had not attended the scheduled services, he or she was doing okay.

This process of carrying inactive "active" cases creates

a significant amount of paperwork for the therapist but does not result in treatment delivery – this only adds to staff's perception of carrying an overwhelmed caseload. Also, this process begs the ethical question of why some consumers experience extended delays before beginning treatment when a significant number of open cases are not routinely receiving services.

Therefore, indicators used to determine full caseloads may be based on a flat number of cases – including some that require a significant amount of chart-



Note. BH = billable hours; PTO = paid time off; FTE = full-time equivalent.

If however, the public and payers perceive community behavioral health organizations as having a prolonged wait time to treatment and if these organizations see their caseloads as "full," which prevents new consumers from entering treatment, then the new managed payers will not look at community behavioral health providers as a valuable partner when designing new integrated healthcare models.

One community behavioral health organization found that their annual costs and billable revenue lost as a result of keeping medication-only clients on therapists' caseloads equaled 14% of the organization's annual salary costs for therapists. With this level of objective information, the organization decided to engage additional nursing services to support the new medication-only caseload management procedure.



ing and paperwork time – rather than on whether each therapist is routinely delivering at or above the standard for key direct service and billable-hour performance.

One of the new MTM calculators being used by community behavioral health organizations is the Level of Care Caseload Calculator. This calculator measures the number of cases a direct service provider needs to meet the monthly billable-hour performance standard. The calculation is based on the number of direct service hours that are targeted to be provided at each level of care, which includes an ability to identify the number of cases at each level and total caseload needed. Figure 1 provides a sample of this important qualitative measurement tool and how it helps organizations move beyond a historical static, specific number of cases as an indicator of full caseloads.

In addition, an excellent way to measure the impact of carrying medication-only cases is to run a utilization study, as follows:

1. Identify the number of no-show and cancellation events that individual therapists have had in the past four months, and develop an average number per clinic day in the trend period.
2. Identify the percentage of the therapists' caseload composed of clients the therapist has not seen face to face in the past four months. In one community behavioral health organization, 722 of the 1,950 adult consumers in active caseloads had not been seen face to face by their

therapist in four months! This demanding level of indirect paperwork and chart maintenance by therapists so that the client can see the physician or nurse creates a significant challenge to community behavioral health organizations as they are trying to improve access to treatment for consumers waiting to receive services.

3. Review the assessed needs and treatment goals and objectives the therapist has developed for each of the inactive "active" clients, and then compare them with the progress notes to confirm the following:
 - a. Have the goals and objectives in the plan changed, or are they stagnant and broad in scope?
 - b. Do the progress notes reflect therapeutic interventions provided and measure any outcomes achieved toward accomplishing the consumers' goals and objectives?
 - c. Measure the level of goal and objective attainment for these consumers (eg. What percentage of the goals and objectives has been attained in the past two years?).
 - d. Has the consumer signed the most current version of the treatment plan (therapists have reported that, in many cases, they find it difficult to get the consumer to come in to complete and sign the treatment plan)?

The MTM Services team has also provided project management consulting to develop statewide stan-

dardized clinical forms in Ohio, Massachusetts, and New York. In all three of these initiatives, a solution was developed for therapists carrying medication-only cases in their caseloads. We helped the states develop a separate psychiatric–psychopharmacological management plan that allows the medication-only clients who are not engaged in therapy to be transferred out of therapists' caseload to a registered nurse who carries 250–350 medication-only clients in his or her caseload. The procedure provides for the nurse to schedule medication-only clients every 2 to 3 months to make a physical assessment (vital signs, weight, side effects, etc.) and then convey the information to the physician or advanced practice nurse to support the medication evaluation and management service that follows. Figure 2 provides a sample of the focused plan that was developed in the Solution to Ohio's Quality Improvement and Compliance initiative. (This plan was developed to meet Ohio's standards and requirements. Please confirm the specific standards and requirements that apply in your state).

When we present this new procedure to CBHO clinical teams, the initial responses are often along the lines of "We don't have enough nurses," "Our nurses are doing other tasks and do not have time to carry a caseload," or "Nurses' salaries are higher than social workers." But community behavioral health organizations should make an objective assessment:

- >> How many consumers are waiting for an initial intake and diagnostic assessment face-to-face



appointment with a therapist, and how long are they waiting, on average? Can we make this process timelier if we open up caseload capacity?

>> How many hours of billable direct service are being lost because therapists are maintaining charts for consumers who are not coming to therapy but are routinely showing up for medication appointments?

>> How many consumers are repeatedly not showing up for therapy appointments, and what are the results at the end of the day for the therapists' ability to deliver services they are uniquely trained to provide?

>> What is the level of billable-hour revenues that therapists are currently losing by scheduling and rescheduling consumers who are not showing up?

When one community behavioral health organization completed this type of assessment, we determined that their annual costs and billable revenue lost as a result of keeping medication-only clients on therapists' caseloads equaled 14% of the organization's annual salary costs for therapists. With this level of objective information, the organization decided to engage additional nursing services to support the new medication-only caseload management procedure.

In summary, as community behavioral health organizations move to a more managed and performance-based payer mix as a part of parity and healthcare reform, new models of care will be needed. A key opportunity is available for these organizations to be at the table as valuable partners as the new models are being developed. If community behavioral health organizations have timely access to treatment and available service capacity to provide treatment then they will be more effective.

If however, the public and payers perceive community behavioral health organizations as having a prolonged wait time to treatment and if these organizations see their caseloads as "full," which prevents new consumers from entering treatment, then the new managed payers will not look at community behavioral health providers as a valuable partner when designing new integrated healthcare models.

We are truly at a crossroads. Do we watch the parade

of integrated service delivery models develop and proceed to implementation without us, or do we join in the march?

Without a capacity for timely treatment that meets the access-to-care performance standards of managed payers and without the ability to open new cases in active treatment because they see themselves full now, community behavioral health organizations will not be able to reap the benefits of healthcare reform.

David Lloyd, author of How to Deliver Accountable Care, published by the National Council for Community Behavioral Healthcare, has successfully facilitated the development and implementation of compliance-based management accountability initiatives with more than 500 community behavioral healthcare organizations, regional medical centers, and primary care practices throughout the United States. He has been a featured presenter at numerous national, regional, state, and local workshops and conferences. Lloyd is founder and president of MTM Services, based in Raleigh, NC, which specializes in providing management, training, and accountable care project management services throughout the nation.

PSYCHIATRIC/PHARMACOLOGICAL MANAGEMENT PLAN			
Client Name (First, MI, Last)		Client No.	
State Desired Results in Client's Own Words		Start Date	
State Goals in Collaboration with Client as Identified on form dated _____ <input type="checkbox"/> Psychiatric Evaluation and/or <input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> DA Update <input type="checkbox"/> Client will remain psychiatrically stable by reducing or stabilizing his/her signs and symptoms of mental illness and maximizing his/her level of independence. <input type="checkbox"/> Client will be able to recognize, accept, and manage his/her mental illness, including working with the medical staff to manage his/her medications. <input type="checkbox"/> Client will establish chemical dependence recovery that leads to improved physical and mental health. <input type="checkbox"/> Other: _____			
Client Strengths and How They Will be Used to Meet the Goal(s)			
Objectives <input type="checkbox"/> Client's current signs and symptoms will be reduced through the use of appropriate psychiatric medications. <input type="checkbox"/> Client will take medications as prescribed with the assistance of medical staff for administration of medications or monitoring self-administration. <input type="checkbox"/> Client and medical staff will develop a medication regimen that is effective in reducing signs and symptoms while limiting side effects, including impact of co-morbid medical conditions. <input type="checkbox"/> Medical staff will provide coordination of care with the client and individuals assisting the client in managing their mental illness and other medical conditions. <input type="checkbox"/> Client's mental status will improve or remain stable. <input type="checkbox"/> Medical staff will refer and client will participate in additional evaluations of medical or mental status. See list below. <input type="checkbox"/> Client will assist medical staff in monitoring side effects through appropriate lab work, monitoring of vital signs, and direct observation/reporting. <input type="checkbox"/> Client understands and controls other lifestyle activities that may increase symptoms or medication side effects, e.g., substance abuse, caffeine, weight control, other diet, etc. <input type="checkbox"/> Client will be able to list medications, uses, and benefits. <input type="checkbox"/> Other: _____ <input type="checkbox"/> Client will take medications as prescribed.			
Therapeutic Intervention	Provider	Frequency	Duration
<input type="checkbox"/> Medication Management	<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Medication Education/Symptom/ Illness Management	<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> RN <input type="checkbox"/> Other (list):	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Injections	<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> RN <input type="checkbox"/> Other (list):	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Physical Assessment (Vital signs, AIMS, weight, etc.)	<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> RN <input type="checkbox"/> Other (list):	<input type="checkbox"/> Weekly <input type="checkbox"/> Other (list): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
<input type="checkbox"/> Other (list):	<input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> RN <input type="checkbox"/> Other (list):		<input type="checkbox"/> 1 Month <input type="checkbox"/> 9 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 1 Year <input type="checkbox"/> 6 Months <input type="checkbox"/> Other:
Referrals/Additional Evaluations <input type="checkbox"/> Physical Assessment <input type="checkbox"/> AoD Assessment <input type="checkbox"/> Neurological Consult <input type="checkbox"/> Psych Testing <input type="checkbox"/> Neuropsych Testing <input type="checkbox"/> Nutritional/Dietician <input type="checkbox"/> Other (list):			
Explained rationale, benefits, risks, and treatment alternatives to/for client? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Client/Guardian Response <input type="checkbox"/> Client: <input type="checkbox"/> Understands Information <input type="checkbox"/> Does not Understand <input type="checkbox"/> Agrees with Medication <input type="checkbox"/> Refuses Medication <input type="checkbox"/> Guardian: <input type="checkbox"/> Understands Information <input type="checkbox"/> Does not Understand <input type="checkbox"/> Agrees with Medication <input type="checkbox"/> Refuses Medication			
If client refuses plan, describe plan for continuation of services.			
Client Signature	Date	Parent/Guardian Signature (if applicable)	Date
Nurse Signature/Credentials (if applicable)	Date	Physician/APRN Signature/Credentials (required)	Date

No More No Shows! How Carlsbad Transformed Service Delivery through Customer Engagement

Noel Clark, CEO, Carlsbad Mental Health Center

Urging community behavioral health organizations to prepare for healthcare reform implementation, Linda Rosenberg, president and CEO of the National Council for Community Behavioral Healthcare commented that “We must become increasingly customer-focused, from the way we greet individuals who come through our door to the way we market our services. We should expect that with more money available in healthcare – particularly for mental health and addiction treatment – that new and well capitalized players will find behavioral health, traditionally a financially unattractive healthcare sector, far more appealing... We must retool our organizations with the knowledge that all individuals will now become true “consumers” of healthcare services.”

We believe that at Carlsbad Mental Health Center, we got a headstart on preparing for this new world order.

In March 2004, Carlsbad MHC’s executive team held a 2-day strategic planning retreat to develop a plan to facilitate our transition from a grant-funded nonprofit agency to an efficient fee-for-service com-

pany. Like providers all over the country, we were preparing for managed care, but we were not ready. Our corporate management style was an innovative combination of emotion and knee-jerk reaction. We knew our corporate culture wasn’t compatible with fee for service, but we didn’t know how to implement the change process. We knew what not to do, however, because multiple previous attempts had been silenced by staff resistance and emotional blackmail.

Two years later, New Mexico was still “planning” the transition from grant funding to fee for service. Carlsbad MHC’s intention to change became less urgent, and we slipped back into dependence on grant funding. We really did want to change, however. Enter the National Council for Community Behavioral Healthcare’s Access and Retention Initiative in June 2007. Carlsbad MHC applied and was invited to participate in the initiative, which was supported by consultation and project management from MTM Services. Listening to David Lloyd, MTM’s chief executive officer, I felt a tremendous sense of relief

– finally, we had the tools we needed to bridge the gap between our motivation and our potential to reduce no-shows, increase productivity, and improve quality of care.

Over the next five months, the Access and Retention team led us to realize that our addiction to grant funding and our center-focused approach to service delivery had defined us. Carlsbad MHC was not customer friendly. Our practice management was designed to gather the information we needed to submit a clean claim and to navigate on-site audits of charts, policies, and procedures.

Participation in the Access and Retention Initiative reenergized Carlsbad MHC’s executive team. The consultation and tools provided intensified our commitment to transform our company. In October 2007, the executive team completed a rapid-cycle change plan that included the following benchmarks:

- >> Enhance access to services.
- >> Centralize client scheduling.
- >> Improve customer engagement.
- >> Provide better leadership (coaching and mentoring).
- >> Ensure quality operations and compliance.

We implemented an accountable-care change process to monitor the rapid-cycle change plan:

- >> Conducting an executive walkthrough.
- >> Monitoring results with service process quality management.
- >> Empowering the management team.

Carlsbad MHC had access standards for routine, urgent, and emergent care, but we only met our goals for urgent and emergent care, and we regularly put the routine customers off sometimes for as long as 6 weeks missing our best opportunity for engagement. Over the next 18 months, customers served, produc-

Participation in the National Council’s 2007 Access and Retention Initiative helped Carlsbad Mental Health Center reduce no-shows for assessments from 43% to 0%, eliminate wait times of 6 weeks and longer, increase customers served per month by 33% without increasing our number of full-time-equivalent employees, and grow commercial insurance customers from 8% to 21%.

tivity, and customer fees were up, although no-shows for the second clinical appointment and medication management continued to be a problem.

In January 2008, we revised our initiative to include open access to intake. This change had a dramatic impact on our business:

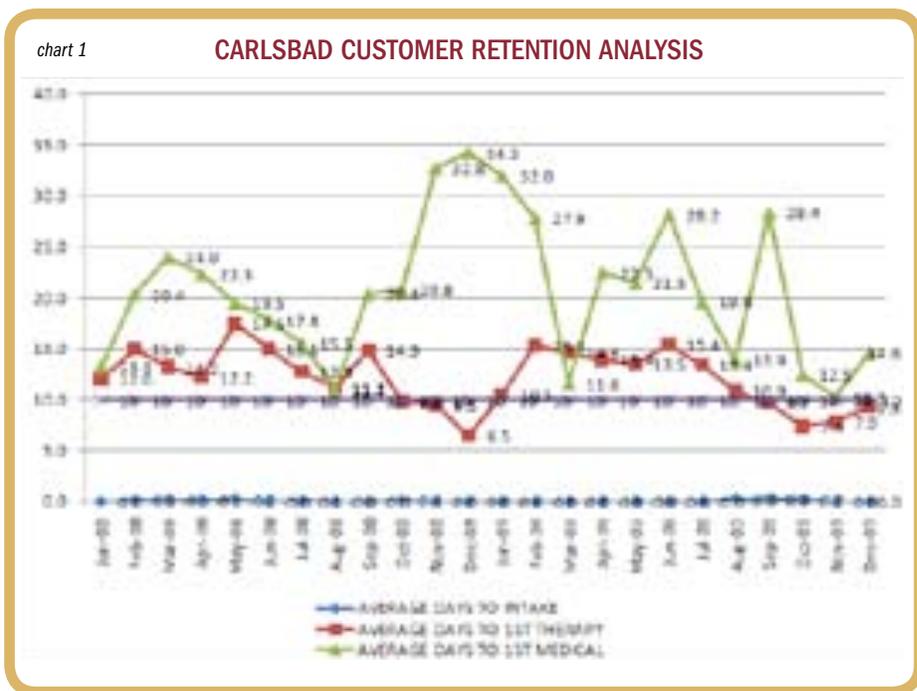
- >> No-shows for assessments were reduced from 43% of scheduled appointments to 0%.
- >> Wait time for assessments was shortened from 6 weeks or longer to no wait.
- >> We realized a 33% increase in customers served per month without increasing our number of full-time-equivalent employees.
- >> We documented a decline in crisis intakes from approximately 15 per month to one or two per month.
- >> Referrals from primary care physicians doubled.
- >> Commercial insurance customers grew from 8% of our business to 21%.

Carlsbad MHC was becoming an efficient practice, but the no-show problem wouldn't go away. In January 2009, our chief operations officer analyzed data from 599 new customers who received an intake between January 1 2009 and May 31 2009 and found the following:

- >> Approximately 95% of the customers who had a second appointment scheduled within 12.2 days of their intake arrived for that appointment.
- >> Approximately 70% of customers who had the second appointment scheduled 22 days or more after their intake did not show up.
- >> A full 100% of the customers whose second appointment was canceled by the center never came back.

In June 2009, using these objective findings, we developed the following customer engagement standards and incorporated them into our continuous quality improvement plan:

- >> Open same-day access — master's-level assessment provided the day of call or walk-in for help.
- >> Initial diagnosis determined during first assessment.
- >> Level of care and benefit design identified with consumer.



- >> Second clinical appointment for treatment scheduled for within 8 days of intake.
- >> First medical appointment scheduled for within 10 days of intake.

Chart 1 tracks our compliance with these standards

We have learned some lessons from our experience:

- >> Customer engagement at intake is a critical part of the treatment process.
- >> Management must be empowered to oversee operations and held accountable for the outcomes.
- >> Management must have the authority to redirect performance at all levels of the company.
- >> Not all customers need the same intake process.
- >> Not all customers need or want the traditional 50-minute session.
- >> Capacity is controlled as much by poor implementation of a discharge policy as by no-shows.
- >> Supervision must be a planned and documented process.
- >> Don't assume that change has occurred or will be maintained simply because policies, procedures, and job descriptions have been amended.
- >> Quality has not been achieved simply because a plan to improve it has been implemented management must check and recheck quality to minimize drift.

Today, seven years after our strategic planning retreat, Carlsbad MHC doesn't look like the same company. Yet we are far from finished. Our next goal is to define an episode of care for each customer at intake. EOCs will include the number and frequency of appointments and the duration of the treatment process. Finally, we will produce clinician report cards so customers can select their provider on the basis of the outcomes the clinician has delivered.

Focusing on our customers' needs has allowed Carlsbad MHC to increase capacity and improve the bottom line. A clear vision of where we wanted to be, objective data, and a willingness to adapt our processes to meet customer needs were the key factors that drove our success. Our company is thriving in the midst of challenging economic times more customers come in, and, more important, they leave having completed what they came for.

Noel Clark has spent his career working in community mental health centers in southeastern New Mexico. He has 13 years of experience as a chief executive officer and is in his 10th year of service in that capacity at Carlsbad Mental Health Center. Carlsbad MHC operates six separate locations in Eddy County, where Noel and his executive team are dedicated to industry leadership as they work to enhance, change, and save lives in New Mexico. Noel also serves as a managing board member of New Mexico's first private nonprofit limited liability corporation.

Stop Waste, Eliminate Wait

National Council Access Redesign Initiative Saves Agencies \$200,000 a Year!

Scott Lloyd, Vice President, MTM Services

Behavioral health must prepare for the significant increase in demand that parity and healthcare reform will generate by making data-driven, sustainable changes that improve the compliance, quality, and cost-effectiveness of services delivered. Community behavioral health organizations across the country have already demonstrated that they can increase their service capacity and improve patients' timely access to care in just 6 months. These organizations were participants in the most recent phase of the National Council for Community Behavioral Healthcare's Access Redesign Initiative facilitated by MTM Services and now in its third year.

The Access Redesign Initiative Phase III (June 2009 to January 2010), funded by Astra Zeneca and Bristol Myers-Squibb, involved change teams from 48 community behavioral health organizations in three states. Participants sought to:

- >> Assess current models of access-to-care process flows and identify the types of barriers to time-effective access.
- >> Identify the number of processes, staff, and client time requirements; documentation requirements, including data collection redundancy; and the costing for each access-to-care flow process.
- >> Use the objective flow charts, costing, and data-mapping outcomes to increase awareness of change in access-to-treatment processes and practices that can improve access to services.
- >> Identify a standardized access-to-care process flow, including costing awareness.
- >> Identify ability to replicate the positive access-to-care models in other states.

TECHNIQUES USED TO GET RESULTS

Each of the participating community behavioral health organizations met virtually with the Access Redesign initiative consultants to develop a de-



tailed flow chart for its access-to-treatment processes. We found that, on average, a community behavioral health organization can have as few as two or three process flows or as many as 19. The flow charts support development of detailed costing of the process for clinical and support staff time, the level of client and family time, and the number of days' wait from the first call for routine help to treatment plan completion.

These kinds of objective measurement techniques provided to reinforce the importance of change. Without the proof that data offer, teams can cycle through endless conversations about change, based on opinions rather than fact. For example, one community behavioral health organization had an access-to-care change team in place for months and multiple meetings had resulted in very little progress. The Access Redesign team completed the flow charting to determine costing and time delay into treatment, and the chief executive officer said that one could have heard a pin drop when the team learned that their access process was costing the organization more than \$700 per client, and the state and Medicaid were willing to reimburse the center \$155.

The National Council's Access Redesign initiative provided specific training on access and engagement enhancement processes and techniques to

each participating community behavioral health organization. Below is a list of the specific change techniques used:

- >> **Streamline documentation:** Help organizations reduce their documentation requirements by focusing on the removal of repetitively captured data elements and data elements that are not required by funding or accreditation organizations and changing the answer formats used to capture data elements to reduce overall documentation time.
- >> **Concurrent collaborative documentation:** Eradicate post-session documentation time while increasing person-centered engagement of clients in their recovery by involving them in the creation of their clinical documentation.
- >> **Walk-in access models:** Implement a zero no-show model to offer more expedient access to care and increased engagement.
- >> **No-show management:** Use policy changes, policy enforcement, engagement specialists, and reminder back-filling programs to help clients increase their show rates and engagement levels.
- >> **Employee engagement and maximization of staff productivity:** Help providers get staff to buy in to change so that they can achieve their

direct service staff's productivity targets.

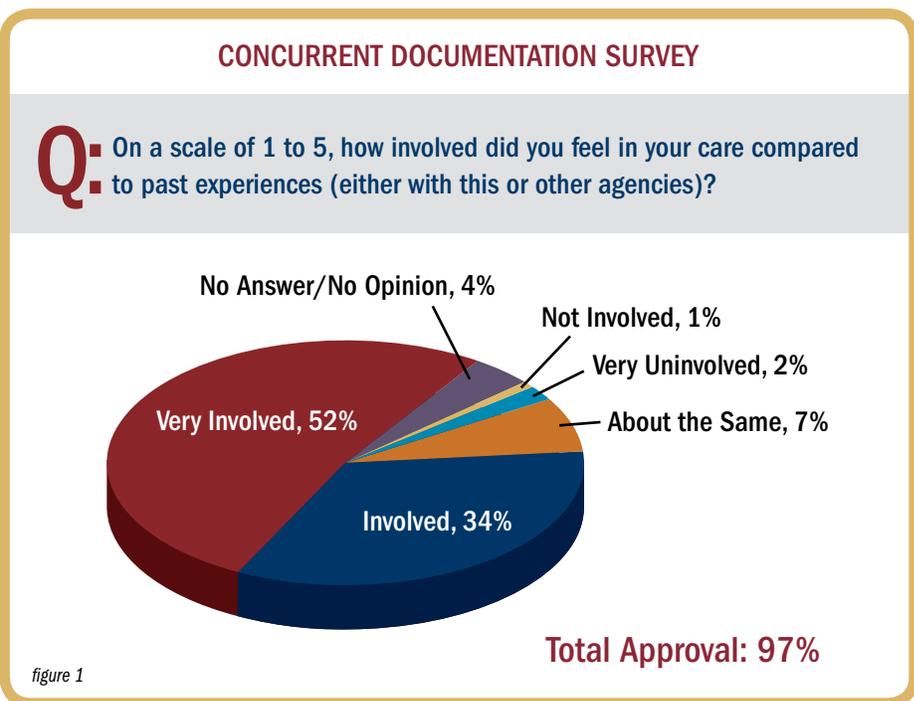
An example of how data can be used to move teams forward in their change efforts can be seen above in Figure 1, which highlights the positive feedback offered by clients about the use of concurrent collaborative documentation by their providers.

OUTCOMES

The project summary report (Figure 2) offers an overview of the changes achieved by the teams participating in the Access Redesign initiative in just 6 months.

>> Total annual savings: Access Redesign changes produced an average annual savings of \$199,989.43 per agency. The changes created a 34% reduction in staff time and an 18% reduction in the time required for clients to complete the average access process. These savings are based on the comparison reports submitted by 28 of the participating organizations from Florida (7), Ohio (12), and Wyoming (9); the annual savings for these organizations was \$5,599,703.99. Extrapolating that average annual savings across all 48 participating organizations would generate a total annual savings of \$9,599,492.64.

>> Total wait time (days): Access Redesign efforts also produced a 40% reduction in the total wait time incurred by the average client. During this initiative, we established a direct link between a client's wait time and his or her level of engagement in the treatment by reviewing more than 17,000 service events that took place during the 6 months. The correlation showed us that for each day the aver-



age client waited for an assessment appointment, he or she was 1% less likely to show up for that appointment (e.g., a client who waits 60 days was 60% less likely to show up for that assessment appointment).

It's time for every community behavioral health organization to focus on changing access-to-treatment processes that are not time-effective and engaging for clients and that create extra "busy work" for staff, resulting in a process cost that cannot be recovered by the revenues.

Community behavioral health organizations can be

an important specialty provider in the new healthcare reform integrated-service-delivery models if we ensure timely access to treatment.

Scott Lloyd is vice president of MTM Services; he works with an approach grounded in an accountable care philosophy. Lloyd's work has focused on helping behavioral healthcare organizations analyze their performance data to establish systemwide changes that improve the overall quality of the services being delivered and on guiding them through changes such as fee-for-service funding conversions. He is the author of Using Data to Drive Your Service Delivery Strategies: A Toolkit for Healthcare Organizations published by the National Council for Community Behavioral Healthcare.

ACCESS REDESIGN INITIATIVE OUTCOMES

After 6 Months

	Total Number of Processes	Total Staff Time (Hrs)	Total Client Time Without Wait Time (Hrs)	Cost for Process	Total Wait Time (Days)
Old Process Average:	5.70	5.06	3.65	(331.63)	49.25
New Process Average:	5.04	3.34	2.99	(210.20)	29.31
Savings:	0.66	1.73	0.65	\$121.43	19.94
Change%:	12%	34%	18%	37%	40%
Avg. Number of Intakes Per Month:				3,843	
Monthly Savings:				\$466,642	
Annual Savings:				\$5,599,704	

figure 2

Prevention Is Better than Cure

David Shern, PhD, President and CEO and Kirsten Beronio, Vice President for Public Policy and Advocacy — Mental Health America

Mental Health America has placed a high priority on improving access to preventive services and mental health promotion as a key component of healthcare reform. We know that half of all people with a diagnosis of mental illness first experience the illness by age 14, but do not receive treatment until age 24. This early age of onset and 10-year delay in treatment often interfere with a young person's ability to succeed in school and gain employment and increase the likelihood of developing a costly disability. Moreover, research indicates that childhood adverse experiences and early onset mood and anxiety disorders may significantly increase the risk of a wide array of chronic physical diseases later in life.

In March of last year, the Institute of Medicine issued a comprehensive report on "Preventing Mental, Emotional, and Behavioral Disorders among Young People" illustrating the dramatic impact these conditions have on our population and the tremendous opportunity we have to prevent them. In recent decades there has been an explosion in research on the prevention of mental health and substance use conditions. Many interventions can result in long-term reductions in behavioral health disorders as well as other positive outcomes such as improved academic achievement. The report asserts that the greatest prevention opportunity is among young people and highlights the finding that there is a window of opportunity from the time a symptom first appears to development of a diagnosable disorder, usually two to four years. A number of successful interventions focus on improving parenting skills and mitigating disruptive family influences such as divorce and maternal depression, as well as engaging schools in prevention initiatives.

We are heartened by the many provisions in the Patient Protection and Affordable Care Act (Pub.L. 111-148) to improve access to preventive services. Within six months of enactment, all new health insurance plans are to cover preventive services with no copays or deductibles. The law further specifies that children are to receive preventive care recommended by Bright Futures, an initiative by the American Academy of Pediatrics and the Health Resources and Services Administration. For example, families with new plans are expected to no longer face co-insurance or co-payment charges for well-child visits, vision and hearing tests, various health and behavioral

assessments, and developmental screenings.

In addition, the PPACA requires that new health plans cover preventive services for children and adults recommended by the United States Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Further, the plans offered to the uninsured through the new health insurance exchanges in 2014 will be required to cover preventive services without cost-sharing. Also important are the provisions requiring Medicare and Medicaid to cover preventive services without cost-sharing requirements.

In light of the IOM report, which discussed the strong evidence showing the effectiveness of nurse home visitation programs, Mental Health America strongly supported authorization of \$1.5 billion in the PPACA for a new grant program to support early childhood home visitation programs.

Another new grant program would fund school-based health clinics with \$50 million for each fiscal year 2010 through 2013. The Affordable Care Act includes explicit direction that clinics are to include mental health and substance use assessments, treatment and referrals.

To develop a national strategy and coordinate federal prevention activities, the PPACA establishes a National Prevention, Health Promotion, and Public Health Council. In addition, a Prevention and Public Health Fund is to be established with \$7 billion for FY 2010 through 2015 and \$2 billion each year after that.

A new community transformation grant program will be established to support delivery of community-based prevention and wellness services. Many of the most effective behavioral health prevention programs are community based, including working with schools to engage them in practices that strengthen social and emotional development while fostering a positive learning environment and mental health literacy.

Employers are also encouraged to establish wellness programs as more flexibility is given to lower premiums or offer other incentives for employees who participate and grants are authorized to help small employers establish wellness programs. A new annual wellness visit benefit is authorized in Medicare — providing each beneficiary a

We are heartened by the many provisions in the Patient Protection and Affordable Care Act (Pub.L. 111-148) to improve access to preventive services. Within six months of enactment, all new health insurance plans are to cover preventive services with no copays or deductibles.

comprehensive health risk assessment and creation of a personal prevention plan. In addition, federal Medicaid funding will be increased by one percentage point for states that cover immunizations and preventive services endorsed by the U.S. Preventive Services Task Force with no cost-sharing.

We realize that to 'bend the cost curve' while improving the health status of Americans, we must emphasize preventive programming. The PPACA makes several important advances in this area as a down payment on the comprehensive health and wellness program need to achieve these dual ends.

With more than 30 years of distinguished service in mental health services research and system reform, David L. Shern, PhD, is one of the nation's leading mental health experts. In 2006 he was appointed president and CEO of Mental Health America. Prior to joining MHA, Shern served as dean of the Louis de la Parte Florida Mental Health Institute at the University of South Florida. He is a recipient of the 2008 Luminary Award from the National Alliance for Research on Schizophrenia and Depression and the 2006 Carl Taube award from the American Public Health Association in recognition of his contributions to mental health services research. He received a Presidential Citation for outstanding service from the American Psychological Association. Shern served as chair of the Florida Commission on Mental Health and Substance Abuse.

Kirsten Beronio focuses on determining Mental Health America's policy positions and advocacy strategies concerning a broad array of federal legislative and regulatory issues, including improving access to mental health care through healthcare reform, mental health parity legislation and regulations, and federal healthcare coverage programs including Medicaid, the Children's Health Insurance Program, and Medicare. Before coming to MHA, Beronio was the Medicaid and State Children's Health Insurance Program Counsel for the Minority Staff of the United States Senate Finance Committee.

Workplace Wellness – On a Budget

Anna Konger, Assistant Editor, *Corporate Wellness Magazine*

The passage of the Patient Protection and Affordable Care Act means a great deal to us in the wellness field. For the first time ever, this bill will provide us with short-term and long-term benefits that will help curtail the organizational costs (mostly financial) of sick employees and the increase the benefits of healthy ones, such as improved productivity, boosted morale, and less usage of the medical system. The provisions will take some time to implement, but employers and employees can expect an increased emphasis on wellness in the workplace as this decade progresses.

This article is a brief question-and-answer session about some of the wellness provisions, their potential implications, and how you might implement wellness programs in your organization.

Q ■ What short-term wellness benefits can we expect from healthcare reform legislation?

A ■ A national prevention and health promotion strategy will be developed for the country. Leaders from the U.S. Departments of Agriculture,

Transportation, Education, and Health and Human Services, along with a group of nonfederal advisors, will shape a policy plan that looks at many societal aspects of health. More funding will be made available for health promotion research studies. You will also begin to see more health plans required to cover preventive services at no additional cost (such services are referenced by the Clinical Preventive Services Task Forces and the U.S. Preventive Services Task Force Community).

Q ■ What are the implications of healthcare reform for small businesses?

A ■ These businesses have the most to gain. The Department of Health and Human Services will provide \$200 million in grant funding to fund comprehensive health promotion programs for employers of 100 or fewer people. Details are forthcoming.

Q ■ What are the benefits for larger employers?

A ■ Larger employers will be able to allow premium differentials of up to 30% for staff who meet specific health goals, such as achieving a certain fitness level, having normal biometric levels, and not smoking.

Q ■ How does this bill benefit employees?

A ■ Employees who are currently taking good care of their health will see decreased medical costs. More incentives (monetary and nonmonetary) will be offered for employees to participate in health promotion programs.

Q ■ How should an employer get started on providing wellness programs?

A ■ Employers can begin by reading up on the wellness provisions of healthcare reform legislation and by joining organizations that can provide materials and technical assistance for planning, implementing, and evaluating employee health programs. A great place to start is the Healthier Worksite Initiative by the Centers for Disease Prevention and Control (www.cdc.gov/nccdphp/dnpao/hwi/index.htm). You will find resources and step-by-step toolkits to help you improve the health of your employees.

Q ■ We don't have a lot of money for employee wellness at my company. Can we still do something?

A ■ Absolutely. Many companies are in the same boat. Start small. Capitalize on the free health benefits for employees provided by your insurance. For instance, some insurers offer free health risk assessments for covered people; others provide pedometers and walking kits. Bring in lunch-and-learn speakers. The Healthier Worksite Initiative website is a great first resource.

Wellness in the workplace will be a growing trend in cost savings for organizations, but more important, it provides a great opportunity for all of us to create a supportive environment for our own staff to become happier and healthier.

Wellness in the workplace will be a growing trend in cost savings for organizations, but more important, it provides a great opportunity for all of us to create a supportive environment for our own staff to become happier and healthier.



Anna Konger is assistant editor of Corporate Wellness Magazine, a source of information for employers, consultants, and health insurance agents about corporate wellness. The magazine offers cutting edge advice from experts involved in the corporate wellness industry. She is also senior meeting manager for the annual Corporate Wellness Conference, which brings together healthcare leaders for two days of educational sessions and networking dedicated to corporate wellness, value based benefit design, and reducing healthcare costs through health and wellness promotion.

Weaving Mental Health First Aid into Workplace Wellness

Meena Dayak, Vice President, Marketing and Communications, National Council for Community Behavioral Healthcare

Every month Anne LaFleur sends employees in her office a quiz about various wellness topics. When the topic was depression, she received twice as many responses as usual from co-workers.

When LaFleur, vice president of human resources at Pawtucket Credit Union in Pawtucket, RI, took a Mental Health First Aid course in February, she quickly understood the reason for the high level of interest in mental health issues. The training also helped her identify people in her office who may be suffering a mental health problem and taught her how to provide help and refer people to self-help and professional resources.

"The training made me realize that mental health issues are very common, yet one of the least talked about problems," LaFleur says.

Of nearly 1,000 participants in a webcast on "Understanding Depression" offered by the National Council for Community Behavioral Healthcare in May 2010, more than 60% said they were concerned about a friend, colleague, family member, or themselves being depressed. And 70% felt more confident to offer support to those in need after gaining a basic understanding through the webcast.

More than one in four people suffer from a diagnosable mental health problem in any given year. Mental illness likely costs businesses more than \$79 billion a year, \$63 billion of it in lost productivity. The statistics point to the significant need to incorporate mental health into burgeoning employee wellness programs, which have received shot in the arm with the passage of federal healthcare reform legislation.

The Patient Protection and Affordable Care Act specifies that starting in 2014, employers can offer bigger incentives for employees' positive lifestyle practices or participation in health promotion programs. The PPACA also creates a grant program to assist small businesses to provide comprehensive workplace wellness programs. Grants will be awarded to eligible employers to provide their employees with access to new workplace wellness initiatives. The grants will be awarded beginning in 2011 with \$200 million appropriated for a five-year period. The PPACA spells out that a comprehensive workplace wellness program must be made available to all employees and include health awareness initiatives (including health education, preventive screenings, and health risk assessments) as well as supportive environment efforts (including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health).

Mental Health First Aid has proved to be an ideal program to promote improved mental health in workplaces across the country.

LaFleur is one of more than 6,000 people certified in Mental Health First Aid since the training was introduced in the United States two years ago by the National Council for Community Behavioral Healthcare along with the Maryland

“Mental illness may not be the most popular water-cooler topic because of the stigma around it, but there’s a real hunger out there for reliable information”



Department of Health and Mental Hygiene and the Missouri Department of Mental Health.

Those who participate in the 12-hour Mental Health First Aid course learn a five-step process to assess a situation, select and implement appropriate interventions and help a person developing signs and symptoms of mental illness or in crisis receive appropriate care. Participants also learn about the risk factors and warning signs of specific illnesses such as anxiety, depression, psychosis, and addiction.

Evaluations show that the evidence-based Mental Health First Aid program saves lives, expands people's knowledge of mental illnesses and their treatments, and reduces the stigma associated with mental illness by helping people understand and accept mental illness as a medical condition. One trial of 301 randomized participants found that those who took the training had greater confidence in providing help to others, greater likelihood of advising people to seek professional help, and decreased stigmatizing attitudes.

Unexpectedly, the study also found that Mental Health First Aid improved the mental health of the participants themselves.

"By understanding the signs and symptoms of depression, I learned to recognize this in myself," says Kellie-Ann Heenan, director of human resources at Lighthouse Computer Services, Inc. in Lincoln, RI.



Heenan, who had the training in February, has an adopted son from Russia who suffers from a number of emotional issues.

“The tools I learned made it easier to connect with him and better understand where he’s coming from,” she says. “In the end, the training improved my own mental health.”

LaFleur has also applied the lessons she learned in the course to her home life.

“My kids are in their 20s and they go through the typical ups and downs,” says LaFleur, “I use my Mental Health First Aid training to see how my kids are feeling.”

LaFleur says she was surprised by the range of mental health issues covered in the course.

“We looked at how to deal with both crisis and non-crisis situations, and it made us very aware of the terminology we use that may not be socially correct,” she says, noting that describing co-workers as “crazy” or a “nut case” may be hurtful to people going through an emotionally trying time.

The training proved to be particularly helpful to Lynn Corwin last January when two employees of the United Way of Rhode Island walked into her office in a panic. They told Corwin, director of human resources at the organization, that a co-worker was extremely upset about the recent earthquake in Haiti. The distressed young woman had a close friend in Haiti and had been unable to contact the person for five days. Fearing the worst, the woman was having difficulty managing her emotions, let alone being able to work.

While the two workers had no idea how to deal with the situation, Corwin sprung into action.

“I used what I learned in the course to calm the woman down and talk with her about how she’s feeling,” says Corwin. “I explained to her that it was OK to be upset, and to not be embarrassed about it.”

“Mental illnesses may not be the most popular water-cooler topic because of the stigma around it, but there’s a real hunger out there for reliable information,” says Linda Rosenberg, the National Council’s President and CEO. “People are interested in the topic because mental illness touches so many lives.”

“Mental Health First Aid will not only help people learn how to respond to various psychiatric crises, but much of the course focuses on educating people about mental health – teaching them that mental illnesses are real, common and treatable,” says Rosenberg. “This program has the potential to become as common as First Aid and CPR in the near future and will help people better understand mental illness.”

“The training left me with a greater sense of confidence about how to deal with a variety of people issues that come up in every office,” concludes Heenan. “There’s such a stigma around mental health and people don’t want to talk about it, so having the information gives me confidence that I’ll be able to handle these types of situations when they arise.”

.....
Meena Dayak has more than 15 years of experience in marketing and media relations for nonprofit healthcare organizations. She spearheads branding, PR, social media, member communication, and public education initiatives – including Mental Health First Aid – at the National Council and serves as editor-in-chief of National Council Magazine. Her mission is to help member organizations tell a compelling story so the world will recognize that mental illnesses and addictions are treatable health conditions from which persons can recover and lead full lives.



**MENTAL
HEALTH
FIRST AID**

About Mental Health First Aid USA

By the Numbers

- **6,500+** Mental Health First Aiders trained
- **800+** instructors certified
- **1,500,000+** media impressions

Mental Health First Aid is the initial help given to a person showing symptoms of mental illness or in a mental health crisis (severe depression, psychosis, panic attack, suicidal thoughts and behaviors...) until appropriate professional or other help, including peer and family support, can be engaged.

Mental Health First Aid is delivered to members of the public through an interactive 12-hour course, which introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact and overviews common treatments. Participants learn a 5-step action plan encompassing the skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, social and self-help care. The course also provides participants with an understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities.

The 12-hour Mental Health First Aid course has been offered to a variety of audiences and key professions, including police/corrections staff/first responders/security personnel; educators/school administrators; human resources professionals; members of faith communities; homeless shelters workers; nurses/physician assistants/primary care workers; social workers; consumers and family members; and caring citizens.

Mental Health First Aid was created in 2001 by Professor Tony Jorm, a respected mental health literacy professor, and Betty Kitchener, a nurse specializing in health education and is auspiced at the University of Melbourne. Five published studies in Australia show that the program saves lives, expands knowledge of mental illnesses and their treatments, increases the services provided and reduces overall stigma by improving mental health literacy. In the USA, Mental Health First Aid is coordinated by three national authorities – the National Council for Community Behavioral Healthcare, the Maryland State Department of Mental Hygiene, and the Missouri Department of Mental Health.

The national authorities certify community organizations to implement Mental Health First Aid in communities throughout the United States. Each Mental Health First Aid site develops individualized plans to reach their communities, but all deliver the core 12-hour program and each participating site undergoes tight credentialing to guarantee fidelity to the original, tested model, while also maintaining the flexibility necessary to reach its unique citizens’ needs and demographics.

.....
To learn more and find a Mental Health First Aid course near you or to learn how you can become a certified instructor, visit www.MentalHealthFirstAid.org or contact 202.684.3732 or info@mentalhelathfirstaid.org.

Comparative Effectiveness — Cost Control or Quality Improvement?

Linda Rosenberg, President and CEO and Charles Ingoglia, Vice President, Public Policy — National Council for Community Behavioral Healthcare

As highlighted in the Institute of Medicine's Quality Chasm Series, our understanding of the effectiveness of healthcare interventions continues to grow — in particular, our understanding of the impact of such interventions on individuals with mental illness and substance use disorders is becoming more robust. And yet, research evidence indicates that the realities of care delivery don't always parallel established clinical guidelines. In the light of state budget cuts and other financial considerations, efforts are underway to realign direct care practices and clinical guidelines as one of several means to control healthcare costs and improve overall quality of care.

For the first time, significant amounts of money are being allocated to the federal government to evaluate the effectiveness of our nation's healthcare.

The economic stimulus bill approved by the U.S. Congress in February, 2009 provides \$700 million to federal agencies to conduct or support Comparative Effectiveness Research. Congress characterizes CER as research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders and other health conditions.

The Patient Protection and Affordable Care Act establishes an independent CER entity, the Patient Centered Outcomes Research Institute. CER is being embraced by public and private healthcare stakeholders as a leading solution to rising healthcare costs, poor quality, and safety concerns.

Despite this recognition, many healthcare stakeholders remain apprehensive about the impact of CER. In fact, while the national healthcare reform bill creates a new federal CER entity, it does not authorize its findings to be used to make decisions about the coverage or reimbursement of services. Clinical guidelines reinforced by financial incentives might become coercive tools, curtail treatment choice, and undermine recovery for a group of clients with very complex, co-morbid mental and physical health conditions.

A study that appears in the July 2010 issue of *Health Affairs* reveals that the general public may value other considerations — for example, recommendations from family and friends — more highly than findings from CER. Such subjective value judgments are at odds with the underpinnings of CER; clearly, additional efforts must be undertaken to achieve consumer buy-in of the value of CER in their decision-making process.

Healthcare advocates are calling for clear language that would prevent the use of CER to deny healthcare recipients needed treatments and therapies. Evidence should drive quality decision-making by the provider

between researchers and users to show a way for adaption and implementation of research results.

- Examine how we effectively translate research into everyday public health policies and programs. Previous efforts to accelerate the translation of research into practice often fail to characterize the knowledge gap between evidence-based interventions and effective delivery and adoption by diverse healthcare delivery systems. We must be diligent in articulating the need to support practice-based research in conjunction with dissemination of comparative research.

Any CER efforts must be publicly accountable. All stakeholders, including clients and providers, can play an active role in the entire research process from setting research priorities to disseminating research results.

Greater focus is needed for identifying the best methods to include clients in translating, disseminating, and implementing evidence to ensure that research is useful for policymaking.

Greater focus is needed for identifying the best methods to include clients in translating, disseminating, and implementing evidence to ensure that research is useful for policymaking.

and the client. Cost is a factor after determining options most appropriate to the individual. CER should support individualized care and not dictate "one-size-fits-all" treatment.

As bipartisan congressional action continues to shape how value and quality are defined in healthcare, there are clear action steps that researchers and providers need to take:

- Encourage Congress and the federal government to further examine important issues, such as population versus individual applications of evidence-based medicine, accountability in generating evidence used by policymakers, and accurate communication of evidence gaps and uncertainties. CER must consider a wide array of evidence that includes observational studies, disease registry data, and expert opinions drawn from clinical guidelines.
- As federal agencies develop their research agenda, it's imperative that providers engage in the development, translation, and dissemination of research findings into policy and practice. The application of research findings within complex healthcare systems requires increased interaction

Linda Rosenberg is an expert in mental health policy and practice with 30+ years of experience in the design, financing, and management of psychiatric treatment and rehabilitation programs. Under Rosenberg's leadership since 2004, the National Council for Community Behavioral Healthcare has more than doubled its membership; helped to secure the passage of the federal mental health and addiction parity law; expanded financing for integrated behavioral health/primary care services; was instrumental in bringing behavioral health to the table in federal healthcare reform dialogue and initiatives; and played a key role in introducing the Mental Health First Aid public education program in the United States. Prior to joining the National Council, Rosenberg served as the Senior Deputy Commissioner for the New York State Office of Mental Health.

Charles Ingoglia is vice president of public policy for the National Council for Community Behavioral Healthcare. He directs the federal affairs function of the National Council and oversees policy and advocacy outreach to more than 1,700 member organizations across the nation. He also serves as adjunct faculty at the George Washington University Graduate School of Political Management. Prior to joining the National Council, Ingoglia provided policy and program design guidance, including the review of state Medicaid waiver applications and other health and human services regulations, to the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration.



Save on Training Costs with E-learning

Visit Booth #10 at the National Council Hill Day Exhibit Hall

Our services are used by over 270 National Council members and over 700 agencies have renewed with us this year – come by our booth and find out why you can't afford not to look!

In this challenging economic environment, with staff time at a premium, Essential Learning offers efficient and cost-effective solutions for training.

- Most comprehensive library in the industry, over 1000 hours of interactive online courses
- Accreditation and Licensing compliance - OSHA, HIPAA, Joint Commission, COA, CARF, URAC, NCQA, EAGLE, and more
- Community Access Site – connect with your community stakeholders

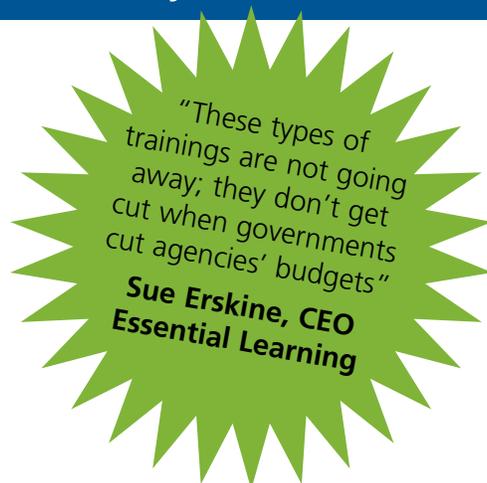
ELEVATE™
ESSENTIAL LEARNING

• State-of-the-art Learning Management System

EL Connect

• The premier online learning community

***National Council members eligible
for significant discounts.***



"These types of trainings are not going away; they don't get cut when governments cut agencies' budgets"

**Sue Erskine, CEO
Essential Learning**

Veterans Courses Available Now
www.CEQuick.com
and click on the Vets Ad

**Visit Our Web Site
Today and View Our Course Library**

www.EssentialLearning.com

Contact us to request an online demonstration
at info@EssentialLearning.com
1-800-729-9198 x284

National Council Member Spotlight

A National Council publication featuring members in action

National Council 2010 Awards of Excellence Winners

Each year, the National Council honors the best and brightest in mental health and addictions services through its Awards of Excellence. Staff and board leaders, consumers and families, programs and community partners are recognized for services that promote recovery and have a lasting impact on children, adults, and families.

EXCELLENCE IN SERVICE INNOVATION

Burrell Behavioral Health, Springfield, Missouri

This award is supported by a grant of \$10,000 to the winner from Mental Health Weekly.

Is it enough to give a homeless man with mental illness a bed in a shelter? Or does that man have the right to more? Burrell Behavioral Health believes that with treatment, support, and respect, every man and woman with mental illness can recover and fully participate in his or her community. Burrell has backed up this belief by making it a reality for hundreds of clients. Representing all National Council members who are devoted to bringing the homeless in from the streets, Burrell has won the admiration of the community and the nation. Thinking outside the box, Burrell formed partnerships with more than 20 organizations, expanding services as it went and overcoming resistance from those who said the plan wouldn't work or couldn't be done. The results speak volumes — nearly 500 people and families with mental illness and addictions have made the leap from the street to stable homes and acquired the strengths and life skills they needed to become productive citizens with homes, jobs, and active social lives.

Denise Mills, director of corporate services for Burrell Behavioral Health, says, "Winning the National Council's award for Service Innovation has been encouraging and has boosted staff morale. It has served as a positive reinforcer for the numerous partner organizations that have dedicated unique talents to making the Journey Home program a success. Without their commitment and collaboration, the program would have never reached the level of success it has today. Burrell particularly extends its appreciation to The Kitchen, Inc., and the Victory Mission for their dedication to the homeless of our community and their daily efforts to see that the individuals who walk through their doors are reestablished with key linkages that had been lost in homelessness—including healthcare, job counseling, educational assistance, housing supports, faith organizations, and other supportive services."

EXCELLENCE IN HEALTH INFORMATION TECHNOLOGY

Northern Arizona Regional Behavioral Health Authority, Flagstaff, Arizona

This award is supported by a grant of \$10,000 to the winner from Qualifacts Services, Inc.

Most mental health provider service areas encompass a few square miles. So how do a handful of psychiatric practitioners service 62,000 square miles in one of the most rugged parts of the country? Employing technology to its fullest, the Northern Arizona Regional Behavioral Health Authority relies on videos rather than vehicles. NARBHAnet is a comprehensive telemedicine network that uses two-way interactive videoconferencing to bring together mental health experts and patients in remote locations. Although telemedicine is often thought of as something new, NARBHAnet has served as an indispensable communications link for 13 years. In that time, it has been recognized as one of the best telemedicine programs in the United States, tallied more than 50,000 clinical psychiatric sessions, and saved millions in travel costs. Most important, NARBHAnet has brought thousands of clients the professional mental health support and services they need—saving time and money and providing a level of service and convenience to rival practices in many of America's most cosmopolitan areas.

Nancy Rowe, telemedicine program manager at the Northern Arizona Regional Behavioral Health Authority, says, "This award is an honor for NARBHA and reinforces the high quality of our telemedicine program to our company leadership, our current and potential member agencies, and the state of Arizona. Recognition by the National Council helps us justify new technology purchases to keep the network up to date and continue expanding it. Most important, this award will encourage growth of telemedicine to improve access to mental healthcare for rural residents across northern Arizona. We thank the Arizona Department of Health Services for awarding NARBHA the 1995 grant to develop our telemedicine program; Susan Morley, NARBHA deputy director, for starting up the network; Sara Gibson, MD, who has been providing psychiatric services solely through NARBHAnet since 1996; and our NARBHA telemedicine staff and all connected agencies who keep the network running successfully. We advise focusing on prompt, responsive customer service and good communication with partner agencies and customers."

Submissions for the National Council
2011 Awards of Excellence open September 27, 2010.
Watch our website at www.TheNationalCouncil.org/Awards.

Questions? Contact
Communications@thenationalcouncil.org or 202.684.7457.



EXCELLENCE IN RISK MANAGEMENT

Institute for Community Living, New York, New York

This award is supported by a grant of \$10,000 to the winner from the Mental Health Risk Retention Group and Negley Associates.

Few endeavors are more beneficial and rewarding than enabling people with serious mental illness to live with dignity and safety in their own homes. Along with a multitude of other services, the Institute for Community Living provides more than 1,400 units of housing for people with serious mental illnesses and co-occurring substance abuse and chronic medical conditions. And helping more than 8,000 consumers navigate and live successfully in New York City's neighborhoods is no easy task. To better ensure safety, ICL has developed and implemented a risk management system for both consumers and staff. Staff are trained to help consumers identify their triggers for risky behavior, and, together, staff and consumers develop a repertoire of strategies to cope with risk-laden situations. The agency measures success by insisting on an agency-wide culture of mutual responsibility and encouraging continuous learning, sharing, and support. ICL has built an exceptional platform that results in a win-win situation for all involved.

Peter Campanelli, PsyD, president and chief executive officer of the Institute for Community Living, says, "What if we could identify clinical risk for suicide, relapse, or more intense need for services before tragedy strikes? That question prompted us to create the Clinical Risk Assessment and Intervention Initiative, which is applicable in a variety of programs and treatment contexts. The collaboration between staff at all levels at ICL has been incredible and certainly is responsible for the significant strides made in assessing clinical risk and facilitating interventions and supports. Management and line staff alike participated in program design, rollout, and implementation and provided feedback for improvement. Without their commitment and dedication, and the perseverance and strengths of our consumers, the program would not have been possible. We are honored to receive the first Excellence in Risk Management Award and hope it will encourage other agencies to think about embedding risk management activities in their standard clinical practices to better support staff and consumers. We thank the National Council and Negley Associates for recognizing our initiative."

EXCELLENCE IN ADDICTIONS TREATMENT AND PREVENTION

Hartford Dispensary, Manchester, Connecticut

If one were able to offer easy and convenient access to a full range of health services for patients who were already receiving treatment for drug addiction, would those patients respond positively? The Hartford Dispensary has found the answer to be a resounding "yes." Hartford, which serves 4,000 patients every day, recognized that many of them suffered from health issues that extended far beyond comorbidities of drug use. Rather than accept the status quo, Hartford took exceptional initiative; it reached out to local healthcare organizations to spearhead a comprehensive care program that encompasses drug treatment, counseling and psychiatric services, primary care, infectious disease treatment, dental care, and women's services. Now, through the convenience of accessing all facets of healthcare from one provider, patients are much more likely to seek care, and the results speak for themselves—not only is patients' overall health much improved, their quality of life has been enhanced, and the incidence of drug use has declined.

Paul McLaughlin, chief executive officer of Hartford Dispensary, says, "This award validates our commitment to our mission to address the needs of traditionally underserved populations. It enhances our credibility in the eyes of the consumers as it demonstrates our commitment to continually improving services. It is also very rewarding to have other professionals give their support for a 'one-stop' model of delivery. The award also demonstrates to our board, employees, funders, and other stakeholders our commitment to provide national best practice service approaches—we are grateful to all of them. We thank our partners, the State Department of Mental Health and the Department of Mental Health and Addiction Service, for their ongoing support of innovative services. We also thank our research partners for using our facilities to conduct research pertinent to the needs of our employees and consumers. Communicating with our consumers and being responsive to their needs [have] resulted in innovation and creative thinking for the nearly 140 years our agency has provided services."

EXCELLENCE IN CONSUMER AND FAMILY ADVOCACY *Austin Travis County Integral Care, Austin, Texas*

Education is an incredibly powerful tool, and the promise of equitable health-care services for all is much more than a hope for many African Americans in the heart of the Lone Star State, thanks to Austin Travis County Integral Care. ATCIC is the organizational brains and brawn behind the Central Texas African American Family Support Conference, an amazing two-day event held annually to acquaint the African American community with information about behavioral and physical healthcare services and supports that are available locally. The conference provides indispensable education and resources that help change attitudes and, literally, save lives. With the help of local public- and private-sector organizations and the assistance of volunteers and health professionals, ATCIC serves as an inspiring force for change and helps break down health disparities by bringing together people in need and those able to help, in a highly engaging, innovative, and supportive way.

David Evans, executive director of Austin Travis County Integral Care, says, “Such an event could not happen without the incredible efforts of our volunteers. Many of them have invested their time and efforts [in] opening doors and impacting the community since the humble beginnings of the conference. We have also had strong endorsement and support from our board of trustees. This award affirms these collaborative efforts and spirit of integrating real world practice to positively impact our community. Of course, the conference would not be possible without the generous continued support of sponsors, including New Milestones Foundation, the Office for the Elimination of Health Disparities, Mr. and Mrs. Willie Williams, the Seton Family of Hospitals, and the Wood Group. This year, we are also thankful for a grant we received from the Substance Abuse and Mental Health Services. We encourage other community centers across the nation to begin local programs to address health disparities by leveraging collaborative partnerships in their communities.”

EXCELLENCE IN STATE GRASSROOTS ADVOCACY

Association for Behavioral Healthcare, Natick, Massachusetts

If necessity is the mother of invention, then the Association for Behavioral Healthcare offers a valuable lesson in how to take a demoralizing situation and turn it into a winning proposition. Faced with the elimination of many of its vital alcohol treatment and support programs as a result of state budget cuts, the Association elected to fight fire with fire. It established a grass-roots organization—the Campaign for Addiction Prevention, Treatment and Recovery—to repeal the Massachusetts sales tax exemption on alcohol. As a result of the aggressive campaign and the untiring efforts of the Association to present its case to lawmakers, not only was the alcohol sales tax exemption repealed, \$115 million in new revenue was generated and then channeled directly back into programs that treat people dealing with alcoholism. At a time when many state and local agencies are seeking solutions to budget shortfalls, this endeavor stands out for its social and fiscal brilliance.

Vic DiGravio, president and chief executive officer of the Association for Behavioral Healthcare, says, “We are extremely grateful to be recognized by our peers and colleagues from across the country. This award reinforces the significance of our accomplishment in repealing the sales tax exemption on alcohol sold in stores. A special thank you goes to the ABH board of directors and our member organizations, whose grassroots advocacy played such a key role in our success. This award is a wonderful recognition of the collective strength of our membership. In addition, our partners in the Campaign for Addiction Prevention, Treatment and Recovery deserve a special round of applause. This joint advocacy effort was critical, as it showed that addiction advocates could work together for a common purpose during a time when state resources were limited. We thank Governor Patrick and the state legislature; without their understanding of the importance of addiction treatment and prevention and their willingness to consider new revenues, this would not have been possible.”

EXCELLENCE IN LOCAL GRASSROOTS ADVOCACY

Colorado West Regional Mental Health Center, Glenwood Springs, Colorado

After three local hospitals closed their psychiatric wings, the prospect of having no psychiatric hospital capacity in the entire western half of Colorado was too much for the Colorado West Regional Mental Health Center to contemplate. With the best of intentions, it took on a \$10 million debt to build a new psychiatric hospital. In the process, however, it drained its financial reserves, and the organization, its patients, and its staff were left vulnerable. Rather than submit to certain foreclosure, Colorado West dug in its heels and went on the offensive, initiating an aggressive grassroots advocacy campaign to build needed support for its operations. With the help of local foundations and policymakers, whose endorsement and support were solidified as a direct result of the grassroots campaign, Colorado West was able to retire the entire debt in just 15 months and return to financial stability. The extraordinary vigor and determination it demonstrated to right its fiscal health is testament to the organization’s commitment, perseverance, and resilience.

Sharon Raggio, chief executive officer of Colorado West Regional Mental Health Center, says, “At Colorado West, Inc., this award exemplified years of hard work and dedication by staff [who] were beginning to lose hope that financial stability could be a reality. This award is a vote of confidence for Colorado West employees and board members, who work tirelessly to carry out our mission. They show up even when times are tough, dedicating countless hours of overtime and volunteer hours so that our mission is realized. We thank every one of them. We would like to thank the Colorado Health Foundation, the Colorado secretary of state, the state Senate majority leader, the Mesa County manager and the Mesa County commissioners, the Boetcher Foundation, the El Pomar Foundation, and Chase Bank. Our advice to others—tell your story every chance you get to any person who will listen. Aim high, and be open to possibilities.”



UP & COMING LEADERSHIP

Rosa M. West, Vice President for Specialty Programs and New Initiatives, Meridian Behavioral Healthcare, Inc., Gainesville, Florida

Rosa West is a rising star who has demonstrated time and again that innovation is not simply an exercise, it's an essential element in finding new ways to solve age-old problems. Distinguished by an indomitable spirit and quest for innovation, West has made a significant difference in the lives of untold numbers of people. She is responsible for initiating special programs in mental health and addictions services at Meridian Behavioral Healthcare. Her successful endeavors include the Medication Assisted Treatment pilot project for people with addiction disorders and the Forensic Diversion Program, designed to keep at-risk people out of jail and in treatment. She also has been a catalyst in implementing state and national initiatives to establish open-access walk-in clinics for mental health and addictions, as well as a foster care redesign initiative to reduce the number of children in out-of-home placements. Rosa West brings extraordinary promise and passion to behavioral healthcare at a time when these qualities are needed most.

Rosa West says, "I am extremely honored by this award. And I am grateful to Richard Anderson, Dr. Maggie Labarta, and my colleagues at Meridian for allowing me the opportunity to improve the quality of care of those we serve and to help create an environment in which behavioral health professionals are the impetus for inspiring growth and change among the mentally ill and substance abuse population. I believe in three keys to successful leadership—learning, resiliency, and service. It is important to continue to look for new ways to accomplish objectives, experiment with new approaches, and learn from them. The path to success is not a straight line, and we can anticipate that there will be barriers to overcome—that requires resilience. However, by being servant leaders and ensuring that we take care of those under our direction, we can garner the support and effort needed to prevail over any impediment. Maya Angelou said, 'When you learn, teach. When you get, give.' I will continue to strive to give back."

VISIONARY LEADERSHIP

Mary Anderson, Board Member, Newaygo County Mental Health Services, White Cloud, Michigan

Walk a mile in Mary Anderson's shoes, and it will be abundantly clear why she is so passionate in her defense of and advocacy on behalf of people with mental illness. As a consumer of mental health services herself, she brings a unique perspective and experience that strengthen her influence and enhance her credibility. Anderson possesses a deep understanding of the complexities of the public mental health system and the funding challenges that always seem to represent a constant threat to its operations. As an experienced and tenacious negotiator, she plays an especially valuable role working with county, state, and national officials to improve quality of life for people with mental illness, along with their families. Anderson sees challenges as opportunities; she is an eternal optimist who channels her uncommon compassion for those in need through community

volunteerism, public office, and service on the boards of the National Council for Community Behavioral Healthcare and the Michigan Association of Community Mental Health Boards.

Mary Anderson says, "The definition of a visionary leader that I can relate to is a person who guides or inspires others to think creatively about the future. Serving on the National Council Board reinforces that — they listen to every board member's point of view and continue to strive for excellence. And my local agency's support of my taking advantage of the opportunities to serve on state and national boards has been amazing. Newaygo County Mental Health Board is a small agency with a big heart and ambition. We are not afraid to try new ideas and put the quality of life of our consumers first and foremost. I also want to thank the Michigan Association of Community Mental Health Boards for all their support in my endeavors to promote a better quality of life for persons with mental illness and developmental disabilities. Unless you have experienced mental illness yourself it is hard to understand how much energy it takes just to appear 'normal,' and even more so to be successful. It means so much for me to be recognized."

VISIONARY LEADERSHIP

Howard Bracco, PhD, CBHE, President and Chief Executive Officer, Seven Counties, Inc., Louisville, Kentucky

Howard Bracco has always been driven by the conviction that anyone in need of professional help deserves quality behavioral healthcare, regardless of his or her lot in life or ability to pay. In his 31 years of distinguished service as president and chief executive officer of Seven Counties, Inc., Bracco has built the agency into the largest provider of mental health, addictions, and developmental disability services in the Louisville area. In his quest to bring quality care to the region, Dr. Bracco diligently sought new partners who shared his vision and forged a comprehensive network of 16 organizations to provide behavioral healthcare treatment and essential services to a region with a population of nearly 900,000. He is an exemplary leader and a powerful team builder who continually inspires staff as well as the people his organization serves. As a result of his encouragement and vision, thousands of clients have realized their potential and live valued lives in their communities.

Howard Bracco says, "I was truly honored to receive the National Council's 2010 Visionary Leadership Award. The award was made even more meaningful for me in that it was shared by four other extraordinary individuals who humble me. No accomplishment occurs in a vacuum. My journey has been dependent on the relationships I have had over the years with friends and colleagues at the [National Institute of Mental Health] Staff College, the National Council, and the Mental Health Corporations of America, [which] collectively served to establish a culture of support, challenge, and continuous learning. I was fortunate as well to have a number of incredible mentors—Dr. Dale Farabee, Dan Howard, and Ashar Tullis, who collectively gave birth to the community mental health system in Kentucky. Vision without implementation is simply the act of dreaming. Leadership without



people who choose to follow is simply the act of hearing oneself talk. Thankfully, I have had the benefit of the vision, leadership, and support of my family, board, staff, consumers, and the community partners of Seven Counties Services, all of whom acted on my dreams and words to help individuals and families who are affected by mental illness, developmental disabilities, addictions, and abuse realize their potential for living satisfying, productive, and valued lives.”

VISIONARY LEADERSHIP

David Guth, Chief Executive Officer, Centerstone of America, Nashville, Tennessee

The world is made up of people who follow and people who lead: David Guth is a man of vision and action. In his ongoing search for new and better ways to treat mental illnesses and addiction disorders, he has combined the best that science and information technology have to offer and invested in treatment research that translates directly to the real world. Under his leadership, Centerstone of America provides a continuum of high-quality, state-of-the-art behavioral healthcare throughout Tennessee and Indiana, serving more than 75,000 people a year. Guth is an exceptionally strong advocate for mental health parity and has a regular seat at the table when it comes to healthcare reform at the local level. Never short on ideas or ways to implement them, he led the integration of behavioral health and general healthcare provider organizations by establishing a dedicated research wing to achieve operational efficiencies and improve service quality — which gives patients a full opportunity for recovery.

David Guth says, “This recognition means so much to me and to the rest of the Centerstone team because it has come from our esteemed peers at the National Council. Each year we bring a large contingent from Centerstone to the National Council Conference — you can’t help but walk away from the conference amazed at the breadth and depth of our community mental health system and humbled by the level of innovation on display. To be singled out in this group means something very special, indeed. I am so pleased to share this award with Mary Anderson, Howard Bracco, Jay Reeve, and Richard Van Horn—to be

considered in the company of these amazing people is a true honor. To hold an inspiring vision, one must first be inspired. I have been so fortunate to be surrounded by passionate and visionary people for many years. Particular thanks go to Ken Baines for making the question ‘How will this benefit the consumer?’ part of our corporate DNA; and to Dick Fitzgerald for his example of how to lead; and to Gwen Watts, who, as I ‘stir the pot,’ ensures ‘the soup’ doesn’t end up on the floor. My advice is to take inspiration from those around you. Question the variables you believe to be constants. Take your mission very seriously, but not yourself. And remember, leadership is a team sport.”

VISIONARY LEADERSHIP

Jay Reeve, President and Chief Executive Officer, Apalachee Center, Tallahassee, Florida

Jay Reeve is a visionary who “walks the walk.” His uncompromising commitment to extending full support to people with mental illness and addiction disorders sets him apart as a person of extraordinary conviction and exceptional compassion. Under his expert guidance and leadership, Apalachee Center has pushed the boundaries of traditional care, both treating co-occurring mental and addiction disorders and attending to patients’ physical health needs. To accomplish this, Reeve has been instrumental in building mutually beneficial local professional relationships and forging partnerships with entities such as Florida A&M University’s College of Pharmacy and Bond Community Health Center. As an untiring advocate and community problem solver, Reeve lends his strong voice as well as his considerable expertise to ensure that people in need receive the care they require and that mental health awareness is never far from mind in Florida.

Jay Reeve says, “This award has been an extraordinary honor. Apalachee’s board of directors, led by our chair, Denise Hannah, has been everything that a CEO could ask for—involved, flexible, supportive, and very mission driven. Apalachee’s chief of operations, Melany Kearley, has energized and infused our organization with the spirit of recovery and an absolute commitment to our clients. Our management team, Sue Conger, Guy Johnson, Ginger Kelly, Candy Landry, Thad Moorer, and Dr. Abdol Mansouri, share commitment to our clients, an extremely strong work ethic, and great team spirit and lead hundreds of committed employees in providing excellent customer service and quality clinical care. I have been lucky to be mentored by some of the industry leaders in Florida, who have also become my friends—Ned Ailes, Gary Bemby, Jon Cherry, Dr. Linda DePiano, Mario Jardon, Jerry Kassab, Dr. Maggie Labarta, and Dr. Steve Ronik have generously shared their extraordinary insight and expertise with me and continue to help me grow as a leader. And there are two individuals without whom I would never have been able to do this job: my predecessor and greatest mentor, Ron Kirkland, who was the best possible teacher of the business side of healthcare, and my wife, Dr. Kate Lyon, who teaches me about excellence and vision on a daily basis. The honor of this award should really be divided among all of them.”



VISIONARY LEADERSHIP

Richard Van Horn, President Emeritus, Mental Health America of Los Angeles, Los Angeles, California

For 30 years, Richard Van Horn has played an exemplary leadership role in helping adults and youths recovering from mental illness lead independent and productive lives in their own communities. His unassailable belief in the power and potential of people with mental illness distinguish him as a man of vision and commitment. As a valued mentor and astute businessperson, Van Horn has guided and built Mental Health America of Los Angeles into one of Southern California's leading nonprofit mental health organizations through continuous service innovations, recurring systems design, and public policy change. Under his leadership, MHALA has become a highly respected service innovator, trainer, educator, and advocate. Van Horn also led MHALA's development of recovery-focused, peer-run programs. He has worked tirelessly for systems change at the local, state, and national levels and serves on the board of the National Council for Community Behavioral Healthcare.

Richard Van Horn says, "Receiving the visionary leader award was truly a memorable moment because it represents what we have achieved at Mental Health America of Los Angeles. We have been fortunate to be in the right place at the right time for innovative programs that have come alive and spread beyond our 'pilot' efforts. The key was recruiting the right people and giving them the freedom to take a germ of an idea and grow it to full bloom. In fact, this is the key to success for MHALA and me—get the right people; give them trust and room to succeed (and live through the occasional failure, if necessary); and reward them with recognition, praise, and raises, if possible. Special thanks go to my wife, Kay, who supports me in all endeavors; Ann Stone, executive vice president, who makes MHA function; Julia Scalise, chief development officer, who keeps the money rolling in; Dave Pilon, our new president; Martha Long, Mark Ragins, and Paul Barry, who have led the MHA Village for 20 years; Gustavo Loera, who created the Human Service Academies; Dena Stein, who builds our workforce development programs; and two board chairs, J. R. Elpers and Areta Crowell, who were great chairs and mentors for me over the past three decades."

EXCELLENCE IN PUBLIC SERVICE

Pamela Greenberg, President and chief executive officer, Association for Behavioral Health and Wellness, Washington, DC

Pamela Greenberg has fashioned a long and noteworthy career advocating for people living with mental health and addiction disorders, along with their families. As president and chief executive officer of the Association for Behavioral Health and Wellness and co-chair of the Coalition on Fairness in Mental Illness Coverage, she led the charge and played an essential role in the 20-year battle to negotiate groundbreaking agreements among providers, advocates, the health insurance industry, and the business community—all of which culminated in the passage by Congress of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Greenberg's contagious energy and determined leadership on behalf of people with traditionally little or no voice in the political process

exemplifies her unbridled passion for equality and fairness and personifies the true spirit of public service.

Pamela Greenberg says, "I was so excited when Linda Rosenberg asked me if I would accept the National Council's Excellence in Public Service award. To be recognized by such a respected organization and, in turn, others in the field was an honor. There were many advocates [who] were dedicated to getting the parity bill signed in to law, including Carol McDaid, who also received an award this year. The colleagues I worked most closely with were the members of the Fairness Coalition (American Hospital Association, American Medical Association, American Psychiatric Association, American Psychological Association, Association for Behavioral Health and Wellness, Federation of American Health Systems, Mental Health America, National Association of Psychiatric Health Systems, and [National Alliance on Mental Illness]). Our coalition also worked with the business and insurance community and senators and the staff from many offices, including Senators Dodd, Domenici, Enzi, Kennedy, and Wellstone. The members of the Association for Behavioral Health and Wellness have supported parity since the organization's inception in 1994. Thank you, National Council, for recognizing my contribution to the field."

EXCELLENCE IN PUBLIC SERVICE

Carol McDaid, Principal, Capitol Decisions, Inc., Washington, DC

For more than a decade, Carol McDaid has worked tirelessly to bring about mental health and addictions parity. In long-term recovery herself, McDaid knows all too well the struggles that millions of Americans in need of mental health and addictions treatment face because they lack adequate insurance coverage. Her unceasing efforts helped immeasurably to ensure the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. She has been a passionate advocate not just for people living with mental health and addiction disorders but also for their families, who are often overlooked and under-represented. Her work with leading nonprofit drug and alcohol treatment centers, physicians, alcohol and drug prevention agencies, and consumer organizations to refine public policy regarding addictions treatment sets her apart as an inspirational leader and a compelling role model.

Carol McDaid says, "I was honored to receive a public service award. Oftentimes those who are paid for their work rather than volunteers in the not-for-profit world are overlooked when it comes to public service awards. Passage of parity was an important milestone professionally and personally. There was a time in my life when I was desperate, suffering silently with addiction, and the insurance that my employer and I had paid for wasn't there for me. I was lucky to have family to pay for my help. Parity for me is about making sure another woman who doesn't have these family resources does not have to face that same desperation. I often have to remind myself what our work is all about. Parity could not have passed Congress in the form it did without the tireless efforts of my colleagues Holly Merbaum, Ellen Gerrity, and Dave Wellstone. The parity regulations are far more thoughtful as a result of the volunteer wisdom and counsel of Henry Harbin, in between golf games. To others seeking advice I'd say—trust your gut; your instincts are better than you think. Don't give up."



Your Opinion Matters!

Blog

with us at

www.mentalhealthcarereform.org



Mental health and addictions services are at the core of healthcare reform

Join us on our blog to

- >>> **Hear from the leaders**
- >>> **Keep up with the latest**
- >>> **Understand the implications**
- >>> **See what's coming**
- >>> **Download PowerPoints, timelines, maps, and more**
- >>> **Add YOUR voice**

Find material to share on your social media sites and subscribe to our email and RSS feeds for live updates.

Integration,
Expansion,
Reform...

Is Your Insurance Keeping Up?



Are you prepared...

- ➔ To think outside the box?
- ➔ To integrate primary care with your behavioral health services?
- ➔ To take on the risks of expanded service?

Turn to the gold standard for behavioral health insurance solutions...

MHRRG and Negley Associates offer customized insurance coverage for primary care services delivered in behavioral healthcare organizations.

MHRRG and Negley Associates also provide a comprehensive insurance program and an exclusive loss prevention series for behavioral healthcare providers:

- Professional Liability • General Liability
- Directors and Officers Liability
- Business Automobile • Commercial Property
- Workers Compensation • Excess Liability

We understand the importance of treating the physical and mental healthcare needs of individuals with serious mental illnesses and responding to the behavioral healthcare needs of all Americans. This is creating a series of exciting opportunities for the behavioral health community and a series of unprecedented challenges.

*— Linda Rosenberg, President and CEO,
National Council for Community Behavioral Healthcare*



Mental Health
Risk Retention Group, Inc.

NEGLEY
ASSOCIATES
UNDERWRITING MANAGERS

qsiconnect.com

Does your vendor connect with you?

With Qualifacts, you get much more than an EHR - you are joining a network of users across the country, working towards the same goals.

**Qsiconnect.com is an online forum,
connecting you to Qualifacts and your peers through:**

- *Online training and support*
- *State and national user groups*
- *Discussion of new features and industry trends*
- *Announcements of grants and industry events*

getconnected!

(And put a smile on your face.)



Are you a Qualifacts user that hasn't connected yet?

Visit www.qsiconnect.com and click "Sign Up"

www.qualifacts.com | 866-386-6755

qualifacts