ASSOCIATION OF OREGON COMMUNITY MENTAL HEALTH PROGRAMS

Addictions • Mental Health • Developmental Disabilities

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Baker County
Mountain Valley Mental Health Programs, Inc.

Benton County Mental Health

Clackamas County Health, Housing & Human Services

Clatsop Behavioral Healthcare

Confederated Tribes Community Counseling Center of Warm Springs

Coos County Mental Health

Crook County Mental Health
Lutheran Community Services

Curry County Human Services

Deschutes County Mental Health Department

Douglas County Health and Social Services

Harney Behavioral Health

Jackson County Health and Human Services

Jefferson County
BestCare Treatment Services

Josephine County
Options for Southern Oregon, Inc.

Klamath County Mental Health

Lake County Mental Health

Lane County Health and Human Services

Lincoln County Health and Human Services

Linn County Health Department

Malheur County
Lifeways, Inc.

Mid-Columbia Center for Living
Sherman, Hood River & Wasco

Multnomah Health and Addiction Services

Polk County Mental Health

Tillamook Family Counseling Center

Umatilla County
Addictions Program

Union County
Center for Human Development, Inc.

Wallowa Valley Center for Wellness

Washington County Behavioral Health & Developmental Disabilities Division

Yamhill County Health and Human Services

August 14, 2012

Lillian Shirley, Vice-Chair, Oregon Health Policy Board

Liz Baxter, Chair, Oregon Health Insurance Exchange Board

Dear Chairs Shirley and Baxter, and Members of OHPB and ORHIX Boards,

The Association of Oregon Community Mental Health Programs (AOCMHP) submitted comments on the Essential Health Benefits recommendation to the Workgroup in June, which are attached for your consideration. Additionally, I would like to emphasize a few of the main points from our comments in this letter.

Our overall concern is that as Oregon transforms its health care system, changing from fee-for-service increments of care to bundled services that help an individual to recover from illness or maintain health, the financing mechanisms need to change from discrete covered services that are easy to quantify to a case rate customized to an individual's needs. Herein lies the dilemma of choosing a benchmark plan using today's insurance benefits paradigm.

Given that the estimated lifetime prevalence of any mental disorder among the U.S. adult population is 46% *(CDC)*, and the striking interconnections between chronic disease, injury, and mental illness, a broad public health approach that includes clinical diagnosis and treatment of mental illness, as well as surveillance, research, and promotion of mental health should be reflected in the benchmark benefits of the individuals. It was difficult to assess not only these qualities in the potential health plans using the plan spreadsheet, but also whether or not the recommended benchmark plan is compliant with Oregon and Federal mental health and addictions parity laws. Additionally, in the workgroup's discussions to determine the recommendation, we perceived a short-term definition of affordability. That is, the recommendation was made based on discrete service coverage costs as commercial insurance operates today rather than on a case rate model/global budget world that Oregon is transitioning into.

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Please consider this policy dissonance and these additional questions:

1. How are prevention and health promotion factored in to the definition of medical necessity? A common definition should be articulated by the State, and understood by insurance companies, treatment providers and consumers. Medical necessity should be defined in all appropriate member handbooks and expressed verbally to individuals who are served.

2. By limiting inpatient hospital days for mental/behavioral health needs to 45 days/year and not covering counseling or training in connection with family, sexual, marital or occupational issues, and acupuncture, chiropractic, or naturopathic care, are we ensuring that mental health needs of all ages are met?

   We support the recommendations of the Coalition for Whole Health, which in addition to the provision of basic outpatient and inpatient services, include appropriate treatments for eating disorders, recovery support services such as peer support and coaching, group and family evidence-based psychotherapy services, and consumer/family education on maintaining healthy weight, good nutrition and substance use prevention.

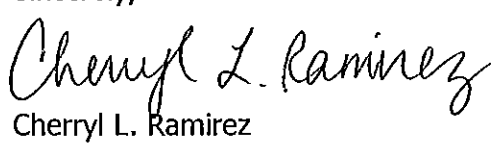
3. Is the impact of trauma factored into covered services? It is the consensus in the behavioral health field that most consumers of mental health services are trauma survivors and their trauma experiences help shape their responses to outreach and services.

4. If we look at cost offset, by committing to a leaner essential health benefits package, will this translate to a smaller total federal subsidy for individuals who will not be able to buy a richer benefit plan? How will Oregon reconcile the differences between the more substantial Medicaid benefits and the floor EHB as people transition out of Medicaid?

If we are to ensure that individuals with substance use disorder and/or mental health needs and their family members are partners with care providers in designing and implementing service plans, as recommended by the Institute of Medicine, the financing mechanism through Medicaid and commercial insurance must follow. If the financing structures are not aligned with health care services innovations, there is no way to truly reform the health care system and to implement informed, patient-centered participation and shared decision-making in prevention, treatment, illness self-management and recovery plans and strategies.

Thank you for the opportunity to provide comments for your consideration as you contemplate a recommendation for essential health benefits.

Sincerely,



Cherryl L. Ramirez

Director, AOCMHP

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Yamhill County Health and Human Services

June 14, 2012

RE: Comments on Essential Health Benefits Workgroup Preliminary Recommendation

Dear Members of the Essential Health Benefits Workgroup:

We believe that achieving mental illness and substance use disorder (SUD) prevention, treatment, and recovery outcomes will be essential to our successful pursuit of the triple aim. Of the 10% of the Medicaid population who account for 70% of the costs, a majority of these individuals suffer from mental illness and/or SUD. Under our current Medicaid system, health care costs for people with serious mental illness are four times higher than the rest of the population. The plan recommended by the Essential Health Benefits (EHB) workgroup will have a direct impact on the health and wellbeing of hundreds of thousands of Oregonians who suffer from mental illness and/or SUD.

As an association whose members represent community mental health programs, local mental health authorities, and mental health organizations, all of which plan and coordinate the mental health system of care in their counties, we appreciate the opportunity to comment on the Essential Health Benefits selection process. In reference to two of your decision-making criteria in particular: 1) the impact of individuals moving to and from Medicaid; and 2) the health care needs of diverse segments of the population (including women, children, persons with disabilities, and others), we ask that you please consider the following four recommendations in making your final recommendation on the floor benefit.

1. **Ensure enforcement of the Oregon Mental Health Parity Act (2005) and the Federal Mental Health Parity and Addictions Equity Act (2008)**

As you may know, the 2008 Paul Wellstone and Pete Dominici Mental Health Parity and Addictions Equity Act (MHPAEA) and the Affordable Care Act (ACA) include provisions to: Increase access to care for individuals and families; Ensure access to ACA essential benefits through full MHPAEA implementation and enforcement; Ensure access to intermediate levels of care

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(intensive outpatient, partial hospitalization and residential); and Protect substantial gains made for individuals with behavioral health conditions. The MHPAEA financial requirements include: Copays and deductibles are the same for mental health as physical health care; Quantitative treatment limitations (e.g., visit limits) are no more restrictive than requirements and limits of medical/surgical benefits; Parity requirement for non quantitative treatment limits (medical management standard); May not impose lifetime annual dollar limit on MH or SUD benefits lower than medical/surgical benefits; MH/SUD benefits must not be limited to inpatient care only. The MHPAEA has not applied to small employers (50 or fewer) and only governs coverage if it is offered, but it does not require coverage. The Interim final regulations for MHPAEA went into effect on January 1, 2011.

Under the ACA, MHPAEA is expanded to cover benefits provided: in new Exchanges; to new small groups and individual plans; and to the new Medicaid population. Further, the ACA subjects all public and private plans to the Essential Health Benefits, both inside and outside insurance exchanges. There are some regulatory issues to be resolved or clarified, however, in the operationalization of mental health parity through the ACA: Disclosure of medical criteria used to make benefit determinations (otherwise, it is not possible to assess if plan complies with parity); Non-quantitative treatment limits; Definition of clinically recognized standard of care; Scope of service (i.e., levels of care should not be excluded).

As you also know, the State of Oregon has conforming legislation. The Oregon Mental Health Parity Law (SB 1, 2005) is stronger than the federal version, e.g., small group plans are included. One of the only additions needed to comply with ACA expansion is to include individual plans. In a recent study led by K. John McConnell, a health economist at Oregon Health and Science University, the researchers found that Oregon's parity law did not lead to costly mental health or addiction treatment. In fact, similar increases in spending on mental health and substance abuse were found in both groups of people in the study - those subject to parity and those who were not. The conclusion of the study was that virtually no expenditures were attributable to the parity law.

Oregon's parity law is one of the few among the states that does not allow restriction of care and prior authorization. We urge the State to require all plans subject to the EHB to comply with the requirements of the Oregon Mental Health Parity law and the MHPAEA. These parity requirements must apply to all financial requirements and treatment limitations on the scope and range of services and settings covered within any benefit classification.

2. **Cover prevention, early intervention, and innovative practices to achieve health outcomes and "bend the cost curve".**

It is not possible to assess the specific details of the Pacific Source small group plan from the "Benefit Differences by Benchmark Option" matrix provided at the EHB workgroup meeting, but cost was clearly the primary driver for the preliminary recommendation that was made on May 22, 2012. If Oregon selects a benchmark that limits some or many MH/SUD diagnoses and services, it cannot claim to offer MH/SUD benefits at parity while excluding many of the conditions/services under a category to treat those conditions (e.g., not covering non-SMI diagnoses or services).

Further, in order to truly bend the cost curve, and to yield better care and better health outcomes, the other

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two components of the Triple Aim in Oregon's Health Reform, there must be a shift in priorities to prevention, early intervention, and innovative practices. This will require innovation and flexibility in insurance plans, and a long term view of health - acknowledging that prevention programs earlier in life will result in less acute and chronic illness care later in life.

For example, in a study linking adverse childhood experiences to risk factors for chronic diseases, it was found that persons with adverse childhood experiences are more likely to have the risk factors for heart disease, cancer, stroke, bronchitis, asthma, diabetes, fractures, chronic headaches and pain. People with four or more categories of childhood exposure compared to none had 4 - 12 times increased health risks for alcoholism, drug abuse, depression, and suicide, and 2 - 4 times increased smoking, poor self-rated health, sexually transmitted disease, and 1.6 times the likelihood of low physical activity and severe obesity. The initial phase of the study, from 1995 to 1997, included 17,000 people insured by Kaiser Permanente and a follow-up study was conducted in five states in 2005. The findings indicated that adverse childhood experiences are common and associated with multiple mental and physical health problems. Implications from this study are to invest resources in evidence-based child abuse prevention programs, home visitations and parenting programs to prevent chronic mental and physical illnesses in adulthood.

A great example of an early intervention program that is conducted in many counties across Oregon is the Early Assessment and Support Alliance (EASA). EASA identifies young people in the early stages of schizophrenia and other psychotic disorders and ensures that they and their families have the proper resources to effectively deal with the illness. The program has shown marked reduction in hospitalizations, which equate to large savings, and participants are more likely to live independently, go to college, and retain employment.

Another reason for focusing more on prevention rather than sick care is the cumulative impact of twentieth century factors that have contributed to the burden of chronic disease: increased stress; sedentary lifestyle; over consumption but undernourishment; fragmented family and community ties; industrial pollution and devitalized food. This bears out the statistic that only 20-30% of chronic disease risk can be attributed to genes, while lifestyle accounts for 70-80% of chronic disease risk. Given the contributing factors to chronic disease, prevention is much more than immunization and early diagnosis - it runs the gamut from health professional advice to improve nutrition, increase exercise and exposure to sunlight, and to get enough sleep, to peer support and coaching to initiate behavioral changes relating to mental/physical illness, or addictions.

The human connection is the common factor in prevention and early intervention programs that helps people become and stay motivated to get healthy, a fact that was clearly acknowledged in the ACA by requiring health navigators, peer wellness specialists and community health workers to play large roles in the new health care system. It is important to ensure that these positions are adequately funded for upstream care to avoid downstream costs.

3. <u>Close the gap between the Medicaid and Commercial Plans' MH/SUD Benefit</u>

In order to maintain continuity of care for people who transition out of Medicaid to health insurance coverage, it is important to adopt a benchmark with an understanding of CCO implementation, including

its global budget, which requires flexibility in benefits to achieve the health outcomes needed to decrease the rise in medical costs. As an example, health navigation and peer support are rooted in the global budget to help steer people toward better health. Currently 11.6% of OHP funding is targeted to mental health vs. 6% for commercial plans, and 3% of OHP funding is targeted to SUD vs. 2% for commercial Plans (Milliman, commercial national averages). Our success in addressing behavioral health issues, which affect more than half of the 10/70 population, will determine the majority of cost savings. Considering the difference between the coordinated care organization world and the insurance world regarding flexible benefits and preventive measures, there will be a disincentive to moving out of Medicaid. The differences will need to be thoughtfully considered by the Oregon Health Policy Board and the Oregon Health Insurance Exchange Board to ensure continuity of quality care for individuals transitioning out of Medicaid and to avoid worsening health status.

Needs vs. Wants - What's the definition of medical necessity?

As mentioned in the May 22nd Essential Health Benefits Workgroup meeting, we have to determine whether a benefit is a need or a want. This comment led us to ponder how needs are determined. Mental Health Parity law does not define medical necessity, but it does require insurance policies to contain a single definition of medical necessity that applies uniformly to all medical, mental or nervous conditions, and chemical dependency. Thus, the standard of medical necessity is most often controlled by the insurer, not the treating professional. According to the Bazelon Center for Mental Health Law, "Medical necessity should be clearly defined to patients as well as physicians and other providers. Decisions made to deny the care recommended by a treating provider, based on the plan's definition of medical necessity, must be clearly explained. There should be a process for independent review, with decisions binding upon the health plan, and the application of medical necessity must take into account the individual's specific overall health care needs and circumstances." The Institute of Medicine states that "the concepts of individualizing care, ensuring value, and having medical necessity decisions strongly rooted in evidence should be reemphasized in any guidance on medical necessity. Inflexibility in the application of medical necessity, clinical policies, medical management, and limits without consideration of the circumstances of an individual case is undesirable and potentially discriminatory."

The interpretations of medical necessity and how they are operationalized, cited above, lead us to believe that the definition of medical necessity needs to be expanded to include treatment that prevents or ameliorates conditions that will become chronic or acute in the future. Secondly, in addition to the payer, the treatment provider and the individual should be involved in the determination of medical necessity.

4. **Maintain Transparency and Allow Consumer/Provider Participation in Annual Updates to Essential Health Benefits**

Health care consumers and providers should have regular opportunities to participate and influence the EHB determination process and its outcomes. The State should also implement a strong consumer and family education campaign to ensure that consumers understand: how to enroll and maintain enrollment in health coverage; the benefits available; and their rights concerning actions to correct violations and to appeal plan decisions.

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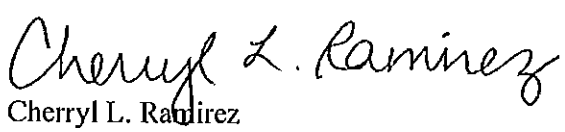
The EHBs should be reviewed and updated annually to ensure that plan enrollees are being well served and that EHBs reflect changes in medical and scientific advancements. As with many other diseases, there is currently much scientific progress being made in the prevention and treatment of MH and SUD. New evidence, research, and medical innovations will need to be adopted by the healthcare system as they are developed and proven.

Thank you again for the opportunity to provide feedback on the Essential Health Benefits Workgroup's preliminary recommendation. We strongly support the goals of the ACA to ensure that all Americans have access to high-quality, affordable health care, including comprehensive care for mental health and substance use disorders. The Triple Aim, Oregon's goals for health reform, cannot be achieved without innovative and integrated MH and SUD prevention and early intervention treatment, supported by all payers of the health care system. We appreciate your consideration of our comments and look forward to working with you further on the development and implementation of the Essential Health Benefits and related provisions. Please contact us if you have any questions or if we can be of assistance.

Sincerely,



Cherryl L. Ramirez
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Sources:

"Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults," Vincent J. Felitti, MD, American Journal of Preventive Medicine, et al., 1998.

Institute of Medicine's Report – "Essential Health Benefits: Balancing Coverage and Cost," released October 7, 2011.

Coalition for Whole Health Response to Health and Human Services on Essential Health Benefits, January 2012.

Bazelon Center for Mental Health Law.

"Understanding Parity and the New Parity Initiative", Henry Harbin and Carol McDaid, Parity Implementation Coalition, March 27, 2012.