Barriers to SUD Integration with Health Care Reform

September 16, 2010

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Opening Points

- Health care reform will reshape what exists today
- Health Care Reform implementation in California will be very challenging because:
  - Existing health programs and financing are complicated
  - The State-County relationship is complicated
  - High degree of variability in local programs
- This presentation will illuminate some major elements, but will be incomplete

Major Public Programs

- Public sector medical sites of varying types (FQHC and other CHC's, ER's, primary care clinics, community hospitals) are now hosting SU/Healthcare integrated care initiatives despite infrastructure/IT challenges, rigid categorical financing requirements, workforce and training issues
- Sustaining such efforts requires motivation, flexible funding, "product/deliverables" , organization champions and staffing, and marketing initiatives.

Financing

- Nature of financing sources: categorical, multiple reporting and auditing requirements, specific requirements re: same day services, provider and organization/setting eligibility differences
- Sustainability of funding challenged by budget deficits and need to minimize costs
- Types of funding sourced for integrated MHSA/Healthcare care efforts:
  - Medicaid (DMC), Medicare, Self-Pay, Public Sector and Foundation Grants, HRSA, HRSA-Ryan White, HRSA-FQHC, state general revenues, voluntary non-profit sector

Financing

- Examples of financing issues:
  - Prohibitions re “mixing” categorical funding
  - Disassembling “bundled” charges difficult
  - Access impeded to SA interventions in primary care by co-pays for these often indigent or low income clients with multiple health issues
  - Public payor reimbursement rates set low and sometimes declining for procedures and for providers
  - State by State regs re Medicare/Medicaid “same day” billing for health and behavioral health visits

Financing

- Financial issues:
  - Denials issued by payors
  - Inflexible or inaccurate billing and coding systems
  - UM and preauthorization requirements, standards and performance reqs
  - Providers lack of knowledge or motivation to use reimbursable codes for procedures

Small Providers

- Small providers have little capacity to bill, manage a 90-120 day reimbursement cycle, comply with workforce requirements of new payers
- Small providers will need assistance to merge or be acquired if they are to survive
- Providers will need assistance to develop new alliances and organizational relationships and to manage increased competition

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Other Issues

- Other infrastructure issues:
  - Credentialing/staffing requirements
  - Recruiting and retaining key staff
  - Training issues: new paradigms and emerging techniques
  - IT systems/EHR and EMR investments
  - New types of staff needed, especially for care coordination, patient “connector” types of roles

Other Issues

- Internal organizational challenges
  - Constant budget cuts in public services inhibit innovation and de-motivate staff
  - Providers may not be in synch with integrated SU/Health services; new models of care may threaten existing paradigms and hierarchic organizational designs
  - Lack of recognition and incentives for integrated care
  - Lack of community demand and outcome studies to support continuing need for innovative SU/healthcare services

Mental Health Parity Alcohol Equity Act (MHPAEA)

- MHPAEA of 2008 provides participants who ***already have benefits*** under MH and SUD coverage parity with benefits limitations similar under their med/surg coverage.
  - Parity is a good thing.
  - Implementation adds another layer of complexity to an already complex problem of HCR.

MHPAEA

– "A non-quantitative treatment limitation." Plan is also non compliant when providers do not meet eligibility and credentialing requirements or the program is not approved by RIBCBS. (ADAW 7/26/10)

MHPAEA

- Title 22. DMC – California Alcohol and Drug Programs.
  - "medical necessity"
    - policy clauses to try to limit coverage
      - Psychiatric Services, December 2009

Questions

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