Position Statement 71: Health Care Reform

Policy

Mental Health America (MHA) believes that all individuals and families should have access to mental health services that are responsive to their needs. This requires minimizing barriers, providing multiple referral and service pathways, redesigning services that are more culturally and linguistically competent[1] and evidence-based,[2] and expanding access in rural and inner-city areas to community-based systems of mental health and substance use services and supports that are integrated with medical care. MHA particularly advocates dedicating new funding "B4stage4."[3] To promote wellness and recovery, governmental initiatives should promote mental health[4] and prevent mental illness[5] and identify people at risk as soon as symptoms become apparent.

Background

As of February 22, 2016, the Patient Protection and Affordable Care Act, commonly known as the ACA, extended health insurance coverage to an estimated 20 million people through a combination of state-based private insurance exchanges, Medicaid expansion, and allowing individuals up to the age of 26 to remain on their parents' health insurance.[6] In addition, the ACA included a number of reforms to curb harmful insurance company practices, to slow the growth of health care costs, and to improve quality of care.[7]

The ACA also took ground-breaking steps toward improving access to mental health and substance use disorder treatment services. Significantly, the ACA includes mental health and substance use disorder services as well as rehabilitative services as components of the "Essential Benefits" package that must be offered to cover the uninsured. The ACA also extended provisions of the Mental Health Parity and Addiction Equity Act to more plans, so now more health insurance plans must offer mental health and substance use benefits on parity with medical and surgical benefits.

Since the passage of the ACA, health care has continued to evolve. In 2015, Congress passed the Medicare Access & CHIP Reauthorization Act, which tasked the Department of Health and Human Services (HHS) to begin paying for value over volume (sometimes called "value-based payment") through Medicare, as well as to encourage more providers to participate in alternative-payment models, which are different ways of paying for health care other than by reimbursing fees-for-service that pay providers based on how many procedures they perform.[8] While these reforms are specific to Medicare, they may set the tone for a larger movement in health care. HHS set the goal that 90% of its Medicare payments to be tied to quality in some way by 2018, and launched the Health Care Payment Learning and Action Network, along with a number of other initiatives, to ensure that Medicaid and private health insurance carriers begin to work together to transition toward alternative-payment models and value-based payment.[9]

These reforms, along with an increasing focus on public health promotion, prevention of illness and community engagement, represent a movement toward population health in which systems work to constantly improve health outcomes, meet the needs of individuals, and reduce total costs.[10] MHA supports the movement toward population health and is working to ensure that health care systems more effectively promote and sustain healthy mental development and

address individuals' mental health needs. But MHA emphasizes that these reforms must be carried out in a way that encourages more providers to accept federal insurance, since the dearth of providers available to serve people with mental illnesses who are dependent on federal and state medical insurance is reaching crisis levels, especially in rural areas.[11]

Major Principles of a Modern Behavioral Health System

As health care reform continues to evolve, MHA will work to ensure that our health care system is more integrated and more effectively meets individuals' needs. MHA believes that an effective system is one that:

Provides comprehensive health insurance coverage to all Americans that affords access to mental health and substance use services that are effective, high-quality, culturally and linguistically appropriate, integrated, person-centered, trauma-informed, strengths-based, affordable and accessible. This should include prevention, early-intervention, treatment, and rehabilitation services, including promising as well as proven, evidence-based practices, which address the continuum of behavioral health needs.

Makes treatment knowledge accessible to individuals and providers for shared decision-making in treatment planning, including comprehensive information from clinical studies and the prevalence of side-effects, comparative effectiveness research, and research on orphan drugs for which the market does not justify the required investment.

Incentivizes providers to promote positive mental development and prevent mental health conditions.

Empowers individuals in treatment for mental health conditions to be engaged and at the center of every level of the health care system that serves them, including in the management and provision of care.

Provides screenings for mental health conditions and continuously and regularly evaluates the healthy mental development of individuals, both during visits and online so individuals can get help as soon as a need arises. All services should ensure that individuals understand their own mental health issues and what they can do to promote wellness, prevent illness and treat difficulties, so that they can evaluate their mental health, support others, and seek treatment as soon as it becomes appropriate.

Identifies how information technology, like Electronic Health Records (EHR) and Personal Health Records (PHR's), can support individuals to share important information for their care. Information shared should be driven by clients with recovery as a goal. Tools should be easily accessible by physical and mental health providers to support coordinated care. EHR's and PHR's could include assessments, treatment plans, treatment options, progress, and goals identified by individuals in recovery. When willing, information provided by clients can be utilized within a learning healthcare system to improve innovation and outcomes.

Focuses on recovery as the goal – Providers should ask about the individual's strengths, challenges, and goals, and the individual and the provider should work together through shared decision-making to design a treatment plan, coordinate supports, and measure the effectiveness of care based on supporting the individual in meeting the identified goals, as they evolve.

Provides flexibility for individuals and providers to best meet the individuals' needs and experiment with innovative approaches, such as capitated payment models, use of peer support specialists, and self-directed care. The effectiveness of the flexible services should be rigorously measured with person-reported, recovery-oriented outcomes, and high-quality care should be financially rewarded and used as an opportunity for shared learning throughout the health care system.

Seamlessly integrates behavioral healthcare services with primary care and other services in interdisciplinary teams, with the focus on the individual as the center of the health care system. Enables peer specialists to support an individual outside of office visits as needed, including home visits and ongoing communication and services in the community.

Gives individuals control over what information is shared and with whom it is shared, including allowing individuals to authorize sharing information between health care systems.

Integrates with other social systems such as education and housing to provide the most effective support for the person in treatment, ensures there is "no wrong door" to receiving care, and provides incentives to focus on the individual as the center of the health care system, with due regard for family, community, and social determinants of health.

Provides transparency in a way that allows people in treatment to make educated choices about their healthcare, providers to learn from one another and the individuals they treat to better promote health and treat illness, government agencies to ensure regulatory compliance, and researchers to study and improve the health care system.

Call To Action

People in recovery, advocates and providers should ensure that legal mandates (statutes and rules) and health care insurance plans assure the following:

Meaningfully engage individuals in recovery at every level of the health care system and clinical research to promote effective, person-centered care.

Enforce parity in reimbursement for mental health and substance use services, including for services provided in primary care, and assure network adequacy so that services are available when needed.

Support the movement toward value-based payment and the use of alternative-payment models to ensure effective, flexible, and integrated care. This includes ensuring that the value in value-based payment is person-reported and recovery-oriented, as well as indicative of longer-term outcomes that ensure that providers have incentives for promotion and prevention. Providers should be trained appropriately in shared decision-making, early intervention, and promoting positive development.

Expand incentives for use of information technology including EHR's and PHR's, in order to facilitate integration of behavioral and general health. Ensure that use of information technology is driven by individuals in recovery with recovery as a goal. Promote sharing of information by physical and mental health providers to support coordinated care. Incentivize use of information technology to support learning healthcare systems. Repeal 42 CFR Pt II to allow for integration of health care and addiction treatment information.[12]

Reimburse services by certified peer specialists and provide assistance to health care systems in integrating peer specialists.

Require greater transparency from agencies, health plans, hospitals, and other providers, making public enough information to demonstrate that they are complying with all mandates, including the ACA and parity. People in recovery should have access to all relevant plan information before they purchase a plan, including medical necessity guidelines and covered services. Parity guidance should be issued to elaborate on compliance with non-quantitative treatment limitations (NQTLs), and require disclosure of all documentation necessary to demonstrate compliance with parity requirements. State agencies should be transparent about their oversight efforts, including investigations of parity, network adequacy, and fairness in plan design, including an evaluation of the risk of high deductibles.

Require healthcare plan disclosure of actual availability of providers for people in need of treatment and waiting lists to allow states and employers and people evaluating the plan to make informed judgments of network adequacy. Where specialty care is not available, plans should not be allowed to waive the network adequacy requirements, but rather should be required to make plans to provide other forms of access, including the use of telehealth, training peer specialists, and innovative uses of technology to increase access.

Require greater transparency from pharmaceutical companies, making all available clinical studies public and disclosing the frequency of all adverse events in those studies and in all subsequent studies conducted by the companies or known to them. Improve FDA oversight of post-market studies to provide ongoing disclosure of the frequency of adverse events and to consider additional label disclosure when merited. Consider requiring additional controls to limit the risk of bias in clinical studies, for example, using and documenting intention-to-treat analysis instead of per protocol analysis..[13] Fund and disclose post-market comparative effectiveness research and clinical studies of orphan drugs and drugs frequently prescribed for off-label uses.

Require periodic review and revision of medical necessity and practice guidelines to ensure that they comport with research in effective behavioral health care and modern practice in community behavioral health, allowing for access to the full continuum of effective care.

Effective Period

The Mental Health America Board of Directors adopted this policy on June 14, 2016. It is reviewed as required by the Mental Health America Public Policy Committee

Expiration: December 31, 2021

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1. See MHA Position Statement 18, Cultural and Linguistic Competency

2. See MHA Position Statement 12, Evidence-based Healthcare

3. MHA's work is guided by its Before Stage 4 (#B4Stage4) philosophy – that mental health conditions should be treated long before they reach the most critical points in the disease process—and driven by its commitment to promote mental health as a critical part of overall wellness, including prevention for all, early identification and intervention for those at risk,

integrated health, behavioral health and other services for those who need them, and recovery as a goal.

4. See MHA Position Statement 17, Promotion of Mental Wellness

5. See MHA Position Statement 48, Prevention

6. https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf

7. http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html

8. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

9. http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html

10. http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/

11. See, e.g., Gray, J.S., Rural Mental Health Research White Paper, published by University of North Dakota School of Medicine and Health Sciences, Center for Rural Health (September, 2011), full text available online at https://ruralhealth.und.edu/pdf/j_gray_nimh_white_paper.pdf

12. https://mhanational.org/issues/integration-confidentiality-protected-health-information

13. See, e.g., Recommendations by Cochrane Review Groups for Assessment of the Risk of Bias in Studies, http://www.biomedcentral.com/1471-2288/8/22/